DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPRACTORS OF ONTARIO

PANEL:	Dr. David Starmer (Chair)	Professional Member
	Ms. Georgia Allan	Public Member
	Ms. Karoline Bourdeau	Public Member
	Dr. Angela Barrow	Professional Member
	Dr. Liz Gabison	Professional Member

BETWEEN:	)	Appearances:[1]
COLLEGE OF CHIROPRACTORS OF ONTARIO	)	Mr. Chris Paliare and Ms. Karen Jones for the College of Chiropractors of Ontario
- and -	)	
DR. DAVID SANGSTER (Registration #5404)	)	Ms. Valerie Wise and Mr. Brendan Farrer for Dr. Sangster
	)	Heard: March 19, 2018

Also present at the hearing were:

Mr. Paul Le Vay - Independent Legal Counsel to the Panel
Ms. Jo-Ann Willson - Registrar and General Counsel CCO
Ms Lydia Pak - Court Reporter

[1] Also in attendance at the hearing were: Mr. Paul Le Vay, Independent Legal Counsel to the Panel; Ms. Jo-Ann Willson, CCO Registrar, and General Counsel; and the Court Reporter, Ms. Lydia Pak.

DECISION AND REASONS

INTRODUCTION

A hearing into allegations of professional misconduct against Dr. David Sangster ("Dr. Sangster" or the "Member") took place before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College" or "CCO") on March 29, 2018. The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest.

The Panel found that the Member engaged in professional misconduct by breaching subsections 51(1)(c) and (c) of the *Health Professions Procedural Code* of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraphs 1(2), (21), (22), (23) and (33) of *Ontario Regulation 852/93*. Below we explain that decision.

THE ALLEGATIONS

The allegations against the Member, were stated in a Notice of Hearing, dated October 28, 2016. The Notice of Hearing was filed as Exhibit 1. The allegations set out therein are as follows:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation 852/93*, in that in 2014 and/or 2015, at Health in Hand Chiropractic in Kitchener, Ontario, you contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to your communications, documentation and/or billing of professional services for a patient known as "Patient A."

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(21) of *Ontario Regulation 852/93*, in that in 2014 and/or 2015, at Health in Hand Chiropractic in Kitchener, Ontario, you falsified a record or records regarding a patient known as "Patient A."

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(22) of *Ontario Regulation 852/93*, in that in in 2014 and/or 2015, at Health in Hand Chiropractic in Kitchener, Ontario, you signed or issued, in your professional capacity, a document or documents that you knew contained false or misleading statements regarding a patient known as "Patient A."

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(23) of *Ontario Regulation 852/93*, in that in 2014 and/or 2015, at Health in Hand Chiropractic in Kitchener, Ontario, you submitted an account or charge for services that you knew was false or misleading regarding billing for professional services for a patient known as "Patient A."

5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that in 2014 and/or 2015, at Health in Hand Chiropractic in Kitchener, Ontario, you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to your conduct, communication, documentation and/or billing regarding a patient known as "Patient A."

THE EVIDENCE

An Agreed Statement of Facts (**Exhibit 2**) was filed. It was a lengthy document. It provided as follows:

The Member

1. Dr. David Sangster ("Member") has been a member of the College of Chiropractors of Ontario ("CCO") since 2007. During the relevant time, he practiced chiropractic at his clinic, Health at Hand, in Kitchener, Ontario ("Clinic").

2. The Member has not been the subject of a previous Discipline Committee hearing.

Background

FSCO

3. The Financial Services Commission of Ontario ("FSCO") regulates insurance in Ontario, including auto insurance. It also regulates service providers who invoice auto insurers for statutory accident benefits claims. For example, FSCO determines which regulated health professions can deliver insured services to persons injured in auto accidents in Ontario and the circumstances under which they can bill insurance companies for such services.

4. Among other things, FSCO prescribes and enforces policies and processes. It has developed standardized Auto Insurance Claims Forms ("OCF Forms") which must be used when claiming insurance coverage for damages suffered in auto accidents.

HCAI

5. Health Claims for Auto Insurance ("HCAI") is an electronic system for the exchange of standardized health claim information between health care providers and insurance companies. A health care practitioner could submit certain OCFs to an insurer through their HCAI account and receive information from an insurer about the status of the claim, such as whether a treatment plan was approved, and whether an invoice would be paid. In 2014, all Ontario auto insurers, as well as health practitioners that treated insured people injured in auto accidents, were required to use the HCAI system. Health practitioners had to be registered with HCAI.

6. The following OCFs and insurer decisions regarding OCFs are transmitted via HCAI:

- Treatment Plan (OCF-18)
- Standard Invoice (OCF-21)
- Treatment Confirmation Form (OCF-23)

7. Other OCFs or other insurance documents are handled outside of the HCAI system by fax or mail.

8. The OCFs that are submitted electronically through HCAI are not signed by either the health practitioner or the claimant. Health practitioners who submitted OCFs via HCAI are required to retain copies of original claims forms signed by the claimant and the health practitioner as well as the documents that gave rise to a claim.

The MIG

9. In 2011, the Superintendent of FSCO issued the Minor Injury Guideline (the "MIG") which set out a FSCO-approved process for the treatment of uncomplicated musculoskeletal injuries caused by auto accidents. The MIG was updated in February 2014 and remains in effect today.

10. A health practitioner is required to follow the MIG when treating or supervising the services provided to a person making an insurance claim for injuries suffered in an auto accident ("claimant") when a claimant's injuries fall within the MIG.

11. In 2014, the maximum initial cost allowable for treatment under an OCF-23 was $2,200.00, including the fees for the health practitioner to fill in the form.

12. The treatment permitted by an OCF-23 occurs over 12 weeks, which is divided into 3 blocks, each of a 4 week duration. If an insured person reaches maximal recovery within a block, the claimant is discharged from the MIG. If the insured person requires additional intervention after the first block, the health practitioner continues to treat under the subsequent block, until the claimant reaches maximum recovery.

13. An insurer pays for treatment under the MIG as follows:

- Fee for initial examination/consultation: $215 (this includes the completion of an OCF-23)
- Fee for block one: $775
- Fee for block two: $500
- Fee for block three: $225

14. Under certain circumstances, a health practitioner can provide guidance, advice, coaching, or counseling ("Monitoring") to a claimant in lieu of any treatment in a block so long as treatment under block 3 has not commenced. The most that a health practitioner can charge for Monitoring is $200.00/block. A health practitioner cannot charge for treatment and Monitoring in the same block.

15. Additional funds up to a maximum of $400.00 are available under the MIG to provide supplementary goods and services to support restoration of functioning, such as treatment services for additional minor injuries arising from an accident, goods for self-directed exercise and/or pain management, assistive devices, and psycho-social interventions.

The OCFs

16. The OCF-1 (Application for Accident Benefits) is the form an applicant uses to apply for insurance benefits for the first time as a result of an accident. The applicant provides information to the insurer about contact information, the health care provider, the accident, insurance coverage, employment and caregiver status, and the effect of injuries caused by the accident on the person's ability to work, caregive, and attend school.

17. The OCF-3 (Disability Certificate) is a form used to apply for a specified benefit such as the income replacement benefit, non-earner benefit, caregiver benefit or housekeeping and home maintenance. Persons are only entitled to such benefits if they are unable to carry on with their normal lives after an auto accident. The applicant fills out Parts 1 to 3 and gives the form to the health practitioner to complete Parts 5 – 10. The applicant signs Part 4 after the health practitioner completes the form.

18. The OCF-5 (Permission to Disclose Health Information) is a form signed by the patient that authorizes their health practitioner to provide health information to the insurer or a person appointed by the insurer to examine the patient.

19. The OCF-23 (Treatment Confirmation Form) is usually the first form provided by a health care practitioner to an insurer via HCAI. The form is completed by the applicant and the health care provider and provides information to the insurer about the applicant, insurance coverage, the health practitioner, and the health status of the applicant. The patient supplies the information for Parts 1 – 3 of the form. The chiropractor completes parts 4 – 7. The patient signs the form after the chiropractor has explained the proposed treatment to the patient and the patient consents to the treatment. The insurer uses the information to determine whether the applicant is covered by an insurance policy, and has injuries that fall within the MIG (i.e., is eligible to receive treatment under the Minor Injury Guideline). An insurer responds to an OCF-23 electronically through HCAI.

20. The OCF-24 (Minor Injury Treatment Discharge Report) is completed by a health practitioner and sent to the insurer after the health practitioner has assessed the patient and determined the patient has reached maximal recovery. The OCF-24 is used to discharge the patient from the MIG or at the end of the MIG.

21. An OCF-18 (Treatment and Assessment Plan) is completed by a health practitioner if an insured person still requires further treatment after completing 12 weeks of treatment under the MIG. The form is signed by the patient after it is completed. The health practitioner sends the completed OCF-18 to the insurer via HCAI, who can approve or deny the proposed treatment plan. Under the MIG, if an insurer approves further treatment, funds up to a maximum of $3,500.00 (including the original $2,200.00) are available for treatment and services.

22. When the treatment under the MIG or an approved OCF-18 is completed, the health practitioner sends the insurer an OCF-21 (Auto Insurance Standard Invoice) through HCAI.

23. Health practitioners who provide care to persons who have been injured in motor vehicle accidents and who are making claims to insurers are required to provide true and correct information on OCFs to insurers. Health practitioners are also responsible for proposing and providing goods and services that are reasonable and necessary for the treatment and rehabilitation of injuries suffered in the accident.

24. Many of the OCFs involving a health practitioner require the health practitioner to sign a declaration certifying the information provided on the form is accurate, that he or she has reviewed the completed document with the applicant, and that the goods and services contemplated or provided are reasonable and necessary for the treatment and rehabilitation of injuries suffered in the accident.

25. It is an offence under the Criminal Code of Canada to defraud or attempt to defraud an insurance company using deceit, falsehood or other dishonest act, and it is an offence under the *Insurance Act* to knowingly make false or misleading representations to an insurer. The standards of practice for chiropractic require documentation by a chiropractor to be accurate, truthful and comprehensive.

26. FSCO prescribes the maximum fees that may be charged by a health practitioner to an insurer for completing certain of the OCFs. For example, a health practitioner can charge:

a. $85.00 for completing a Minor Injury Discharge Report (OCF-24);
b. $200.00 for completing a Disability Certificate (OCF-3); and
c. $200.00 for completing a Treatment and Assessment Plan (OCF-18).

Patient A.

27. On May 22, 2014, "Patient A." was in a car accident. She was the passenger in a car and another car backed into the car she was riding in, hitting her side of the car.

28. Patient A. had a pre-existing back injury and the car accident exacerbated the injury, causing increased back pain. Patient A. was able to carry on her normal life after the accident, including performing housework, looking after her children, and looking for employment.

29. Patient A. had recently returned to Canada after 3.5 years of being out of the country. She had no job, no income, and no health insurance. Patient A. and her 5 children were staying with a friend until the children's school was completed for the year on June 28, 2014.

30. At the time of the accident, Patient A.'s address was 31 Frankfurt Street, Kitchener, Ontario.

31. After the school year was completed on June 28, 2014, Patient A. and her children moved to a shelter until she could find a place to live. They were at the shelter for 6 weeks, until the 15th of August, 2014. The address of the shelter was 84 Frederick Street, Kitchener.

32. Patient A. then rented an apartment, and, during the period August 15, 2014 to November 2016, her address was 294 Chandler Drive, Kitchener.

33. Patient A. was covered by the insurance of the owner of the car that had been hit. The insurer, Peel Maryborough Mutual Insurance ("Insurer") sent Patient A. a package, "Accident Benefits Coverage in Canada" which included an OCF-1 Application for Accident Benefits Form. Patient A. filled out the OCF-1 on June 27, 2014 and returned to the Insurer by mail.

34. On July 4, 2014, the Insurer advised Patient A. in a letter that she had up to $3,500.00 for treatment, subject to any collateral or specific benefits, such as income replacement benefits, non-earner benefits, caregiver benefits, housekeeping benefits, and attendant care benefits, that she had available to her in accordance with the MIG.

35. Although the OCF-1 was not completely filled in by Patient A., the Insurer was able to ascertain from it that Patient A. did not qualify for collateral or specified benefits under the MIG as she was not employed, and was able to carry on a normal life.

36. On July 14, 2014, Patient A. attended at the Clinic and saw the Member. The Member did an assessment, sent her for an x-ray, and told her that she would be on maintenance treatment until her back was better. She signed an Informed Consent to Chiropractic/Acupuncture Treatment. The Member adjusted her back.

37. At the July 14, 2014 appointment, Patient A. was oriented to the Member's appointment system. His appointments were managed online. Patients could schedule or cancel appointments on line and would receive electronic appointment and cancellation confirmations from the Clinic. Patient A. was also given two blank insurance forms, an Application for Accident Benefits (OCF-1) and a Disability Certificate (OCF-3). There was yellow highlighting on the forms indicating the areas she was supposed to fill out. She was instructed to take the forms home, fill in the portions that were highlighted, and return the documents to him.

38. On July 14, 2014, the Member completed a Treatment Confirmation Form (OCF-23) which provided for treatment costing $2,280.71 and sent it electronically to the Insurer.

39. Although the Member was required to retain a copy of the original OCF-23 signed by both himself and Patient A. in his chiropractic record for Patient A., he did not do so. Instead, the OCF-23 in the Member's file contains the Member's signature in ink. Patient A.'s signature is a "cut and paste" copy of her signature from the Informed Consent to Chiropractic/Acupuncture Treatment form that Patient A. signed on July 14, 2014.

40. Patient A. began receiving treatment pursuant to the MIG on July 14, 2014. She received chiropractic treatments from the Member and massage therapy treatments from a Registered Massage Therapist ("RMT").

41. On July 21, 2014, the Insurer sent the Clinic an electronic OCF-23 Insurer fax back, confirming Patient A. was covered by an insurance policy and was eligible for the MIG.

42. On July 22, 2014, the Insurer sent Patient A. a letter indicating it had received an OCF-23 from the Clinic, and that, pursuant to the MIG, it had partially approved the treatment plan and would approve $2,200.00 in treatment.

43. Patient A. had taken the two insurance forms she received from the Clinic on July 14, 2014 home and forgotten them. The Member reminded her about the forms, and, on July 29, 2014, she completed the highlighted areas on the two insurance forms and took them in to the Member. On the OCF-3, she had completed parts 1, 3, and signed Part 4 and signed the form. Later, someone else completed other parts of the form, including misspelling her name in Part 4. On the OCF-1, Patient A. had completed Part 1, the description of accident part in Part 3, the information about vehicle ownership in Part 4, Part 7, the "N/As" in Part 8 and Part 9, and she signed and dated the form. She did not see the forms again after she gave them to the Member.

44. Patient A did not complete an OCF-5 (Permission to Disclose Health Information). The Member completed an OCF-5, which contains incorrect information. Patient A.'s address on the OCF-5 was the address she lived at from April 9, 2014 to June 27, 2014, prior to moving to the shelter on June 28, 2014. As well, although Patient A. first saw the Member on July 14, 2014, the OCF-5 is dated June 27, 2014.

45. The OCF-1, OCF-3, and OCF-5 were sent to the Insurer by mail by the Member and were received by the Insurer on August 12, 2014.

46. The OCF-3 received by the Insurer was incomplete, in that the parts of the form that had to be completed by the health practitioner had not been completed.

Although the OCF-3 was not complete, the information on the OCF-1 confirmed Patient A. was not eligible for collateral or specific benefits because she was not employed, could carry on her normal life and had not sustained an injury beyond the MIG. Therefore, there was no need for the Insurer to obtain a completed OCF-3 to adjudicate Patient A's claim. The Insurer never asked Patient A. or the Member to provide a completed OCF-3.

47. On August 12, 2014, the Insurer sent a letter to Patient A at the shelter address, indicating it had received the OCF-1, the OCF-3, and the OCF-5. However, Patient A. had already moved from the shelter and did not receive the letter. The letter was returned to the Insurer marked "Return to Sender" on September 26, 2014.

48. On September 6, 2014, the Member completed an OCF-24 (Minor Injury Treatment Discharge Report), indicating Patient A. required additional intervention outside of the MIG and that he would be submitting a Treatment and Assessment Plan (OCF-18).

49. Patient A.'s treatment under the MIG ended on September 30, 2014. The Member did not advise Patient A. that her treatment under the MIG had ended. He also did not advise her that she could apply for additional treatment. Patient A. did not see the Member after September 30, 2014 until October 20, 2014.

50. On October 8, 2014, the Member faxed the OCF-24 to the Insurer. The Insurer received a similar OCF-24 from the Member again by fax on October 9, 2014.

51. On October 9, 2014, the Member sent an Auto Insurance Standard Invoice (OCF-21) to the Insurer, claiming $1,800.00 for services and treatments he had provided to Patient A. under the MIG. The Member also claimed for $400.00 for Supplementary Goods and Services, which he indicated he had provided to Patient A. on July 16, 2014. In fact, the Member himself did not provide any Supplementary Goods or Services to Patient A.

52. Had he testified, the Member would have said the $400.00 for Supplementary Goods and Services actually referred to six registered massage treatments administered by the RMT.

53. On October 17, 2014, the Insurer paid the Member $2,200.00 directly for the fees set out in the OCF-21. The Insurer did not send anything to Patient A. regarding the receipt or payment of the OCF-21.

54. Patient A. had a massage with the RMT on October 14, 2014 and a chiropractic treatment from the Member on October 20, 2014. She believed the treatments were being paid for by the Insurer as she did not know she had been discharged from the MIG.

55. Other than her treatment from the Member on October 20, 2014, Patient A did not receive any treatment from the Member between September 30, 2014 and January 8, 2015. During the period November 4, 2014 to December 5, 2014, Patient A. was taking a course.

56. On December 12, 2014, the Member sent Patient A. an email asking her to book an appointment as she had not been in the Clinic for a while.

57. Patient A. resumed treatment with the Member on January 8, 2015. Patient A. had been taking a bus to her class in November and December and her back had started hurting again. Once her course was over and the holidays had finished, she started scheduling treatment from the Member again.

58. Patient A. received chiropractic treatment from the Member on January 8, 2015, January 14, 2015, January 22, 2015, January 29, 2015 and February 5, 2015. Patient A. also had a massage from the RMT on January 22, 2015. The Member did not tell Patient A. during that period that she was discharged from the MIG, that he intended to send a Treatment and Assessment Plan (OCF-18) to the Insurer for treatment that had already been provided, or that he intended to bill the Insurer for treatment provided under the OCF-18, assuming it was approved.

59. On February 12, 2015, the Member sent a Treatment and Assessment Plan (OCF-18) dated October 9, 2014 via HCAI to the Insurer. The proposed plan, which required approval from the Insurer, was for sessions of physical therapy provided by the Member, two sessions of therapy provided by the RMT, the completion of the OCF-18, and the completion of a Disability Certificate (OCF-3).

60. An OCF-3 was not required by the Insurer or otherwise needed by Patient A.

61. Patient A. had an appointment with the Member scheduled for February 17, 2015. However, she cancelled her appointment with the Member at the last minute because she was ill. At the time, Patient A. had to take a bus to the Clinic, and riding on the bus hurt her back. Patient A. decided that she would wait and get further treatment from the Member after she had recovered from her illness and could afford gas for her car so she could drive to the appointments.

62. On February 18, 2015, the Insurer sent Patient A. a letter informing her the Member had submitted an OCF-18 and that the Insurer would pay for the goods and services described in the plan. The letter was sent to an old address and was not received by Patient A. The letter was returned to the Insurer with the envelope marked "Moved Return to Sender" on May 28, 2015.

63. On February 24, 2015, the Insurer received an OCF-21 dated February 24, 2015 via HCAI from the Member for the goods and services provided under the OCF-18. The OCF-21 indicated, among other things, that the Member had completed an OCF-3 on October 9, 2014 and had provided physical rehabilitation

to Patient A. on October 14, 2014, November 4, 2014, November 19, 2014, December 4, 2014, December 22, 2014, and February 17, 2015.

64. "Physical rehabilitation" for a chiropractor means an in-person treatment session.

65. In fact the Member never provided the OCF-3 to the Insurer and he did not provide the physical rehabilitation set out above in paragraph 63 to Patient A.

66. On March 26, 2016, the Insurer paid the fees set out in the OCF-21 to the Member.

67. Patient A. received a call from the Insurer on March 26, 2015. The Insurer informed her, among other things, that she had been discharged from treatment and had been given exercises to do at home by the Member. The Member never told Patient A. that she had been discharged.

68. Patient A. then called the Member and left him a voice mail. The Member did not respond to her. On July 6, 2015, Patient A. sent the Member an email, asking if he had discharged her and, if so, to confirm the discharge and/or send her a copy of his statement for her treatments. The Member never responded to Patient A.'s email.

Admissions

69. The Member admits, based on the facts set out above, that he committed acts of professional misconduct as set out in the Notice of Hearing dated October 28, 2016, and in particular:

a. he contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to his communications, documentation and billing of professional services as set out in Allegation #1;

b. he falsified a record or records regarding Patient A. as set out in Allegation # 2;

c. he signed or issued, in his professional capacity, a document or documents that he knew contained false or misleading statements regarding Patient A. as set out in Allegation #3;

d. he submitted an account or charge for services that he knew was false or misleading regarding professional services for Patient A., as set out in Allegation #4; and

e. he engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional with respect to his

conduct towards, communication, documentation and billing regarding Patient A. as set out in Allegation #5.

Other

70. The Member agrees that he obtained independent legal advice from his lawyer, Valerie Wise, prior to signing this Agreed Statement of Facts, and that is signing the Agreed Statement of Facts freely and voluntarily.

FINDINGS OF PROFESSIONAL MISCONDUCT

The Panel accepted the facts as set out in the Agreed Statement of Facts (Exhibit 2). Having considered those facts, as well as the Member's admissions of professional misconduct, the Panel found that the Member engaged in the forms of professional misconduct described in paragraph 69 of Exhibit 2, which mirror the allegations in paragraph 1-5 of the Notice of Hearing (Exhibit 1). In light of his answers to the Chair's questions, the Panel was satisfied that the Member's admissions of professional misconduct were voluntary, informed and unequivocal. Therefore, the panel finds that the Member:

a. contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to his communications, documentation and billing of professional services as set out in Allegation #1;

b. falsified a record or records regarding Patient A. as set out in Allegation # 2;

c. signed or issued, in his professional capacity, a document or documents that he knew contained false or misleading statements regarding Patient A. as set out in Allegation #3;

d. submitted an account or charge for services that he knew was false or misleading regarding professional services for Patient A., as set out in Allegation #4; and

e. engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional with respect to his conduct towards, communication, documentation and billing regarding Patient A. as set out in Allegation #5.

PENALTY AND COSTS SUBMISSIONS

Following the Panel advising the parties of our decision on the findings of professional misconduct, they presented us with a Joint Submission as to Penalty and Costs (the "Joint Submission"; Exhibit 3) which provided as follows:

Further to the pre-hearing conference of March 27, 2017 held before Dr. Drew Potter, and in view of the Agreed Statement of Facts and of the Undertaking which is attached as Appendix "A" to this Joint Submission on Penalty and Costs, the College of Chiropractors of Ontario ("CCO") and Dr. David Sangster ("Member") jointly submit that the panel of the Discipline Committee make an Order:

1. Requiring the Member to appear before the panel to be reprimanded;

2. Directing the Registrar to suspend the Member's certificate of registration for a period of eight months ("Suspension");

3. Directing the Registrar to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:

    a. within six months of the start of the Suspension, the Member must:

        i. successfully complete the Legislation and Ethics Examination and CCO's Record Keeping Workshop at his own expense and provide evidence of successful completion to the Registrar; and

        ii. review, and agree in writing to comply with, all CCO regulations, standards of practice, policies and guidelines.

    b. requiring the Member to be peer assessed at his expense within 6 months after he returns to practice following the lifting of the Suspension.

4. Directing the Registrar to suspend two months of the Suspension if the Member complies with the Conditions set out in paragraph 3a., above.

5. Requiring the Member to pay the CCO a portion of its costs and expenses related to the investigation and prosecution of these matters in the amount of $15,000.00 by December 31, 2018, to be paid by way of postdated cheques to be provided at the hearing.

6. Requiring that the results of the proceeding be recorded in the public portion of the Register and published in the Annual Report or other CCO publications at the discretion of the CCO.

7. The Member agrees that he obtained independent legal advice from his lawyer, Valerie Wise, prior to signing this Joint Submission on Penalty and Costs, and that he is entering into this Resolution Agreement freely and voluntarily.

The Joint Submission also contained an Undertaking signed by the Member, which read as follows:

To: The Registrar and General Counsel of the CCO ("Registrar")
College of Chiropractors of Ontario ("CCO")

I, Dr. David Sangster, undertake to the Registrar and agree to do the following:

1. On or before October 1, 2018, I will provide:

    a. a written Undertaking to the Registrar and General Counsel ("Registrar") confirming that I have reviewed, and will comply with all CCO by-laws, regulations, standards of practice, guidelines and policies including but not limited to S-002 Record Keeping, S-013 Consent, G-008 Business Practices, and the business practices section of the professional misconduct regulation; and

    b. written evidence to the Registrar that I have successfully completed the CCO's Legislation and Ethics Examination and taken the Record Keeping Course at my own expense.

2. I will be peer assessed at my own expense within six months after I return to practice following the lifting of the suspension.

3. I will pay to the CCO $15,000.00 by December 31, 2018 and will provide post dated cheques for this amount at my Discipline Committee hearing.

4. I will not appeal or ask for a judicial review of the decision of the Discipline Committee regarding the allegations set out in the Notice of Hearing so long as the panel of the Discipline Committee accepts the Joint Submission on Penalty contained in my Resolution Agreement with the CCO.

5. I acknowledge that failure to abide by any of the terms of this Undertaking could result in the referral of specified allegations of professional misconduct to the Discipline Committee.

I have been advised by the CCO to obtain legal advice prior to executing this Undertaking and have obtained the advice of my counsel, Val Wise of Wise Health Law. I am executing this Undertaking freely and voluntarily after reading and understanding its contents.

Mr. Paliare referred to the proposed penalty as indicating to the public and the profession that this conduct would not be tolerated. While protection of patients must be the paramount concern, Mr. Paliare submitted that the proposed penalty order provides for general deterrence, specific deterrence, and remediation. He commented that Dr. Sangster had cooperated with the College's investigation and that, by entering into the resolution agreement, had saved the cost of a contested hearing. He advised that Dr. Sangster had already completed the courses listed at 1(b) of Exhibit 3.

Ms Wise similarly invited the Panel to accept the Joint Submission. In doing so, Ms. Wise pointed out that Dr. Sangster did not have any prior discipline history.

The Panel sought and obtained the advice of its independent legal counsel. In his advice to us, Mr. Le Vay explained that, having regard to how a joint submission is negotiated, the Panel should accept the Joint Submission unless by accepting it, the Panel would bring the discipline process into disrepute or otherwise be acting contrary to the public interest. It was his advice to us that the proposed penalty order was within the appropriate range of penalty for the professional misconduct found in this case.

DECISION AS TO PENALTY AND COSTS

After deliberation, the Panel accepted the Joint Submission and ordered that its terms be implemented. The Panel did so after carefully considering the need for protection of the public, specific and general deterrence, and remediation of the Member. Our reasons are as follows: The proposed penalty was proportionate to what was necessary to ensure that the public was protected in light of the findings of professional misconduct that we made and was therefore in the public interest. The panel was satisfied that the penalty is fair given that the member had no prior discipline history. The panel was also content that the penalty was fair and in the public interest considering the Member's admission of professional misconduct and the fact that these admissions avoided the need for a hearing, which was a mitigating factor. The panel also agreed that the penalty takes into account both specific deterrence: to discourage any repetition of the misconduct by the member, and general deterrence: to send a clear message to the profession about how this type of conduct will not be tolerated. The Panel felt that the proposed penalty order properly ensures that patient safety concerns have been dealt with as there are mechanisms in place to ensure remediation of the member before he reenters practice, as well as peer and practice assessments within 6 months of reentry.

ADMINISTRATION OF REPRIMAND

It was noted on the record that in paragraph 4 of his undertaking, Dr. Sangster waived his right to appeal; therefore, at the conclusion of the hearing, the Panel administered the reprimand required by paragraph 1 of the penalty order.

I, Dr. David Starmer, sign this decision and reasons for the decision as Chair of this Discipline panel and on behalf of the members of the Discipline panel as listed below.

Dr. David Starmer, Chair Date April 12, 2018

Panel Members:

Dr. David Starmer
Ms. Georgia Allan
Dr. Angela Barrow
Ms. Karoline Bourdeau
Dr. Liz Gabison