DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Davis 2024 ONRCDSO 2

Date: 2023-12-04

File Nos.: 22-0514; 22-0659

IN THE MATTER OF:	A Hearing held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*)
AND IN THE MATTER OF:	the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation")
AND IN THE MATTER OF:	the Statutory Powers Procedure *Act,* Revised Statues of Ontario, 1990, Chapter S.22, as amended;

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Dr. Karen Davis

FINDING AND PENALTY REASONS

RESTRICTION ON PUBLICATION

In the matter of the Royal College of Dental Surgeons of Ontario and Dr. Karen Davis the Discipline Panel ordered, under ss. 45(3) of the Health Professions Procedural Code, that no person shall publish or broadcast the identity of any patients of the Registrant, or any information that could disclose the identity of any patients who are named in the Notice of Hearing and/or the Agreed Statement of Facts in this matter.

PANEL MEMBERS:
Dr. Judy Welikovitch, Public Member (Chair)
Dr. Noha Gomaa, Professional Member
Dr. Eilyad Honarparvar, Professional Member

APPEARANCES:
Ms. Erica Richler, for the College
Mr. Neil Abramson for Dr. Karen Davis
Ms. Luisa Ritacca, Independent Legal Counsel

Heard: December 4, 2023, by videoconference
Decision Date: December 4, 2023
Release of Written Reasons: March 19, 2024

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on December 4, 2023. This matter was heard electronically.

At the outset of the hearing, the College sought an order banning the publication of the name of the patient or any information that could be used to identify the patient. The Registrant consented to the request. The Panel granted the order, which extends to the exhibits filed, as well as to these reasons for decision.

PRELIMINARY ISSUE

Prior to the commencement of this hearing, the Registrant brought a motion pursuant to Section 45(2) of the *Code* seeking an order that the public be excluded from the hearing. In the alternative, the Registrant sought an order pursuant to Section 45(2) of the Code that Dr. Jean-Paul Davis, her estranged spouse, be excluded from the hearing.

Pursuant to the *Health Professions Procedural Code*[1]*,* the operating presumption for Discipline Committee panels of a regulated health profession in Ontario is that all hearings shall be open to the public. From a practical point of view, and in the context of virtual hearings, this means that people who wish to attend a Discipline Committee hearing ask to attend a hearing; that they are thereafter provided with the log-in information for the hearing concerned. While in attendance at the hearing, the expectation is that attendees who are neither parties nor witnesses will remain with their cameras off and mute function on.

The presumption that all hearings will be open to the public is subject to four exceptions: where the panel is satisfied that:

i. Matters involving public security may be disclosed;

[1] *Regulated Health Professions Act*, *1991*, SO c. 18, Schedule 2

ii. Financial or personal or other matters may be disclosed where the harm created by disclosure would outweigh the desirability of adhering to the principle that hearings be open to the public;

iii. A person involved in a criminal proceeding or in a civil proceeding may be prejudiced; or

iv. The safety of a person may be jeopardized.

The Registrant's motion was based upon the last-enumerated ground and her concern that the presence of Dr. J.P. Davis would be intimidating for her. In support of this motion, the Registrant filed the letter of her family law lawyer which was appended as an exhibit to the Affidavit of Amanda Rampersaud sworn December 1, 2023.

Pursuant to Section 45(5) of the *Code,* the Panel did order that the public be excluded from the part of the hearing that dealt with the motion to exclude the public.

Upon consideration of the Notice of Motion and the Affidavit of Ms. Rampersaud together with its Exhibits, the relevant legislation, and the submissions of counsel for the parties and the advice of the panel's Independent Legal Counsel, the panel determined that the argument and evidence presented on behalf of Dr. Davis was not sufficient to rebut the presumption that the hearing should remain open to the public. Dr. J.P. Davis was present and remained on the video platform to observe the hearing.

THE ALLEGATIONS

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1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2017, 2018, 2019 and/or 2020, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one or more of your patients, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - With respect to nine (9) patients whose records were obtained by the College, you prescribed opioids in quantities that exceeded the recommended maximum number of tablets for a single opioid prescription,

with no documented justification for doing so, contrary to the College's Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015*.

Patients

Person A

Person B

Person C

Person D

Person E

Person F

Person G

Person H

Person I

- For nine (9) patients (Person A, Person B, Person C, Person D, Person E, Person F, Person G, Person H, and Person I), you prescribed opioids without considering non-opioid medication first, contrary to the College' s Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015.*
- For nine (9) patients (Person A, Person B, Person C, Person D, Person E, Person F, Person G, Person H, and Person I), you prescribed opioids without documenting the reason for the opioid prescription.
- In addition to the patients for whom the College obtained patient records, Ontario's Narcotics Monitoring System (NMS) identified that you prescribed opioids for eight (8) patients in quantities that exceeded the recommended maximum number of tablets for a single opioid prescription, contrary to *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015.*

Patients

Person J

Person K

Person L

Person M

Person N

Person O

Person P

Person Q

- For one (1) patient, Person A, involving 18 narcotic prescriptions, it appears that you wrote prescriptions at an inappropriate frequency. You did not limit the number of consecutive prescriptions to a maximum of three (3) with further prescribing taking place only in consultation with the patient's primary health care provider and/or a dental specialist with expertise in pain management, contrary to the College's Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015.*
- For the patient, Person A, involving 18 narcotic prescriptions, the patient records do not appear to support that she had a dental issue justifying the prescriptions.
- With respect to one (1) prescription for yourself, for benzodiazepines:
  - There is no justification or reason documented for the prescription.
  - You prescribed this drug to yourself. It was improper for you to prescribe a drug to yourself.
- You prescribed drugs and/or performed Botox treatment for the patient, Person G, for migraine headaches. In doing so, you practiced outside the scope of the profession of dentistry, on the following dates according to the chart notes: June 4, 2019; March 24, 2017; and January 31, 2020.
- You prescribed drugs and/or performed Botox treatment for the patient, Person B, for migraine headaches. In doing so, you practiced outside the scope of the profession of dentistry, on the following date according to the chart notes: April 4, 2019. The office drug register at your practice location (L'Heritage Family Dentistry at 1350 L'Heritage Drive, Sarnia, Ontario), contrary to the College's Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015*, and *Dental Recordkeeping, May 2008*:
  - did not record and account for all narcotics, controlled drugs, benzodiazepines and targeted substances kept on-site;
  - did not have entries that were initialled or attributable to the person who made the entry;
  - did not have entries that contain the full drug name, the date and

location of purchase, the invoice number, and/or the balance of drugs left.

- The second drug log you used, contrary to the College's Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015*, and *Dental Recordkeeping, May 2008*:
    - did not have entries that contain details such as the full drug name, the date and location of purchase, the invoice number, and/or the balance of drugs left.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2017, 2018, 2019 and/or 2020, you prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly the authority to prescribe, dispense or sell drugs relative to one or more of your patients, contrary to paragraph 10 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- For the patient, Person A, involving 18 narcotic prescriptions, you prescribed opioids for a non-dental purpose.
- With respect to one (1) prescription for yourself, for benzodiazepines:
    - There is no justification or reason documented for the prescription.
    - You prescribed this drug to yourself. It was improper for you to prescribe a drug to yourself.
- You prescribed drugs and/or performed Botox treatment for the patient, Person G, for migraine headaches. In doing so, you practiced outside the scope of the profession of dentistry, on the following dates according to the chart notes: June 4, 2019; March 24, 2017; and January 31, 2020.
- You prescribed drugs and/or performed Botox treatment for the patient, Person B, for migraine headaches. In doing so, you practiced outside the scope of the profession of dentistry, on the following date according to the chart notes: April 4, 2019.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of

the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2017, 2018, 2019 and/or 2020, you engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to one or more of your patients, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- You prescribed benzodiazepines to yourself with respect to one (1) prescription, with no justification or reason documented. It was improper for you to prescribe a drug to yourself.
- You prescribed opioids to Person A, involving 18 prescriptions, for a non-dental purpose. It was improper for you to prescribe a drug to Person A for a non-dental purpose.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2017, 2018, 2019 and/or 2020, you failed to keep records as required by the Regulations relative to one or more of your patients, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- With respect to five (5) patients, involving 18 prescriptions for Person A, one (1) prescription for Person F, three (3) prescriptions for Person G, one (1) prescription for Person H, and one (1) prescription for Person I, there do not appear to be corresponding chart entries and/or a prescription in the patient chart with respect to the narcotic prescription that was filled.
- With respect to one (1) prescription for yourself, for benzodiazepines, there does not appear to be a corresponding entry in the patient chart.
- For the following patients, for the following dates, where there is a prescription scanned into the patient chart and/or there is documentation in the patient chart of a narcotic and/or antibiotic prescription provided, there does not appear to be documentation in the progress notes of the drug prescribed, the quantity and/or the dose of each.

Patients	Dates
Person B	September 27, 2019
Person C	July 19, 2019
Person D	April 1, 2019
Person F	April 12, 2018
Person H	September 12, 2019

- For the following patients, for the following dates, where there is a prescription scanned into the patient record and/or there is documentation in the patient chart of a narcotic and/or antibiotic prescription provided, there does not appear to be documentation of the full instructions for use.

Patients	Dates
Person B	September 27, 2019
Person C	July 19, 2019
Person D	April 1, 2019
Person E	October 24, 2019
Person F	April 12, 2019
Person H	September 12, 2019

- For one (1) patient, Person F, for the date of March 22, 2018, the documentation in the patient chart does not appear to correspond to the number of tablets dispensed as per the NMS. The chart notes indicate that 20 Percocet were prescribed, but the script refers to 40 tablets and the NMS data indicates that 40 tablets were dispensed.
- For one (1) patient, Person I, involving one prescription on January 29, 2018 for 60 Percocet, 40 Ibuprofen 600 mg, the “NR” (no repeats) field was left blank. In addition, this prescription was signed twice by you, without an explanation for the second signature.
- For the patient, Person A, while the College requested records for January 1, 2018, to February 27, 2020, there were no patient charts provided for the timeframe prior to January 1, 2019, while billing records were provided back to February 16, 2018.
- The office drug register at your practice location (L’Heritage Family Dentistry at 1350 L’Heritage Drive, Sarnia, Ontario), contrary to the College’ s Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015*, and

Dental Recordkeeping, May 2008:

  - did not record and account for all narcotics, controlled drugs, benzodiazepines and targeted substances kept on-site;
  - did not have entries that were initialled or attributable to the person who made the entry;
  - did not have entries that contain the full drug name, the date and location of purchase, the invoice number, and/or the balance of drugs left.

- The second drug log you used, contrary to the College's Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015*, and *Dental Recordkeeping, May 2008*:
  - did not have entries that contain details such as the full drug name, the date and location of purchase, the invoice number, and/or the balance of drugs left.

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1. You committed an act or acts of professional misconduct as provided by s.51(1) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18 in that, during the year 2021, you contravened section 85.6.4 of the Code in that you failed to file a report in writing with the Registrar that you had been charged with an offence, as soon as reasonably practicable, contrary to paragraph 48 of Section 2 of the Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On May 29, 2021, you were charged with:
  - Operating a conveyance while your ability to operate it was impaired to any degree by alcohol, or a drug, or both, contrary to Section 320.14(I)(a) of the Criminal Code; and
  - Having a blood alcohol concentration that was equal to or exceeded 80 mg of alcohol in 100 mL of blood, within two hours after ceasing to operate a conveyance, contrary to Section 320.14(I)(b) of the Criminal Code.

- A member of the public reported the charges to the College on June 17, 2021, and you did not report the charges to the College until a College investigator interviewed you on July 28, 2021.

THE REGISTRANT'S PLEA

The Registrant admitted the allegations as set out in the Notices of Hearing.

THE EVIDENCE

On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 3) which substantiated the allegations. The Agreed Statement of Facts provides, in part, as follows:

Allegations of Professional Misconduct

Background

1. At the material times, Dr. Karen Davis (the "Registrant"), was a duly registered member of the Royal College of Dental Surgeons of Ontario (the "College") practising at L'Heritage Family Dentistry in Sarnia, Ontario.

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2. This matter came to the attention of the College when it received a report that the Registrant had prescribed large quantities (640 tablets) of oxycocet and Percocet to Person A. [redacted]

3. The College initiated an investigation into the Registrant's prescribing practices. The College investigator collected records from the Narcotic Monitoring System and from a pharmacy. The investigator also obtained a sample of patient records relating to Persons A, B, C, D, E, F, G, H, and I. The investigation related to the Registrant's practice from 2017 to 2020.

4. At the material times, Persons A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were patients of the Registrant.

Allegations 1, 2 & 3: Prescriptions & Failing to Maintain Standards

5. At the material times, the College's Guidelines, *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice, November 2015* ("Opioid Guidelines"), set out the expectations for dentists, including the following:

   a. Opioids should only be prescribed in appropriate cases, taking into consideration the diagnosis or clinical indication. Before prescribing an opioid, the dentist should consider whether the patient's pain is well documented, whether the patient is currently taking an opioid, and/or whether the patient's medical history suggests signs of substance misuse, abuse and/or diversion;

   b. Before prescribing an opioid, dentists should consider alternative treatment such as non-opioids;

   c. Dentists who prescribe an opioid should place reasonable limits on their prescriptions and consider opportunities for collaborating with other health care professionals. If the use of an opioid is determined to be appropriate, the dentist should limit the number of tablets dispensed, generally as follows:

      i. codeine 15 mg, to a maximum of 36 tablets;

      ii. codeine 30 mg, to a maximum of 24 tablets;

      iii. oxycodone 5 mg, to a maximum of 24 tablets;

   d. Dentists should also limit the number of consecutive prescriptions to a maximum of three; and

   e. Long term use of such medication should be avoided, whenever possible.

6. It is admitted that the Registrant prescribed opioids to Persons A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q in quantities that exceeded the recommended maximum number of tablets for a single opioid prescription, contrary to the Opioid Guidelines.

7. It is admitted that the Registrant failed to consistently document that she considered non-opioid medication before prescribing opioids, contrary to the Opioid Guidelines.

8. It is further admitted that the Registrant failed to document the reason for the opioid prescription in relation to Persons A, B, C, D, E, F, G, H, and I.

9. It is admitted that for Person A, the Registrant wrote 18 narcotic prescriptions at an inappropriate frequency. The Registrant did not limit the number of consecutive prescriptions to a maximum of three (3) with further prescribing taking place only in consultation with the patient's primary health care provider and/or a dental specialist with expertise in pain management, contrary to the Opioid Guidelines.

10. It is admitted that for Person A, involving 18 narcotic prescriptions, the patient records do not support that the patient had a dental issue justifying the prescriptions. It is admitted that the Registrant prescribed opioids for a non-dental purpose.

11. It is admitted that the Registrant prescribed drugs and/or performed Botox treatment for the patient, Person G, for migraine headaches. In doing so, the Registrant practiced outside the scope of the profession of dentistry, on the following dates according to the chart notes: June 4, 2019; March 24, 2017; and January 31, 2020.

12. It is admitted that the Registrant prescribed drugs and/or performed Botox treatment for the patient, Person B, for migraine headaches. In doing so, the Registrant practiced outside the scope of the profession of dentistry, on the following date according to the chart notes: April 4, 2019. *Allegation 4: Recordkeeping*

13. Ontario Regulation 547 made under the *Drug and Pharmacies Regulation Act*, R.S.O. 1990, c. H.4, requires dentists to keep a clinical record for each patient that must contain not less than the patient's history, the examination procedures used, the clinical findings obtained, the treatment prescribed and provided, and the member's fees and charges.

14. The College's Guidelines for *Dental Recordkeeping, May 2008* ("Recordkeeping Guidelines") state that the progress notes for each visit should provide a concise and complete description of all services rendered and include any drugs prescribed, dispensed or administered, including the quantity and dose of each. Dentists must also document the patient's condition, a diagnosis and treatment plan, and justification for treatment recommendations (which would include medication prescriptions).

15. In addition, the Opioid Guidelines require dentists to document the following information when issuing a prescription: name of the patient, full date (day, month and year), name of the drug, drug strength and quantity or duration of therapy, full instructions for use of the drug, refill instructions, if any, printed name of prescriber, address and telephone number of the dental office where the patient's records are kept, signature of prescriber or appropriate electronic identifier.

16. The Opioid Guidelines and Recordkeeping Guidelines require in-office drugs to be maintained securely and logged in a drug register. Whenever opioids, other narcotics, controlled drugs, benzodiazepines and targeted substances are used or dispensed, a record containing the name of the patient, the quantity used or dispensed, and the date should be entered in the register for each drug. Each entry should be initialed or attributable to the person who made the entry. In addition, this same information should be recorded in the patient record, along with any instructions for use.

17. It is admitted that the Registrant failed to comply with the Opioid Guidelines and the Recordkeeping Guidelines in relation to the drug register. In particular, the Registrant's drug register:

a. did not record and account for all narcotics, controlled drugs, benzodiazepines and targeted substances kept on-site;

b. did not have entries that were consistently initialed or attributable to the person who made the entry; and

c. did not have entries that contain the full drug name, the date and location of purchase, the invoice number, and/or the balance of drugs left.

18. In addition, it is admitted that a second drug log the Registrant used did not have entries that contain details such as the full drug name, the date and location of purchase, the invoice number, and/or the balance of drugs left, contrary to the Opioid Guidelines and Recordkeeping Guidelines.

19. It is admitted that with respect to five (5) patients, involving 18 prescriptions for Person A, one (1) prescription for Person F, three (3) prescriptions for Person G, one (1) prescription for Person H, and one (1) prescription for Person I, the Registrant did not keep corresponding chart entries and/or a prescription in the patient chart with respect to the narcotic prescription that was filled.

20. It is admitted that, for the following patients, for the following dates, where there is a prescription scanned into the patient chart and/or there is documentation in the patient chart of a narcotic and/or antibiotic prescription provided, the Registrant did not maintain documentation in the progress notes of the drug prescribed, the quantity and/or the dose of each:

Patients	Dates
Person B	September 27, 2019
Person C	July 19, 2019
Person D	April 1, 2019
Person F	April 12, 2018
Person H	September 12, 2019

21. It is admitted that, for the following patients, for the following dates, where there is a prescription scanned into the patient record and/or there is documentation in the patient chart of a narcotic and/or antibiotic prescription provided, the Registrant did not maintain documentation of the full instructions for use:

Patients	Dates
Person B	September 27, 2019
Person C	July 19, 2019
Person D	April 1, 2019
Person E	October 24, 2019
Person F	April 12, 2019
Person H	September 12, 2019

22. It is admitted that, for one (1) patient, Person F, for the date of March 22, 2018, the documentation in the patient chart does not correspond to the number of tablets dispensed as per the Narcotics Monitoring System (NMS). The chart notes indicate that 20 Percocet were prescribed, but the script refers to 40 tablets and the NMS data indicates that 40 tablets were dispensed.

23. It is admitted that, for one (1) patient, Person I, involving one prescription on January 29, 2018 for 60 Percocet, 40 Ibuprofen 600 mg, the “NR” (no repeats) field was left blank. In addition, this prescription was signed twice by the Registrant, without an explanation for the second signature.

24. It is admitted that, for the patient, Person A, while the College requested records for January 1, 2018 to February 27, 2020, there were no patient charts provided for the timeframe prior to January 1, 2019, while billing records were provided back to February 16, 2018.

Voluntary Practice Restrictions

25. The Registrant entered into an undertaking voluntarily on December 21, 2021 to restrict her practise such that she will not prescribe any monitored drugs (narcotics and targeted drugs), as defined under the *Narcotics Safety and Awareness Act, 2010*, until the completion of the present discipline proceeding.

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26. Section 85.6.4 of the *Health Professions Procedural Code* requires registrants to report to the College in writing as soon as reasonably practicable if they have been charged with an offence.

27. It is admitted that on May 29, 2021, the Registrant was charged with:

a. Operating a conveyance while her ability to operate it was impaired to any degree by alcohol, or a drug, or both, contrary to Section 320.14(l)(a) of the Criminal Code; and

b. Having a blood alcohol concentration that was equal to or exceeded 80 mg of alcohol in 100 mL of blood, within two hours after ceasing to operate a conveyance, contrary to Section 320.14(l)(b) of the Criminal Code.

28. It is admitted that a member of the public reported the charges to the College on June 17, 2021. The Registrant had not reported the charges in writing to the College. On July 28, 2021, the College contacted the Registrant and the Registrant confirmed that she had been charged.

<u>Professional Misconduct Admitted</u>

29. The Registrant admits and acknowledges that her conduct described above constitutes professional misconduct pursuant to Section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, SO 1991, c 18 and as defined in the following paragraphs of section 2 of Ontario Regulation 853/93:

a. Paragraph 1: Contravening a standard of practice or failing to maintain the standards of practice of the profession [File 22-0514];

b. Paragraph 10: Prescribing, dispensing or selling a drug for an improper purpose, or otherwise using improperly the authority to prescribe, dispense or sell drugs [File 22- 0514];

c. Paragraph 25: Failing to keep records as required by the regulations [File 22-0514];

d. Paragraph 59: Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional, or unethical [File 22-0514]; and

e. Paragraph 48: Contravening a provision of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts, more particularly contravening section 85.6.4 of the *Health Professions Procedural Code* [File 22-0659].

DECISION

Having considered Dr. Davis' plea, the Agreed Statement of Facts and Dr. Davis' admissions contained therein, the Panel finds that the Registrant engaged in professional misconduct.

REASONS FOR DECISION

The Panel reviewed and accepted the admissions of misconduct made by the Registrant in the Agreed Statement of Facts and in her Plea Inquiry. The Panel assessed this evidence as both credible and reliable. Together with the Registrant's admissions, the Agreed Statement of Facts provided clear, cogent and convincing evidence to prove the allegations against her.

File 22-0514: Allegations 1, 2 and 3

For the sake of brevity and clarity, the Panel will deal with Allegations 1, 2, and 3 together, as follows.

Allegations Re: Prescription of Opioid Medications:

(a) The Panel finds that Dr. Davis committed an act or acts of professional misconduct in that she failed to follow the College's *Opioid Guidelines* and *Recordkeeping Guidelines* and that she thereby contravened a standard of practice contrary to Section 51(1)(c) of the *Code*. More specifically, there was clear and cogent evidence before the Panel that during the years 2017, 2018, 2019 and/or 2020, she:

i. contravened a standard of practice and failed to maintain a standard of practice of the profession by prescribing opioids to seventeen (17) patients in quantities that exceeded the recommended maximum number of tablets for a single opioid prescription, and with no documented reason for doing so;

ii. further with respect to this finding, Dr. Davis wrote eighteen (18) narcotic prescriptions for Person A [redacted] at an inappropriate frequency and did not limit the number of consecutive prescriptions to three (3), with further prescribing taking place only in consultation with the patient's primary care health provider and/or a dental specialist with expertise in pain management, contrary to the *Opioid Guidelines*;

iii. further with respect to this finding, Dr. Davis prescribed a large amount of oxycocet and Percocet – i.e. 640 tablets – to [redacted] Person A;

iv. further prescribed opioid medication to Person A for a non-dental purpose;

v. prescribed opioids for multiple patients without consistently documenting the reason for doing so, contrary to the *Opioid Guidelines* and the *Recordkeeping Guidelines*;

vi. wrote eighteen (18) narcotic prescriptions for a single patient at an inappropriate frequency and without documenting the reason(s) for doing so, and for a non-dental purpose, contrary to the *Opioid Guidelines*.

There was no evidence to support the allegation that Dr. Davis wrote one narcotic prescription for herself for benzodiazepines without documenting the justification or reason for doing so.

In reaching these findings, the Panel relied upon the agreed facts, the admissions by Dr. Davis contained in the Agreed Statement of Facts, the submissions of counsel for the parties and the advice of its own Independent Legal Counsel.

Allegations Re: Prescribing Botox and/or Performing Botox Treatments

(b) Dr. Davis admitted, and the Panel finds that Dr. Davis practiced outside the scope of the profession of dentistry in prescribing and administering Botox for two (2) patients, contrary to Section 2, Para. 10 of Ontario Regulation 853/93. More specifically, there was credible and reliable evidence that Dr. Davis prescribed Botox and performed Botox treatment for migraine headaches for two patients, as follows:

i. Dr. Davis prescribed and administered Botox treatment for migraine to Person G on March 24, 2017, June 4, 2019, and January 31, 2020;
ii. Dr. Davis prescribed and administered Botox treatments to Person B on April 4, 2019.

The Panel finds that prescribing Botox and performing Botox treatments for migraine headaches is well beyond the scope of a dentist's practice.

In reaching this finding, the Panel again relied upon the agreed facts, the admissions by Dr. Davis contained in the Agreed Statement of Facts, the submissions of counsel for the parties and the advice of its own Independent Legal Counsel.

Allegation 4: Failure to Maintain Patient Records as Required

(c) *Ontario Regulation 547* made under the *Drug and Pharmacies Regulation Act*[2] requires that dentists maintain a clinical record for each patient that must contain, at a minimum, the patient's history, the examination procedures used, the clinical findings obtained, the treatment prescribed and provided and the Registrant's fees and charges.

The College's *Recordkeeping Guidelines* require that progress notes for each visit should provide a concise and complete description of all the services rendered and include any drugs prescribed, dispensed or administered, including the quantity and dose of each. The patient's condition, a diagnosis and treatment plan, and justification for treatment recommendations must all be documented.

In addition, the *Opioid Guidelines* require that when issuing a prescription, dentists must document the name of the patient, the full date, the name of the drug, drug strength and quantity or duration of treatment, refill instructions, if any, the printed name of the prescriber,

[2] *Drug and Pharmacies Regulation Act*, R.S.O. 1990, c. H.4, Section 38(b)

address and phone number of the dental office where the patient's records are kept, and the signature of the prescriber.

The *Opioid Guidelines* and the *Recordkeeping Guidelines* further require that any in-office drugs be maintained securely and logged in a drug register; that whenever opioids, other narcotics, controlled drugs, benzodiazepines and targeted substances are used or dispensed, a record containing the name of the patient, the quantity used or dispensed, and the date, should be entered in the register for each drug; that each entry should be initialed or attributable to the person who made the entry; that this same information should be recorded in the patient record, along with any instructions for use.

The Registrant admitted, and the Panel finds that Dr. Davis failed to comply with the *Opioid Guidelines* and the *Recordkeeping Guidelines* in relation to the drug register maintained by her. More particularly, and pursuant to the Registrant's own admissions, the Panel finds that:

i. Dr. Davis did not record and account for all narcotics, controlled drugs, benzodiazepines, and targeted substances kept on-site;
ii. Dr. Davis' records did not have entries that were consistently initialled or attributable to the person who made the entry;
iii. Dr. Davis' records did not have entries that contained the full drug name, the date and location of purchase, the invoice number, and the balance of drugs left;
iv. Dr. Davis used a second drug log that did not have entries that contained the required details, including the full drug name, the date and location of purchase, the invoice number and/or balance of drugs left;
v. With respect to five (5) patients involving multiple prescriptions, Dr. Davis did not keep corresponding chart entries and/or a prescription in the individual patient's chart with respect to the narcotic prescription that was filled. More particularly, Dr. Davis did not keep corresponding chart entries and/or a prescription in the charts for the following patients:
    (i) Person A, eighteen (18) prescriptions;
    (ii) Person F, one (1) prescription;
    (iii) Person G, three (3) prescriptions;
    (iv) Person H, one (1) prescription; and
    (v) Person I, one (1) prescription;
vi. With respect to five (5) patients, Dr. Davis did not maintain documentation in the progress notes of the drug prescribed, the quantity and/or the dose of each,

notwithstanding that a prescription was scanned into the patient's chart and/or there was other documentation in the patient's chart. These failures occurred during the period April 1, 2019 to September 27, 2019;

vii. With respect to six (6) patients, Dr. Davis did not maintain documentation of the full instructions for use of the medications prescribed in circumstances where a prescription was scanned into the patient chart and/or documentation was provided in the chart of the narcotic and/or antibiotic prescribed;

viii. With respect to Person F, for the date of March 22, 2018, the documentation in Dr. Davis' patient chart indicates that twenty (20) Percocet tablets were prescribed , but the prescription itself refers to forty (40) tablets and the Narcotics Monitoring System indicates that forty (40) tablets were dispensed to Person F;

ix. With respect to Person I, for the date of January 29, 2018, sixty (60) Percocet and forty (40) Ibuprofen 600 mg were prescribed but the "NR" (no repeats) field was left blank. Moreover, the prescription itself was signed twice by Dr. Davis, without an explanation by her for the second signature; and

x. With respect to Person A, that the College requested records for the period January 1, 2018 to February 27, 2020 but that no patient charts were provided for the timeframe prior to January 1, 2019 in circumstances where billing records were provided back to February 16, 2018.

File 22-0659: Failure to Report Having Been Charged with an Offence

The *Health Professions Procedural Code*, Section 85.6.4, requires that registrants report to the College, in writing, as soon as reasonably practicable, when they have been charged with an offence.

Dr. Davis admitted that:

(a) on 29 May 2021, she was charged with the following offences:

i. Operating a conveyance while her ability to operate it was impaired by alcohol, or a drug, or both, contrary to Section 320.14(1)(a) of the *Criminal Code*[3]*;* and

ii. Having a blood alcohol concentration that was equal to or exceeded 80mg of alcohol in 100ml of blood, within two hours after ceasing to operate a conveyance, contrary to Section 320.14(1)(b) of the *Criminal Code*[4];

(b) on June 17, 2021, a member of the public reported the charges to the College;

[3] *Criminal Code of Canada*, RSC 1985, c. C-46
[4] Ibid

(c) on July 28, 2021, the College contacted Dr. Davis regarding the charges that had been reported by a member of the public, at which time she confirmed that she had been charged with the above-described offences.

The Panel finds that Dr. Davis' admissions with respect to the criminal offences with which she was charged are both clear and reliable. Accordingly, the Panel finds the allegations against Dr. Davis with respect to her failure to report the criminal offences with which she had been charged are supported by the evidence.

Having considered the evidence before it, including the Agreed Statement of Facts and Dr. Davis' admissions contained therein, the submissions of counsel for the parties and the advice of its own Independent Legal Counsel, the Panel finds that there is sufficient evidence to substantiate its finding that Dr. Davis' conduct constitutes professional misconduct pursuant to Section 51(1)(c) of the *Code*[5]*,* and as defined in the following paragraphs of Section 2 of Ontario Regulation 853/93[6]:

(a) With respect to File 22-0514:
   i. Paragraph 1: contravening a standard of practice or failing to maintain the standards of practice of the profession;
   ii. Paragraph 10: prescribing, dispensing or selling a drug for an improper purpose or otherwise using improperly the authority to prescribe, dispense or sell drugs. In particular, that Dr. Davis prescribed drugs for a non-dental purpose;
   iii. Paragraph 25: Failing to keep records as required by the regulations; and
   iv. Paragraph 59: engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members of members of the profession as disgraceful, dishonourable, unprofessional or unethical. In particular, that Dr. Davis prescribed opioids to Person A, [redacted] for a non-dental purpose;

(b) With respect to File 22-0659:
   i. Paragraph 48: contravening a provision of the *Act*[7], the *Regulated Health Professions Act*[8] or the regulations under either of those *Acts*. More

[5] *Regulated Health Professions Act*, *1991*, SO 1991 c 18. Schedule 2
[6] *Ontario Dentistry Act 1991*, SO 1991 c 24, *Regulation 853/93:Professional Misconduct*
[7] Ibid
[8] *Regulated Health Professions Act*, *1991*, SO 1991 c 18

specifically, contravening section 85.6.4 of the *Health Professions Procedural Code*[9].

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission on Penalty (Exhibit 5), which provides as follows:

1. That the Royal College of Dental Surgeons of Ontario (the "College") and Dr. Karen Davis (the "Registrant") jointly submit that this panel of the Discipline Committee impose the following penalty on the Registrant as a result of the Panel's finding that the Registrant is guilty of professional misconduct, namely, that it make an order:

   (a) requiring the Registrant to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

   (b) directing the Registrar to suspend the Registrant's certificate of registration for a period of three (3) months, commencing December 16, 2023 at 12:01 am. The suspension shall run without interruption;

   (c) that the Registrar impose the following terms, conditions and limitations on the Registrant's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Registrant's certificate of registration as referred to in paragraph 1(b) above has been fully served:

      (i) while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

         - staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;
         - dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;
         - dentists or other individuals who routinely refer patients to the Registrant;

[9] Supra note 4

- faculty members at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;
- owners of a practice or office in which the Registrant works;
- patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

(ii) while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

- acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;
- giving orders or standing orders to dental hygienists;
- supervising work performed by others;
- working in the capacity of a dental assistant or performing laboratory work;
- acting as a clinical instructor;

(iii) while suspended, the Registrant must not be present in offices or practices where the Registrant works when patients are present, except for emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

(iv) while suspended, the Registrant must not benefit or profit, directly or indirectly from the practice of dentistry and

- the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed

for actual out-of-pocket expenses incurred in respect of the practice during the suspension period;

- the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension;

(v) the Registrant must not sign insurance claims for work that has been completed by others during the suspension period; the Registrant shall cooperate with any office monitoring which the Registrar thinks is needed to ensure that the Registrant has complied with the Suspension Conditions. The Registrant must provide the College with access to any records associated with the practice that the College may require to verify that the Registrant has not engaged in the practice of dentistry or profited during the suspension; and

(vi) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(v) above shall be removed at the end of the period that the Registrant's certificate of registration is suspended.

(d) directing that the Registrar also impose the following additional terms, conditions and limitations on the Registrant's Certificate of Registration, namely:

(i) The Registrant shall successfully complete, at her own expense, the following courses approved by the Registrar within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar:

1. the PROBE Program for Professional/Problem-Based Ethics (must obtain an "unconditional pass" grade); and
2. an individualized, comprehensive course with an evaluative component that is pre-approved by the College that addresses recordkeeping in prescribing analgesics including opioids and a review of the College's Guideline: The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice, including indications/contra indications for the use of analgesics including conservative management of pain.

(ii) The Registrant shall provide proof, acceptable to the Registrar, of successful completion of a record-keeping course approved by the College within six (6) months of the date of the panel's order.

(iii) The Registrant shall not prescribe narcotics or controlled drugs until after completing all required coursework set out in subparagraphs 1(d)(i) and (ii) above and receiving written confirmation from the College that she may commence prescribing such medications.

(iv) The Registrant shall cooperate with inspections of her office and patient charts during Practice Monitoring (office visits) for 24 months following completion of the suspension and the courses referenced above.

(v) The Practice Monitor will submit a report to the College after each visit detailing the Registrant's progress, summarizing the patient charts reviewed, listing any practice or treatment recommendations made to the Registrant and whether she implemented such recommendations.

(vi) At the conclusion of 24 months of Practice Monitoring, if the Practice Monitor reports to the College in writing that the Member is progressing well and recommends that the Practice Monitoring cease, and if approved by the College, this term, condition and limitation will be removed from Dr. Davis' certificate of registration. The Registrant shall pay to the College in respect of the cost of Practice Monitoring, the amount of $1000.00 per inspection/office visit and chart review, such amount to be paid immediately after completion of each inspection/office visit.

(vii) The Registrant must maintain a log of all narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and/or all other monitored drugs that she prescribes during the practice monitoring period (24 months), in a form acceptable to the College, which will include at least the following information:

1. the date of the appointment;
2. the name of the patient and chart/file number;
3. the name of the medication prescribed, dose, direction, number of tablets to be dispensed and frequency; and
4. the clinical indication for the prescription.

The log will be made available by the Registrant to the College or the College's practice monitors upon request.

(viii) The Registrant must keep a copy of all prescriptions she writes for narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and/or all other monitored drugs in the corresponding patient chart during the practice monitoring period (24 months).

(ix) The Registrant shall give her irrevocable consent to the College to make inquiries of the Narcotics Monitoring System ("NMS") implemented under the *Narcotics Safety and Awareness Act, 2010* and/or any person or institution who may have relevant information, for the College to monitor her compliance with the provisions of the Order during the practice monitoring period (24 months).

(x) that the Registrant pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing within three (3) months of the date this Order becomes final.

2. The College and the Registrant further submit that pursuant to the *Code*, as amended, the results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and practice address of the Registrant included.

3. Dr. Karen Davis has not previously appeared before the Discipline Committee of the College.

PENALTY DECISION

The Panel agreed and accepted the Joint Submission on Penalty and ordered that:

(a) the Registrant appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

(b) the Registrar suspend the Registrant's certificate of registration for a period of three (3) months, commencing December 16, 2023 at 12:01 am. The suspension shall run without interruption;

(c) the Registrar impose the following terms, conditions and limitations on the Registrant's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Registrant's certificate of registration as referred to in paragraph (b) above has been fully served:

(i) while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

- staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;
- dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;
- dentists or other individuals who routinely refer patients to the Registrant;
- faculty members at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;
- owners of a practice or office in which the Registrant works;
- patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

(ii) while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

- acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;
- giving orders or standing orders to dental hygienists;
- supervising work performed by others;

- working in the capacity of a dental assistant or performing laboratory work;
- acting as a clinical instructor;

(iii) while suspended, the Registrant must not be present in offices or practices where the Registrant works when patients are present, except for emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

(iv) while suspended, the Registrant must not benefit or profit, directly or indirectly from the practice of dentistry and

- the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period;
- the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension;

(v) the Registrant must not sign insurance claims for work that has been completed by others during the suspension period; the Registrant shall cooperate with any office monitoring which the Registrar thinks is needed to ensure that the Registrant has complied with the Suspension Conditions. The Registrant must provide the College with access to any records associated with the practice that the College may require to verify that the Registrant has not engaged in the practice of dentistry or profited during the suspension; and

(vi) the Suspension Conditions imposed by virtue of subparagraphs (c)(i)-(v) above shall be removed at the end of the period that the Registrant's certificate of registration is suspended.

(d) directing that the Registrar also impose the following additional terms, conditions and limitations on the Registrant's Certificate of Registration, namely:

(i) The Registrant shall successfully complete, at her own expense, the following courses approved by the Registrar within six (6) months of this

Order becoming final or such further time as may be permitted by the Registrar:

3. the PROBE Program for Professional/Problem-Based Ethics (must obtain an "unconditional pass" grade); and
4. an individualized, comprehensive course with an evaluative component that is pre-approved by the College that addresses recordkeeping in prescribing analgesics including opioids and a review of the College's Guideline: The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice, including indications/contra indications for the use of analgesics including conservative management of pain.

(ii) The Registrant shall provide proof, acceptable to the Registrar, of successful completion of a record-keeping course approved by the College within six (6) months of the date of the panel's order.

(iii) The Registrant shall not prescribe narcotics or controlled drugs until after completing all required coursework set out in subparagraphs (d)(i) and (ii) above and receiving written confirmation from the College that she may commence prescribing such medications.

(iv) The Registrant shall cooperate with inspections of her office and patient charts during Practice Monitoring (office visits) for 24 months following completion of the suspension and the courses referenced above.

(v) The Practice Monitor will submit a report to the College after each visit detailing the Registrant's progress, summarizing the patient charts reviewed, listing any practice or treatment recommendations made to the Registrant and whether she implemented such recommendations.

(vi) At the conclusion of 24 months of Practice Monitoring, if the Practice Monitor reports to the College in writing that the Member is progressing well and recommends that the Practice Monitoring cease, and if approved by the College, this term, condition and limitation will be removed from Dr. Davis' certificate of registration. The Registrant shall pay to the College in respect of the cost of Practice Monitoring, the amount of $1000.00 per inspection/office visit and chart review, such amount to be paid immediately after completion of each inspection/office visit.

(vii) The Registrant must maintain a log of all narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and/or all other monitored drugs that she prescribes during the practice monitoring period (24 months), in a form acceptable to the College, which will include at least the following information:

1. the date of the appointment;
2. the name of the patient and chart/file number;
3. the name of the medication prescribed, dose, direction, number of tablets to be dispensed and frequency; and
4. the clinical indication for the prescription.

The log will be made available by the Registrant to the College or the College's practice monitors upon request.

(viii) The Registrant must keep a copy of all prescriptions she writes for narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and/or all other monitored drugs in the corresponding patient chart during the practice monitoring period (24 months).

(ix) The Registrant shall give her irrevocable consent to the College to make inquiries of the Narcotics Monitoring System ("NMS") implemented under the *Narcotics Safety and Awareness Act, 2010* and/or any person or institution who may have relevant information, for the College to monitor her compliance with the provisions of the Order during the practice monitoring period (24 months).

(e) that the Registrant pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing within three (3) months of the date this Order becomes final.

4. The College and the Registrant further submit that pursuant to the Code, as amended, the results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and practice address of the Registrant included.

REASONS FOR PENALTY DECISION

It is settled law that a decision-maker should not lightly depart from an agreement that has been reached by the parties with respect to an appropriate penalty. The leading case on this issue is *R. v. Anthony Cook* [10] in which the Supreme Court of Canada described this as an "undeniably high threshold." The Court stated the following:

> "Rejection denotes a submission so unhinged from the circumstances of the offence and the offender that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down."[11]

The test as to whether it is appropriate to reject a joint submission on penalty is thus not one of "fitness of sentence" but rather, the more stringent test of whether the jointly proposed penalty "would bring the administration of justice into disrepute or would otherwise be contrary to the public interest."[12]

The Panel accepted the parties' Joint Submission with respect to Penalty and Costs.[13] It did so bearing in mind that the paramount principle of penalty proceedings is to protect the public. A penalty must also address the principles of maintaining public confidence in the profession and in its ability to self-regulate. A penalty must serve as a measure of general deterrence in that it sends a message to members of the dental profession that this type of conduct will not and cannot be tolerated. It must also serve as a measure of specific deterrence with respect to the dentist concerned. An appropriate penalty should also provide for remediation or rehabilitation of the dentist concerned, where possible and appropriate.

Counsel for both the College and the Registrant argued that the Panel should accept the Joint Submission. The parties submitted that the joint proposal meets the goals of public protection, specific and general deterrence, and remediation. They argued that the proposed penalty reflects the seriousness of the misconduct, and that it is appropriate

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[10] *R. v. Anthony Cook* 2016 SCC 43 per Mr. Justice Michael Moldaver, cited with approval in *Ontario College of Teachers v Merolle,* 2023 ONSC 3453

[11] *R. v. Anthony Cook,* para 34

[12] *Ontario College of Teachers v. Merolle,* 2023 ONSC 3453, para 32

[13] Exhibit 5

having regard to the aggravating and mitigating factors in this case and to the interests of the public, the profession, and the Registrant herself.

The College submitted that *R. v. Anthony-Cook*[14] sets a high threshold for a panel to reject a joint submission and that this threshold has not been triggered in this case. Counsel for the Registrant took a similar position. He argued that the joint position must be defensible on the law and the facts, and that the position proposed in this case was defensible on both.

Counsel for the parties directed the Panel to several cases that, in their submissions, were similar to this one.[15] They argued that the penalties proposed in this case were within the range of penalty that has been ordered in these other, similar cases.

The Panel considered the submissions of the parties' counsel and the cases they referred to as well as the advice of its own Independent Legal Counsel.

The Panel considered as aggravating factors the seriousness of Dr. Davis' misconduct, the fact that the misconduct admitted by her with respect to Hearing File No. 22-0514 continued over a period of approximately three (3) to four (4) years, that she engaged in this misconduct with respect to a significant number of patients, and that her record-keeping with respect to her drug register for all narcotics, controlled drugs, benzodiazepines and targeted substances kept on-site fell well below the standard set out in the College's *Opioid Guidelines* and *Recordkeeping Guidelines.*

In assessing the Joint Submission, the Panel also considered mitigating factors, including that Dr. Davis has no prior discipline history with the College, that she cooperated with the College's investigation, that she pleaded guilty to the misconduct, as alleged, thereby demonstrating insight into her misconduct, and remorse. By pleading guilty, Dr. Davis also avoided a potentially costly and time-consuming hearing. Further in this regard, the Panel also considered the voluntary undertaking entered into by Dr. Davis on December 21, 2021, in which she agreed to restrict her practise such that she would not prescribe any monitored drugs such as narcotics and targeted drugs until the completion of these proceedings.

As noted above, the Panel's primary concern when considering the adequacy of the penalty being proposed was and is public protection. The Panel is satisfied that public protection is being met through the terms of the Joint Submission, as filed, and through the practice

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[14] *Supra*, note 9

[15] *The Royal College of Dental Surgeons of Ontario v. Bekesch, 2020 ONRCDSO 7*; *College of Physicians and Surgeons of Ontario v. Aly*, 2018 ONCPSD 33, *College of Physicians and Surgeons of Ontario v. Schwarz*, 2020 ONCPSD 18

restrictions to which Dr. Davis voluntarily agreed on December 21, 2021, and which will continue in effect until she has completed all required coursework and received written confirmation from the College that she may commence prescribing such medications.

The Panel agrees that the penalty proposed with respect to Dr. Davis is within the range of penalties administered in other, similar cases. Specifically, the Panel was directed to and considered the three (3) cases contained in the parties' Joint Book of Authorities: all of these cases involved matters that came before the Discipline Committee of the Royal College of Dental Surgeons of Ontario and the College of Physicians and Surgeons of Ontario; all involved acts of misconduct related to the prescription of opioids, other narcotics and targeted drugs. The Panel is satisfied that the penalty being proposed falls within the range of penalties that were ordered for like acts of misconduct.

The Panel is satisfied that a three (3) month suspension, a reprimand, and the recording of the results of these proceedings on the College register will function to deter Dr. Davis from conducting herself in this manner again. These aspects of the penalty will also send a clear message to other members of the profession that professional misconduct of this nature cannot be and will not be tolerated by the College. In this way, these elements of the penalty will have both specific and general deterrent impact.

The additional terms, conditions, and limitations—including College-approved coursework and practice monitoring for a period of twenty-four (24) months immediately following the date Dr. Davis returns to practice—will further ensure public protection and will support Dr. Davis' remediation.

Further in this regard, Dr. Davis is restricted from prescribing narcotics or controlled drugs until after she has completed all required coursework and receiving written confirmation from the College that she may commence prescribing such medications.

More specifically, Dr. Davis is required:

i. to complete the PROBE program for Professional/Problem-Base Ethics with an "unconditional pass" within six (6) months of this order;

ii. to complete an individualized, comprehensive course with an evaluative component that is pre-approved by the College and that addresses recordkeeping in prescribing analgesics including opioids and a review of the College's Guideline: The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice within six (6) months of this order;

iii. to retain a College-approved practice monitor for a period of twenty four (24) months following her completion of the courses referenced above and her return to practice, and to cooperate with all requirements of the Practice Monitor.

These terms and conditions will serve to minimize the potential for Dr. Davis again engaging in the misconduct found herein.

In consideration of the above, the Panel is satisfied that the penalties proposed by the parties are within the range for the type of misconduct engaged in by Dr. Davis, and that it is reasonable in all the circumstances. The Panel is also confident that it will serve the functions of public protection, the maintenance of public confidence in the profession and in its ability to self-regulate, specific and general deterrence, and remediation and rehabilitation of Dr. Davis.

Finally, the parties' joint submission that the Panel order the Registrant to pay costs to the College in the amount of $10,000 is appropriate and reasonable. The Panel sees no reason to depart from the parties' agreement on costs.

THE REPRIMAND

The Registrant received her reprimand at the end of the hearing. A copy of the reprimand is attached as Appendix "A" to these Reasons.

I, Judy Welikovitch, sign these Reasons for Decision as Chairperson of this Discipline Panel.

Dated this 19th day of March, 2024 ______________________________

Appendix "A"

RCDSO v. Dr. Karen Davis

Dr. Davis, as you know, this Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the seriousness of your misconduct.

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

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found that you have engaged in multiple acts of professional misconduct. The misconduct related to over-prescribing opioids in a manner that exceeded the College's Guidelines, failing to keep proper records with regard to those prescriptions, and failing to report to the College, in a timely fashion, that you had been charged with an offence. The cumulative effect of your conduct regarding the opioid over-prescription would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged has involved:

a) Your failure to follow the College's guidelines and best practices with respect to record-keeping, particularly as it relates to your record-keeping regarding the prescription of opioid medications to your patients;
b) The prolonged period of time over which the misconduct at issue took place. More specifically, the misconduct took place from 2017 until 2020;
c) The excessive number of opioid prescriptions written for Person A;
d) Prescribing Botox and administering Botox to some of your patients as a treatment for migraine headaches. In so doing, you practised outside the scope of your practice as a dental professional; and
e) Your failure to follow the College's Guidelines or the Ontario Health Professions Procedural Code in that you did not report to the College that you had been charged by the police with operating a conveyance while impaired, and having a blood alcohol concentration that exceeded 80mg/100ml of blood. In fact, it was a member of the public who reported this to the College.

We have ordered a three (3) month suspension of your license and the recording of the results of these proceedings on the College register as a deterrent to you conducting yourself in this manner in the future. These aspects of the penalty will also send a clear message to other members of the profession that professional misconduct of this nature cannot be and will not be tolerated by the College.

We also ordered additional terms, conditions and limitations including: College-approved coursework and practice monitoring for a period of twenty-four (24) months immediately following your return to practice. These measures will further ensure public protection and will support your remediation.

We also ordered that you are restricted from prescribing narcotics or controlled drugs until after you have completed all required coursework and you have received written confirmation from the College that you may commence prescribing such medications. These additional terms will serve to minimize the potential for your again engaging in the professional misconduct that we have found in this disciplinary process.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is **not** an opportunity for you to debate the merits or the correctness of the decisions we have made.

Do you have any questions or do you wish to make any comments?

Since Dr. Davis has indicated that she has no comments to make, this hearing is adjourned.

Thank you for attending today.