H140005
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IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario 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*") respecting one **DR. JOVANKA ZIZEK,** of the City of Richmond Hill, in the Province of Ontario;

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 Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

Members in Attendance:

Dr. Richard Hunter, Chair
Dr. Lisa Kelly
Dr. William Coyne
Mr. Gregory Larsen – Public Member
Mr. Derek Walker – Public Member

Appearances:

Mr. Nick Coleman for the RCDSO

No one for Dr. Jovanka Zizek

Mr. Brian Gover, Independent Legal Counsel
to the Discipline Committee of the RCDSO

Ms. Krystal Evans, Hearings Clerk

DECISION AND REASONS

Introduction

On March 16, 2016, a Panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("Panel") convened a hearing respecting allegations against Dr. Jovanka Zizek ("Dr. Zizek" or the "Member"), pursuant to the provisions of the *Health Professions Procedural Code* ("Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18.

The hearing was scheduled to begin at 9:00 a.m. However, at that time, Dr. Zizek was not in attendance. Consequently, the Panel convened the hearing but ordered a recess to 9:30 a.m. Upon reconvening at 9:30 a.m., Dr. Zizek was still not in attendance, and there was no indication that she would be attending the hearing. The Panel was satisfied that the Member was given notice of the hearing date. Having heard submissions from College Counsel and the Panel's independent counsel on our ability to proceed with the hearing in the Dr. Zizek's absence,[1] the Panel determined that it was appropriate to proceed in that manner.

Before proceeding, the Panel made an order under subsection 45(3) of the *Health Professions Procedural Code*,[2] banning the publication or broadcasting of the names of the two patients involved.

The Panel then received and reviewed two Notices of Hearing (filed as **Exhibits 1 and 2**). As will be explained below, although the two Notices of Hearing contained a total of 12 allegations, the hearing proceeded in relation to 9 of them. In her absence, the Member was deemed to have denied the allegations.

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[1] Independent counsel referred us to subsection 7(1) of the *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, which provides as follows:

> 7. (1) Where notice of an oral hearing has been given to a party to a proceeding in accordance with this Act and the party does not attend at the hearing, the tribunal may proceed in the absence of the party and the party is not entitled to any further notice in the proceeding.

[2] Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c 18

The allegations contained in Notice of Hearing H140005 (**Exhibit 1**) were as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 to 2012, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely LG., contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - In or about November 2010 and January 2012 you employed/used an individual who was not a registered dental technologist or denturist to fabricate dentures for your patient, L.G., and you did not supervise this individual during the fabrication of the dentures contrary to subsections 32(1), 32(2) and 32(3) of the *Regulated Health Professions Act, 1991*.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 to 2012, you failed to keep records as required by the regulations relative to one of your patients, namely L.G., contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between October 2010 and January 2012 you failed to keep adequate records of your treatment of your patient L.G., including no financial documentation and only minimal clinical records.

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 to 2012, you contravened a provision of the *Dentistry Act, 1991*, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts relative to one of your patients, namely L.G., contrary to paragraph 48 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - In or about November 2010 and January 2012 you employed/used an individual who was not a registered dental technologist or denturist to

fabricate dentures for your patient, L.G., and you did not supervise this individual during the fabrication of the dentures contrary to subsections 32(1), 32(2) and 32(3) of the *Regulated Health Professions Act, 1991*.

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 to 2012, 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 of your patients, namely L.G., contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between October 2010 and January 2012 you failed to keep adequate records of your treatment of your patient L.G., including no financial documentation and only minimal clinical records.

   - Between October 2010 and January 2012 you failed to provide your patient L.G.with a statement of account or a detailed receipt for the treatment you provided despite her requests. Subsequent to January 2012 you ignored the patient's attempts to contact you.

   - In or about November 2010 and January 2012 you employed/used an individual who was not a registered dental technologist or denturist to fabricate dentures for your patient, L.G., and you did not supervise this individual during the fabrication of the dentures contrary to subsections 32(1), 32(2) and 32(3) of the *Regulated Health Professions Act, 1991*.

College Counsel advised us that the College was not seeking findings of professional misconduct in relation to Allegations 3 and 4 that had been set out in Exhibit 1.[3]

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[3] These were Allegations #3 (which alleged that the Member "failed to provide a statement of account to a patient upon the completion of a dental service or failed to state in the statement of account the service provided and the fee charged for it relative to one of your patients, namely L.G., contrary to paragraph 22 of Section 2 of the Dentistry Act Regulation") and #4 (which alleged that the Member "failed to itemize or explain, when requested to do so by a patient or the patient's guardian or authorized representative, the services provided and the fee charged for each service using terminology understandable to a patient relative to one of your patients, namely L.G., contrary to paragraph 23 of Section 2 of the Dentistry Act Regulation").

The allegations contained in Notice of Hearing H140006 (**Exhibit 2**) are set out below:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2004 to 2011, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely B.M., contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between 2004 and 2011 the dental care or lack thereof you provided to your patient, B.M., amounted to supervised neglect, in that:
     - You failed to take radiographs for the patient between September 2004 and July 2011.
     - You failed to diagnose and provide an appropriate referral for treatment of the patient's impacted tooth 38 (lower left 3rd permanent molar) and a cystic lesion on that tooth.
     - You failed to diagnose and adequately treat decay in the patient's tooth 17 (upper right 2nd permanent molar).
   - Between 2005 and 2011 you repeatedly submitted claims for multiple units of scaling for your patient B.M. that were not supported by radiographic or clinical findings and therefore were excessive or unreasonable.
   - In or about July 2011 you submitted claims for surgical curettage for your patient B.M., with no clinical and/or radiographic support and with no local anaesthetic administered.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2004 to 2011, you failed to keep records as required by the regulations relative to one of your patients, namely B.M., contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between September 2004 and July 2011 you failed to keep adequate records

with respect to your treatment of B.M., including: no financial records; no updated medical history; no record of complete examination and radiographs; no notations of specific findings, diagnosis, and treatment plan (options); no documentation of use of local anaesthesia; and no documentation of the patient's periodontal condition.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2004 to 2011, you charged a fee that is excessive or unreasonable in relation to the services performed relative to one of your patients, namely B.M., contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between 2005 and 2011 you repeatedly submitted claims for multiple units of scaling for your patient B.M. that were not supported by radiographic or clinical findings and therefore were excessive or unreasonable.

   - In or about July 2011 you submitted claims for surgical curettage for your patient B.M., with no clinical and/or radiographic support and with no local anaesthetic administered.

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2004 to 2011, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to one of your patients, namely B.M., contrary to paragraph 33 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between 2005 and 2011 you repeatedly submitted claims for multiple units of scaling for your patient B.M. that were not supported by radiographic or clinical findings and therefore were excessive or unreasonable.

   - In or about July 2011 you submitted claims for surgical curettage for your patient B.M., with no clinical and/or radiographic support and with no local anaesthetic administered.

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2004 to 2011, 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 of your patients, namely B.M., contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Between 2004 and 2011 the dental treatment or lack thereof you provided for your patient, B.M., amounted to supervised neglect, in that:
     - You failed to take radiographs for the patient between September 2004 and July 2011.
     - You failed to diagnose and provide an appropriate referral for treatment of the patient's impacted tooth 38 (lower left 3rd permanent molar) and a cystic lesion on that tooth.
     - You failed to diagnose and adequately treat decay in the patient's tooth 17 (upper right 2nd permanent molar).
   - Between September 2004 and July 2011 you failed to keep adequate records with respect to your treatment of B.M., including: no financial records; no updated medical history; no record of complete examination and radiographs; no notations of specific findings, diagnosis, and treatment plan (options); no documentation of use of local anaesthesia; and no documentation of the patient’s periodontal condition.
   - Between 2005 and 2011 you repeatedly submitted claims for multiple units of scaling for your patient B.M. that were not supported by radiographic or clinical findings and therefore were excessive or unreasonable.
   - In or about July 2011 you submitted claims for surgical curettage for your patient B.M., with no clinical and/or radiographic support and with no local anaesthetic administered.

College Counsel advised us that the College was not seeking a finding of professional misconduct in relation to what had been set out as Allegation #3 in

Exhibit 2.[4]

Evidence

The sole witness called at the hearing was Dr. Fred Eckhaus, since 1992 has served as the College's Senior Advisor, Dental and was involved in investigating the complaints of L.G. and B.M. In the course of his testimony, Dr. Echhaus referred to various documents in the College's Book of Documents, Volumes 1 (**Exhibit 3**, relating to general matters), 2 (**Exhibit 4**, relating to L.G.'s complaint) and 3 (**Exhibit 5**, relating to B.M.'s complaint).[5]

L.G's Complaint / Exhibit 1: Allegations 1, 2, 5 and 6

In relation to L.G's complaint (and the allegations set out in Exhibit 1), Dr. Echkaus testified that initially, the Member provided what were described as "duplicate patient records",[6] not the original patient records that had been sought by the College. Subsequently, when Dr. Zizek provided a copy of the original patient records,[7] it became appear that there were differences between the two versions of these patient records.[8] In addition, there were entries in the copy of the original notes provided by the Member (**Exhibit 4-14**) that were out of chronological sequence, particularly in 2011.

The College repeatedly requested that the Member provide transcripts of her handwritten notes.[9] Eventually, by letter dated March 3, 2013 (and received by the College on March 11, 2013) the Member provided a typed transcript of her

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[4] The Member was alleged to have "signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to one of your patients, namely B.M., contrary to paragraph 28 of Section 2 of the Dentistry Act Regulation."

[5] Documents included in these exhibits are referred below to by exhibit number and tab number; for example, **Exhibit 3-3** (Exhibit 3, Tab 3) was a letter to Dr. Zizek from Ms. Long, the College's Manager, Professional Conduct and Regulatory affairs, informing the Member of the hearing dates set in relation to this matter.

[6] **Exhibit 4-1**.

[7] **Exhibit 4-14**.

[8] These included entries appearing on the copy of the original patient records (**Exhibit 4-14**) for November 13, 2010, December 28, 2010 and February 2, 2011, as well as an indication that L.G. complained of (headaches) "both sides occasionally".

[9] See **Exhibits 4-4**, **4-5**, **4-7** and **4-8** (the College's letters to Dr. Zizek, dated December 17, 2012, January 14, 2013, February 7, 2013 and February 27, 2013).

handwritten clinical chart entries relating to her treatment of L.G.[10]

It was Dr. Eckhaus' evidence that L.G. claimed she paid the Member $2,000.00 for her dentures, but that L.G. was dissatisfied with them. However, Dr. Zizek's notes reflect that L.G. was charged a total of either $250.00 or $500.00.[11] The Member's notes reflect that on November 13, 2010, impressions were taken for upper full and lower partial dentures, and that a "try-in" took place on November 17, 2010. However, according to Dr. Zizek's chart entry for January 15, 2011, L.G. "(did) not like her dentures", and by February 2, 2011, the Member decided to make new upper full dentures for L.G. when her technician returned. According to the Member's notes, the final try-in did not occur until December 4, 2011.

The "technician" Dr. Zizek referred to, and whose services she employed in order to have the dentures fabricated was Miroslav Bakic, DDS.[12] College records indicate that Dr. Bakic was a member of the College from 1974 to 1999, when he resigned.[13] Other documents tendered as evidence established that Dr. Bakic has never been a member of either the College of Dental Technologists of Ontario or the College of Denturists of Ontario.[14]

When Dr. Eckhaus visited Dr. Zizek at her office on August 22, 2013, she told him that she has never charged a patient $2,000.00 for dentures but that all financial transactions were in cash with no receipts, and that she used Dr. Bakic's services as a means of obtaining the lowest possible laboratory fee.[15] The Member agreed that her chart in relation to L.G. was incomplete. Dr. Zizek did not have an on-site dental laboratory at her office.

In the course of his evidence, Dr. Eckhaus was referred to subsection 38(2) of

[10] **Exhibit 4-9**.
[11] See Exhibit **4-14**.
[12] **Exhibit 4-13**.
[13] **Exhibit 4-15**.
[14] Also **Exhibit 4-15**.
[15] See **Exhibit 4-12** (Dr. Eckhaus' Report to the Registrar).

Regulation 547,[16] as well as the College's *Guidelines for Dental Recordkeeping* in force as of January 2002[17] and May 2008,[18] as well as Dr. Michael Gardner's Practice Check article in the November/December 2007 issue of *Dispatch*, entitled "College Draws Clear Distinction between Supervision of In-Office Laboratory and a Commercial Operation".[19]

B.M.'s Complaint / Exhibit 2: Allegations 1, 2, 4, 5 and 6

B.M. was the Member's patient from 2004 to 2011. The main issues arising out of B.M.'s complaint and the resulting allegations against Dr. Zizek were the Member's failure to properly treat a decaying tooth (17) and an impacted wisdom tooth (38), and her failure to take proper radiographs ("x-rays"). Subsequently, both of these teeth were extracted and a cystic lesion was removed by an oral and maxillofacial surgeon, Dr. Claudio Tocchio.[20]

Despite the College's April 22, 2013 request for radiographs relating to B.M.,[21] Dr. Zizek never provided any radiographs to it. A review of the Member's chart for B.M. indicates only three radiographs of B.M. were ever taken by Dr. Zizek; this was on October 25, 2006 when periaptical radiographs of tooth 17 were taken.

In the course of the almost 7 years in which she was B.M.'s dentist, the Member charted reference to tooth 17 on two occasions; October 25, 2006 (when Dr. Zizek indicated that this tooth "needs crown")[22] and February 22, 2010. The only reference to tooth 38 in Dr. Zizek's chart was in the odontogram.[23]

One of the particulars in relation to Allegation 1 in **Exhibit 2** alleged that "[b]etween 2005 and 2011 [Dr. Zizek] repeatedly submitted claims for multiple

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[16] R.R.O. 1990, reproduced at **Exhibit 3-7**, which sets out the minimum requirements for clinical and financial records maintained by member of the College engaged in the practice of dentistry.
[17] **Exhibit 3-8**.
[18] **Exhibit 3-9**.
[19] **Exhibit 3-10**.
[20] **Exhibit 5-13** (Dr. Tocchio's report of March 9, 2012 to Dr. Randy Fisher).
[21] **Exhibit 5-8**.
[22] **Exhibit 5-12**, fourth page.
[23] **Exhibit 5-12**, third page.

units of scaling for [her] patient B.M. that were not supported by radiographic or clinical findings and therefore were excessive or unreasonable". By reference to Dr. Zizek's chart in relation to B.M. (**Exhibit 5-12**), Dr. Eckhaus identified at least 8 occasions when the Member charged for scaling that was not supported by radiographic or clinical findings.[24] Dr. Eckhaus testified that when confronted with a patient requiring this level of scaling on an ongoing basis, a dentist would normally (1) express concern to the patient over the issue and (2) discuss options with the patient, including referral to a periodontist.

Surgical curettage is a surgical procedure involving deep scraping between root surface and gum tissue. It cannot be done without anaesthesia and there is often post-operative recall. Another particular set out in relation to Allegation 1 in **Exhibit 2** was that "[i]n or about July 2011 [Dr. Zizek] submitted claims for surgical curettage for [her] patient B.M., with no clinical and/or radiographic support and with no local anaesthetic administered". There was no charting in **Exhibit 5-12** to support the need to perform surgical curettage on B.M. However, the Member's notes indicate that she performed surgical curettage on B.M. on July 7, 2011 and that "topical anaest[hesia] only [was] administered".[25]

Exhibit 2, Allegation 2 was that Dr. Zizek "failed to keep records as required by the regulations relative to one of [her] patients, namely B.M." In this respect, Dr. Eckhaus referred the Panel to the College's *Guidelines for Dental Recordkeeping* in force as of January 2002[26] and May 2008.[27] The Panel had previously been referred to Exhibit 3-7, an extract from Regulation 547, setting out section 38.[28]

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[24] These were on September 10, 2004 (B.M.'s initial appointment); September 10, 2005; March 16, 2006; September 11, 2007; October 18, 2008; June 13, 2009; October 30, 2010; and May 30, 2011.
[25] **Exhibit 5-12**, sixth page.
[26] **Exhibit 3-8**, and especially pages 5-6 (medical history questionnaire), 6 (periodontal evaluation), 7 (radiographs), 8 (charting of diagnoses and treatment plans), 9 (patient follow-up and recall, specific and emergency examinations) and 11(sample chart and treatment record).
[27] **Exhibit 3-9**. Dr. Eckhaus drew the Panel's attention to two aspects of the updated *Guidelines*: the medical history questionnaire has been expanded to two full pages (pp. 6-7), and the sample clinical record is now more expansive than previously.
[28] Because of its relevance, section 38 of Regulation 547 (**Exhibit 3-7**) is set out below in its entirety:

Submissions of College Counsel and Advice of Independent Counsel

In his submissions, College Counsel indicated that the College's case relied mainly on Dr. Zizek's own patient records, both for what those records show and what they do not show.

Mr. Coleman referred us in particular to three cases: *F.H. v. McDougall*[29] (on the standard of proof applicable to discipline cases); *Rassouli-Rashti v. College of Physicians and Surgeons of Ontario*[30] (also on the standard of proof, and especially, that while there is only one standard of proof in civil cases – that of proof on a balance of probabilities – the court or tribunal "must always scrutinize the evidence with case in order to determine if an alleged event occurred"); and *Re Golomb and College of Physicians and Surgeons of Ontario*[31] (on what constitutes a "*prima facie*" case calling for a response, failing which the court or tribunal can infer that the case has been proven).

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38. A member in the practice of dentistry shall exercise generally accepted standards of practice and procedures in the performance of professional services, and shall,
(a) maintain the office in which and the equipment with which the member engages in the practice of dentistry in a sanitary and hygienic condition;
(b) make and keep clinical and financial records respecting his or her patients and the record for each patient shall contain not less than,
(i) the patient's history,
(ii) the examination procedures used,
(iii) the clinical findings obtained,
(iv) the treatment prescribed and provided, and
(v) the member's fees and charges;
(c) keep the records required under clause (b) in a systematic manner and such records shall be retained for a period of at least ten years after the date of the last entry in the record or until two years following the death of the member, whichever first occurs;
(d) where any person other than a member performs acts in the practice of dentistry on behalf or while employed by the member, ensure that the person performs only the specified acts in the practice of dentistry that are authorized by the regulations and that the specified acts are performed under the supervision of a member;
(e) where giving directions for the making, producing, reproducing, constructing, furnishing, supplying, altering or repairing of any prosthetic denture, bridge, appliance or similar thing,
(i) give the direction in writing,
(ii) sign the direction, and
(iii) where a member would reasonably consider it advisable or the person who is directed by the direction requests it, give a design impression or cast with the direction. R.R.O. 1990, Reg. 547, s. 38.

[29] [2008] S.C.R. 41(and especially paragraphs 40, 46 and 49)
[30] [2009] O.J. No. 4762 (and especially paragraph 60)
[31] (1976), 12 O.R. (2d) 73

The College sought findings of professional misconduct in relation to each of **Exhibit 1**, Allegations 1, 2, 5 and 6; and **Exhibit 2**, Allegations 1, 2, 4, 5 and 6.

In connection with **Exhibit 1**, Allegation 5 (contravening a provision of the *Dentistry Act, 1991*, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts by employing/using an individual who was not a registered dental technologist or denturist to fabricate dentures for her patient, L.G., and failing to supervise this individual during the fabrication of the dentures), College Counsel also referred the Panel to section 32 of the *Regulated Health Professions Act, 1991*.[32] Mr. Coleman submitted that utilizing the services of Dr. Miroslav Bakic to fabricate prosthetic dental devices (dentures) for L.G. constituted a contravention of section 32 of the Dentistry Act Regulation.

With respect to **Exhibit 1**, Allegation 2, Mr. Coleman submitted that the Member had failed to keep records as required by the regulations. The records contained little or no financial documentation, and the Member's clinical records were minimal and inadequate. In addition, some of the entries in **Exhibit 4-14** were out of chronological sequence, something that may ground an

[32] Section 32 of the *Regulated Health Professions Act, 1991* is set out below:

Dental devices, etc.

32. (1) No person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless,

(a) the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario; or

(b) the person is a member of a College mentioned in clause (a).

Employers

(2) A person who employs a person to design, construct, repair or alter a dental prosthetic, restorative or orthodontic device shall ensure that subsection (1) is complied with.

Supervisors

(3) No person shall supervise the technical aspects of the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device unless he or she is a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario.

Denturists

(4) This section does not apply with respect to the design, construction, repair or alteration of removable dentures for the patients of a member of the College of Denturists of Ontario if the member does the designing, construction, repair or alteration or supervises their technical aspects.

Exceptions

(5) This section does not apply with respect to anything done in a hospital as defined in the *Public Hospitals Act* or in a clinic associated with a university's faculty of dentistry or the denturism program of a college of applied arts and technology. 1991, c. 18, s. 32.

inference that at least some aspects of the chart notations were only made after L.G.'s complain was brought to Dr. Zizek's attention.

Exhibit 1, Allegation 6 alleged in part that "[s]ubsequent to January 2012, [Dr. Zizek] ignored the patient's attempts to contact [her]". Mr. Coleman noted that in her response to L.G.'s complaint, Dr. Zizek's stated that she "decided to ignore [L.G.'s] calls".[33]

Turning to **Exhibit 2** and by reference to **Exhibit 5-12**, Mr. Coleman pointed to the Member's failure to take radiographs between September, 2004 and July 2011.[34] The Member failed to diagnose B.M's impacted wisdom tooth (tooth 38). There was no examination of this tooth and no inquiry at all by Dr. Zizec, who also failed to diagnose the cystic lesion. Mr. Coleman also submitted that the Member failed to diagnose and adequately treat tooth 17. College Counsel also submitted that it was apparent from the evidence that between 2005 and 2011, Dr. Zizek repeatedly submitted claims for multiple units of scaling that were unsupported by radiographic or clinical findings and were therefore excessive or unreasonable. Similarly, Mr. Coleman submitted that the evidence at the hearing established that the Member had submitted claims for surgical curettage performed on B.M. with no clinical or radiographic support and with no local anaesthetic administered.

In his advice to us, independent counsel returned to *F.H. v. McDougall*, pointing out the passage stating that "evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test."[35]

Independent counsel advised the Panel that the word "employs" in subsection 32 of the *Regulated Health Professions Act, 1991*[36] should be given a broad

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[33] **Exhibit 4-6**.
[34] In his advice to us, independent counsel pointed to the periaptical radiographs apparently taken on October 25, 2006. Mr. Gover advised that it was open to the Panel to find that this particular in **Exhibit 2**, Allegation 1 had been proven with the exception of these radiographs, i.e., that "With the exception of three radiographs taken on October 25, 2006, you failed to take radiographs for the patient between September 2004 and July 2011."
[35] Note 29 at paragraph 46.
[36] Excerpted above in Note 32.

meaning, extending the duty set out there beyond employers in the strict sense, to anyone who uses the services of a person to "design, construct, repair or alter a dental prosthetic, restorative or orthodontic device".

With respect to the allegations of inadequate recordkeeping (**Exhibit 1**: Allegations 2 and 6; **Exhibit 2**: Allegations 2 and 6), Mr. Gover advised the Panel to focus on the requirements set out in section 38 of Regulation 547.[37]

Mr. Gover also reminded us of the meaning of the terms "disgraceful", "dishonourable", "unprofessional" or "unethical" in connection with **Exhibit 1**, Allegation 6 and **Exhibit 2**, Allegation 6, and advised us that because the disjunction word "or" is used, the Panel must decide which, if any, of these descriptions applies to the Member's alleged conduct.

"Disgraceful", "dishonourable" and "unprofessional" conduct can each be seen in a spectrum.

"Disgraceful" conduct is conduct that has the effect of shaming the Member and, by extension, the profession. In order to be disgraceful, the conduct should cast serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet. "Dishonourable" conduct is similar, but need not be as severe. However, "dishonourable" conduct is often the best description for conduct involving dishonesty or deceit. Such conduct is considered in most areas of law to be the most serious and worthy of sanction, and in many cases dishonest conduct should also be regarded as "disgraceful". Both dishonourable and disgraceful conduct have an element of moral failing. By contrast, "unprofessional" conduct does not require any dishonest or immoral element to the act or conduct. Many courts have found that unprofessional conduct includes a "serious or persistent disregard for one's professional obligations." This term recognizes the general traits of good judgment and responsibility that are required of those privileged to practice the profession. Whether or not a member commits an act that disgraces him or her

[37] **Exhibit 3-7**, excerpted above in Note 28.

and dishonours the profession, failure to live up to the standards expected of him or her can demonstrate that a member is, simply put, not professional.

The definition of "unethical" conduct is straightforward.

Decision

The Panel unanimously found the Member guilty with respect to the each of the allegations of professional misconduct on which the College sought such findings. In other words, the Panel found that the Member engaged in the forms of professional misconduct described in each of **Exhibit 1**, Allegations 1, 2, 5 and 6; and **Exhibit 2**, Allegations 1, 2, 4, 5 and 6.

Reasons

Exhibit 1, Allegations 1 and 5: Dr. Zizek employed/used an individual who was not a registered dental technologist, denturist or member of the Royal College of Dental Surgeons of Ontario to fabricate dentures for a patient contrary to subsections 32(1) and 32(2) of the *Regulated Health Professions Act, 1991*.

Exhibit 2, Allegation 1: Dr. Zizek failed to provide proper dental care to a patient contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation. The Member failed to diagnose and provide a proper referral for treatment of an impacted tooth 38 with an associated cystic lesion. She failed to diagnose and adequately treat decay in tooth 17 which led to extraction of the tooth.

Exhibit 1, Allegation 2 and **Exhibit 2**, Allegation 2: Dr. Zizek failed to keep records for the two patients, as required by the regulations contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation. The treatment records were incomplete and likely altered. Medical Questionnaires were deficient, radiographs were absent and no financial records were available. The Member failed to keep the patient's records as set out by the Regulation.

Exhibit 2, Allegation 4: The Panel found that the Member charged a fee that was excessive or unreasonable in repeatedly submitting claims for multiple units of scaling that were not supported by radiographic or clinics findings, and by submitting claims for surgical curettage with no clinical or radiographic support and with no local anaesthetic administered.

Exhibit 2, Allegation 5: The Panel found that in submitting the claims referenced in the preceding paragraph, the Member submitted an account for services that she knew or ought to have known was false or misleading.

Exhibit 1, Allegation 6 and **Exhibit 2**, Allegation 6: The Panel found the Member's conduct to be disgraceful, dishonourable, unprofessional and unethical. The Member's conduct was disgraceful due to her inadequate patient treatment and flagrant violation of the Regulated Health Professions Act. The Member's unsupported and excessive claims for treatment were dishonourable. The Member's conduct was considered unprofessional and unethical due to the lack of adequate records and the unreasonable submission of claims for treatment.

Penalty Submissions

College Counsel is directed to contact Ms. Evans, the College's Administrative Assistant, Hearings, in order that arrangements may be made for receipt of the College's penalty submissions. The Panel understands that the College may make these submissions in writing rather than in the context of an oral hearing. Whether the College's penalty submissions are heard orally or in writing, it is understood that consistent with subsection 7(1) of the *Statutory Powers Procedure Act*,[38] the Member is not entitled to notice of the penalty hearing.

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[38] Excerpted in Note 1, above.

March 28, 2016

Dr. Richard Hunter, Chair
on behalf of the Panel:

Dr. Lisa Kelly
Dr. William Coyne
Mr. Gregory Larsen – Public Member
Mr. Derek Walker – Public Member

H140005
H140006

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario 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*") respecting one **DR. JOVANKA ZIZEK,** of the City of Richmond Hill, in the Province of Ontario;

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 Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

Members in Attendance:

Dr. Richard Hunter, Chair
Dr. Lisa Kelly
Dr. William Coyne
Mr. Gregory Larsen – Public Member
Mr. Derek Walter – Public Member

Appearances:

Mr. Nick Coleman for the RCDSO

No one for Dr. Jovanka Zizek

Mr. Brian Gover, Independent Legal Counsel to the Discipline Committee of the RCDSO

Ms. Krystal Evans, Hearings Clerk

DECISION AND REASONS – PENALTY AND COSTS

Introduction

In a decision dated March 28, 2016, this panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario (the "Panel") found that Dr. Jovanka Zizek (the "Member") engaged in professional misconduct as set out in nine (9) allegations against her.

These were the forms of professional misconduct described in each of **Exhibit 1, Allegations 1** (contravening or failing to maintain the standards of practice of the profession), **2** (failing to keep patient records as required by the regulations), **5** (contravening a provision of the *Dentistry Act, 1991*, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts relative to one of her patients), and **6** (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, relative to one of her patients); and **Exhibit 2, Allegations 1** (contravening or failing to maintain the standards of practice of the profession), **2** (failing to keep patient records as required by the regulations), **4** (charging a fee that is excessive or unreasonable in relation to the services performed relative to one of her patients), **5** (submitting an account that she ought to have knows was false or misleading relative to one of her patients) and **6** (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, relative to one of her patients).

Because the Member had not attended the hearing on March 16, 2016 despite being given notice of it and the Panel had proceeded in her absence, the Panel did not reconvene the hearing for submissions as to penalty and costs but instead received written submissions from the College, on which it deliberated.

The College's Submissions on Penalty and Costs and Proposed Order

In its written submissions, the College suggested that the order as to penalty and costs reproduced at Appendix "A" would be appropriate in the circumstances of this case.

The College noted that the Member had resigned her membership in the College in January, 2016 and is currently not permitted to practise dentistry. The proposed penalty order's provisions for suspension of her certificate of registration and imposition of term, conditions and limitations would therefore only come effective if her certificate of registration is reinstated or she obtains a new one, if ever. It was also submitted that the amount of costs being sought ($5,000.00) represents only a "very limited portion of the actual legal costs incurred by the College".

The College submitted that the penalty order it proposed was appropriate having regard to the following factors:

(a) the seriousness of the misconduct;

(b) the objectives of deterrence and remediation;

(c) past decisions of the Discipline Committee regarding similar misconduct; and

(d) the interests of the public, the profession and the Member.

Decision on Penalty and Costs

On June 6, 2016, the Panel convened by teleconference in order to deliberate about the appropriate order to make concerning penalty and costs. .

The Panel concluded that the College's proposed order as to penalty and costs was appropriate in all circumstances of this case. It therefore ordered its terms as set out in Appendix "A" be implemented.

Reasons for Decision as to Penalty and Costs

The Panel was satisfied that a reprimand, a three (3) month suspension and the awarded costs will act as specific and general deterrents.

The Panel noted that the Member does not currently hold a certificate of registration due to her resignation from the College. However, the terms, limitations and conditions shall be imposed if the Member is reinstated or obtains a new certificate of registration. If the Member resumes practising, College approved courses in diagnosis, treatment planning, radiology and communication with patients regarding diagnosis and treatment options will facilitate remediation of her practice and will protect the public. Monitoring the Member's practice for a 24-month period will also serve to protect the public.

The Member's absence from the hearing and lack of a defense left the Panel with no mitigating factors to consider. The Panel did recognize that the Member has not appeared before a Discipline Panel in the past.

Overall, the Panel was satisfied that the provisions set out in this penalty adequately protect the public.

June 13, 2016

Dr. Richard Hunter, Chair
on behalf of the Panel:

Dr. Lisa Kelly
Dr. William Coyne
Mr. Gregory Larsen – Public Member
Mr. Derek Walter – Public Member

Appendix "A"

Proposed Order on Penalty and Costs

1. Requiring the Member to appear before the Panel of the Discipline Committee to be reprimanded, on a date to be fixed by the Registrar.

2. Directing the Registrar to suspend the Member's certificate of registration for a period of three (3) months, with the suspension to commence on the date that the certificate of registration of the Member is reinstated or she obtains a new certificate of registration, and shall run without interruption.

3. Directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which Conditions shall take effect on the date that the suspension of the Member's certificate of registration commences pursuant to paragraph 2 above and shall continue until the suspension of the Member's certificate of registration has been fully served, namely:

   (a) while the Member's certificate of registration is under suspension, the Member shall not be present in her dental office when patients are present, save and except for unforeseen non-patient related emergencies, and where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact, including details of the nature of the emergency;

   (b) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

   (c) during the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do anything that would suggest to patients that the

Member is entitled to engage in the practice of dentistry during the suspension;

(d) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in the connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

(e) the Conditions imposed in clauses (a)-(d) of paragraph 3 above shall be removed at the end of the period during which the Member's certificate of registration is suspended.

4. Directing the Registrar to impose the following additional terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which Conditions shall take effect on the date that the certificate of registration of the Member is reinstated or she obtains a new certificate of registration, namely:

(a) that the Member shall successfully complete, at her own expense, the following courses, with the Member to provide proof of successful completion of the courses in writing to the Registrar within six (6) months of this Condition taking effect:

(i) a course or courses in diagnosis, treatment planning, sufficiency of radiographs, radiographic interpretation, and communication with patients regarding diagnosis and treatment options, as approved by the College; and

(ii) the College course on Recordkeeping for Ontario Dentists;

(b) that the Member's practice shall be monitored by the College by means of inspection(s) by representative(s) of the College at such time or times as the College may determine during the period commencing with the date the College receives confirmation in writing acceptable to the Registrar that the courses set out in clause (a) of paragraph 4 above have been completed successfully and ending on the date that is twenty-four (24) months from the date of successful completion of the courses referred to in clause (a) of

paragraph 4 above, or the date a panel of the Inquiries, Complaints and Reports Committee ("ICRC") of the College decides that monitoring is no longer necessary, whichever date is earlier, on the following terms:

(i) the Member shall cooperate with the College during the inspection(s);

(ii) the Member shall pay to the College in respect of the costs of monitoring, the amount of $600.00 per monitoring inspection such amount to be paid immediately after completion of each of the inspections, provided that the overall cost of monitoring paid by the Member shall not exceed $2,400.00, regardless of number of inspections performed; and

(iii) the representative or representatives of the College shall report the results of the inspections to the ICRC and the ICRC may, if deemed warranted, take such action as it considers appropriate;

(c) that the Conditions imposed by virtue of clause (a) of paragraph 4 shall be removed from the Member's certificate of registration on the date the College receives confirmation in writing acceptable to the Registrar that the courses set out in clause (a) of paragraph 4 above have been completed successfully; and

(d) that the Conditions imposed by virtue of clause (b) of paragraph 4 above shall be removed from Member's certificate of registration the date following twenty-four (24) months from the date that the College receives confirmation in writing acceptable to the Registrar that the courses set out in clause (a) of paragraph 4 above have been completed successfully, or the date the ICRC decides that monitoring is no longer necessary, whichever date is earlier.

5. The Member shall pay costs to the College in the amount of $5,000.00 no later than 30 days following the date this Order becomes final.