THE DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

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 ("Regulated Health Professions Act") respecting one **DR. WAJAHAT KHAN** of the City of Kingston 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").

Members in Attendance: Dr. Richard Hunter, Chair, Professional Member
Dr. William Coyne, Professional Member
Dr. Nancy Di Santo, Professional Member
Mr. Gregory Larsen. Public Member
Mr. Derek Walter. Public Member

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Johanna Braden Independent Counsel for the Discipline Committee of the Royal College of Dental Surgeons of Ontario
- and -	)	
	)	Mr. Nick Coleman For the Royal College of Dental Surgeons of Ontario
DR. WAJAHT KHAN	)	Mr. David Crowe For Dr. Khan

Hearing held on December 12 and 13, 2016.

REASONS FOR DECISION

This matter first 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 12, 2016. The parties advised that they were in the process of negotiating a resolution of the matter. The hearing was adjourned and took place on December 13, 2016.

PUBLICATION BAN

At the request of the parties, the Panel made an order pursuant to subsection 45(3) of the *Health Professions Procedural Code* banning the publication and broadcasting of the names of the patients identified in the hearing, including in any exhibits tendered at the hearing, or any information that would tend to identify the patients, other than the fact that one of the patients was Dr. Khan's mother, who may be identified with her initials.

THE ALLEGATIONS

The allegations concerning Dr. Wajahat Khan (the "Member") are set out in the Notice of Hearing dated July 24, 2014. College Counsel requested leave to withdraw some of the allegations and some of the particulars of the allegations. The remaining allegations and particulars against the Member are as follows.

IT IS ALLEGED THAT:

1. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
DG., T.	2012
F, B.	2013
K., S.	2012
M., R.	2013

Particulars:

- You prescribed an excessive quantity of narcotic pain medication (96 tablets each of Hydromorphone 1.0 mg and 0.5 mg) for your mother, Ms. S.K.
- You prescribed Pantoloc, a proton pump inhibiter typically used to treat gastroesophageal reflux disease, for your mother, Ms. S.K..
- You prescribed medication (Flexeril, Pantoloc and Pantoprazole) for treatment of non-dental related conditions. Prescribing this medication fell outside the scope of dentistry (T.DG., B.F., R.M.).

2. *withdrawn*;

3. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, you failed to keep records as required by the Regulations relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
C., J.	2012
DG., T.	2012
F., B.	2013
H., J.	2012
K., S.	2012
L., A.	2012
M., R.	2012
N., K.	2013
R., L.	2012

- You failed to keep records of the prescriptions of Hydromorphone and Pantoloc, for your mother, Ms. S.K.
- You failed to keep adequate records of your treatment of your mother, Ms. S.K., including no clinical chart entries with respect to extractions and dental implant treatment.
- You were unable to account for a prescription for 30 tablets of Lorazepam 1.0 mg filled on or about June 19, 2012, which does not appear in your drug logbook.
- You failed to keep adequate records of your prescriptions for patients, including incomplete or no documentation of the following prescriptions:

Patient	Date	Prescription
C., J.	Nov. 07/12	60 Flexeril 10 mg (quantity not noted)
DG., T.	Oct. 04/12	90 Pantoprazole 40 mg (nothing noted in chart) 60 Flexeril 10 mg (nothing noted in chart)
	Nov. 13/12	15 Amoxicillin 500 mg (nothing noted in chart)
F., B.	Mar. 05/13	30 Pantoloc 40 mg (quantity not noted) 20 Hydromorphone 1 mg (quantity not noted)
	Mar. 26/13	42 Amoxicillin 500 mg (nothing noted in chart)
	May 09/13	15 Amoxicillin 500 mg (nothing noted in chart)
H., J.	Feb. 02/12	30 Amoxicillin 500 mg (nothing noted in chart)
L., A.	Jul. 02/12	60 Ketoprofen 50 mg (nothing noted in chart)
M., R.	Feb. 22/12	30 Ratio-Lenoltec #3 (nothing noted in chart) 20 Ratio-Oxycocet 5/325 mg (nothing noted in chart)
N., K.	Mar. 07/13	20 Ratio-Oxycocet 5/325 mg (nothing noted in chart)
	Apr. 10/13	20 Lenoltec #3 (nothing noted in chart)

R., L.	Oct. 01/12	30 Amoxicillin 500 mg (nothing noted in chart)

4. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, you engaged in conduct or performed an act or acts 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 the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
DG., T.	2012
F., B.	2013
K., S.	2012
M., R.	2013

Particulars:

- You prescribed an excessive quantity of narcotic pain medication (96 tablets each of Hydromorphone 1.0 mg and 0.5 mg) for your mother, Ms. S.K.
- You prescribed Pantoloc, a proton pump inhibiter typically used to treat gastroesophageal reflux disease, for your mother, Ms. S.K.
- You prescribed medication (Flexeril, Pantoloc and Pantoprazole) for treatment of non-dental related conditions. Prescribing this medication fell outside the scope of dentistry (T.DG., B.F., R.M.).

THE MEMBER'S PLEA

The Member orally admitted the allegations of professional misconduct other than those withdrawn by the College. He also made admissions in writing in the Agreed Statement of Facts, which had been signed by him, and in which he expressly admitted the facts as set out in the Notice of Hearing and further admitted that these acts constitute professional misconduct as alleged. The Panel found that the Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, College Counsel introduced into evidence an Agreed Statement of Facts which substantiated the allegations. The Agreed Statement of Facts is as follows.

Allegations of Professional Misconduct

1. The allegations of professional misconduct against Dr. Wajahat Khan are set out in the Notice of Hearing dated July 24, 2014 (Exhibit 1).

Background

2. Dr. Khan has been registered with the Royal College of Dental Surgeons of Ontario ("the College') as a general dentist since June 2001. At the relevant times, Dr. Khan owned and practised at Cataraqui Woods Dentistry in Kingston and also practised as an associate at two other dental clinics in Kingston and Barrie.

3. Dr. Khan's current places of practice include Kingston and Toronto.

4. Dr. Khan has no prior record of discipline with the College.

Investigation

5. The College's investigation of Dr. Khan was prompted by a report received from a pharmacist in October 2012 regarding prescriptions that Dr. Khan had issued to his mother, S.K., on October 7, 2012. The prescriptions included 96 Hydromorphone 1.0 mg, 96 Hydromorphone 0.5 mg, 60 Ketoprofen 100 mg and a three month supply of Pantoloc 40 mg (three month supply).

6. Hydromorphone is a narcotic for treating pain. Ketoprofen is an NSAID also for treating pain. Pantoloc is a proton pump inhibitor typically used to treat gastro-esophageal reflux disease but also excessive stomach acid caused by NSAIDs.

7. The pharmacist reported to the College that he was concerned both about the quantity of narcotics that had been prescribed for the patient and the dental or non-dental reasons for the prescriptions to be issued. Even after discussing these matters with Dr. Khan, the pharmacist

declined to fill the prescriptions and reported his concerns to the College.

8. The Registrar of the College appointed an investigator to inquire into Dr. Khan's conduct with respect to prescribing practices, including the prescriptions issued for S.K..

9. The College investigator attended at Dr. Khan's practice in December 2012 to interview Dr. Khan and to obtain from him Dr. Khan's patient chart for S.K.

10. The College investigator's analysis of Dr. Khan's patient chart for S.K. revealed the following:

- The chart contained only three progress note entries, dated August 7, 2012; August 14, 2012; and August 21, 2012. All three chart entries deal with hygiene appointments, and there were no entries regarding extractions, implants or periodontal treatments.

- There was no entry in the records regarding the prescriptions that were issued by Dr. Khan on October 7, 2012.

- The chart contained a periapical radiograph dated August 7, 2012 that showed an implant at the 46 location. A panoramic radiograph dated December 13, 2012 showed two implants in the 36 and 46 locations. The progress notes did not include any entries regarding either radiograph.

- There was no financial ledger in Dr. Khan's patient chart for S.K.

11. The College investigator prepared a Report of Investigation ("ROI") which was submitted to the Registrar and the Inquiries, Complaints and Reports Committee ("ICRC") in July 2013. Dr. Khan was provided with a copy of the ROI and was invited to make submissions in response to the report.

12. Dr. Khan provided his submissions in August 2012. In his submissions, Dr. Khan stated:

- He operated on S.K., his mother, on October 6, 2012. He performed periodontal surgery on the right side of her dentition, extracted a tooth that was unrestorable (unplanned) and

performed stage 2 implant surgery on a previously placed implant.

- At the time of the surgery on October 6, 2012, S.K. was being managed for pain relating to an acute bout of osteoarthritis in her knee with oral NSAIDs and Percocet 325/5.

- The day after surgery, S.K. reported unrelenting pain from the dental operations despite the pain medications she had for her knee. She also reported that she was having problems with her stomach, presumably because of the NSAID medication she was taking. As a result, Dr. Khan prescribed the additional medications for pain relief on October 7, 2012 that he thought were appropriate for her in the circumstances.

- Dr. Khan acknowledged that he prescribed a larger quantity of narcotics than he would normally prescribe but he thought his mother was a reliable patient and he wanted to ensure that she would be comfortable.

- According to Dr. Khan, he understood the pharmacist's concern regarding the prescriptions, particularly because his sister-in-law had described, in error, a non-dental reason for prescribing the narcotics for S.K.

- Dr. Khan also apologized for his poor recordkeeping with respect to S.K. He claimed that he had seen her for dental treatments at the end of the days in question and had forgotten to write appropriate notes regarding her treatments, including prescriptions.

13. The ICRC reviewed the case in August 2013. Following the review, the ICRC directed the College investigator to make further inquiries regarding Dr. Khan's prescribing practices.

14. The College investigator attended Dr. Khan's practice in September 2013 to obtain additional patient charts for patients for whom Dr. Khan had prescribed controlled substances, including narcotics and targeted substances such as benzodiazepines.

15. In the course of the additional investigation, the College investigator obtained records from nine pharmacies in the Kingston area regarding all prescriptions for controlled substances prescribed by Dr. Khan from January 2012 to September 2013. The College investigator then

obtained from Dr. Khan the patient charts for 40 patients for whom prescriptions had been issued by Dr. Khan.

16. The College investigator's analysis of the records for the 40 patients revealed the following:

- Dr. Khan had prescribed Flexeril (cyclobenzaprine) and/or Pantoloc (Pantoprazole) for the patients, T.DG., B.F. and R.M., without charting why these medications were being prescribed, or why such quantities or strengths of each medication were being prescribed.

- With respect to T.DG., Dr. Khan prescribed 90 Pantoprazole 40 mg and 60 Flexeril 10 mg on or about October 2, 2012 but did not chart the prescriptions, or anything other than a reference to toothache, in the patient record.

- With respect to B.F., Dr. Khan prescribed 30 Pantoprazole 40 mg on March 5, 2013 without charting why the prescription was required or why the quantity and dose were appropriate.

- With respect to R.M., Dr. Khan prescribed 60 Flexeril 10 mg on July 24, 2013 without charting anything to explain why the prescription was being issued.

17. The College investigator's analysis of the records regarding the other patients also revealed the following:

- With respect to the patient, J.C., Dr. Khan prescribed 60 Flexeril 10 mg on November 7, 2012 but failed to record the quantity of the drug prescribed.

- With respect to T.DG. (as noted above), Dr. Khan issued a prescription for 90 Pantoprazole 40 mg and 60 Flexeril 10 mg on October 4, 2012 but failed to chart the prescriptions in the patient record.

- With respect to B.F. (as noted above), Dr. Khan prescribed 30 Pantoloc 40 mg and 20 Hydromorphone 1 mg on March 5, 2013 but failed to chart the quantity prescribed of each medication. As well, Dr. Khan prescribed 42 Amoxicillin 500 mg on March 26, 2013 and 15 Amoxicillin 500 mg on May 9, 2013 but failed to chart either prescription in the patient record.

- With respect to the patient, J.H., Dr. Khan prescribed 30 Amoxicillin 500 mg on February 2, 2012 but failed to chart the prescription in the patient record.

- With respect to the patient, A.L., Dr. Khan prescribed 60 Ketoprofen 50 mg on July 2, 2012 but failed to chart the prescription in the patient record.

- With respect to the patient, R.M., Dr. Khan prescribed 30 Tylenol #3 (acetaminophen 300 mg/codeine 30 mg) and 20 Percocet (oxycodone/acetaminophen 325 mg) on February 22, 2012 but failed to chart either prescription in the patient record.

- With respect to the patient, K.N., Dr. Khan prescribed 20 Percocet on March 7, 2013 and Tylenol #3 on April 10, 2013 but failed to chart either prescription in the patient record.

- With respect to the patient, L.R., Dr. Khan prescribed 30 Amoxicillin 500 mg on October 1, 2012 but failed to chart the prescription in the patient record.

18. The College investigator also confirmed that Dr. Khan had issued a prescription for a clinic supply of 30 Lorazepam 1 mg on June 17, 2013. This prescription was not accounted for in the drug logbook kept by Dr. Khan. Dr. Khan advised that he had decided not to keep the supply of Lorazepam in his possession so he destroyed the supply, which he had witnessed by a staff member. Dr. Khan acknowledged that he had failed to record the clinic supply of Lorazepam, or the destruction of the supply, in the drug logbook, as required.

19. The College investigator's further inquiries and analysis of records were summarized in an Addendum to the ROI which was submitted to the Registrar and the ICRC on March 19, 2014.

20. In the Addendum to the ROI, the College investigator also identified numerous prescriptions issued for narcotics for patients receiving dental treatment that raised concerns regarding Dr. Khan's prescribing practices with respect to narcotics for pain relief. However, experts consulted by both the College and Dr. Khan following the referral to discipline advised that the prescriptions for narcotics for the patients in question (other than S.K.) were within the range of acceptable prescribing practices.

21. A copy of the Addendum of the ROI was provided to Dr. Khan in March 2014 and he was invited to make submissions in response to the report.

22. Dr. Khan provided his submissions in response to the Addendum to the ROI in April 2014.

23. The investigation of Dr. Khan's prescribing and recordkeeping practices was reviewed by the ICRC at its meeting in June 2014.

24. Dr. Khan was invited to make further submissions to the ICRC which he did prior to the meeting in June 2014. Dr. Khan acknowledged that he had prescribed too much pain medication for his mother, S.K., on October 7, 2012. However, he also provided his further explanation regarding the dental treatments he had performed for her on October 6, 2012 and his subsequent concern with respect to managing her pain when she was already taking narcotics and NSAIDs for her osteoarthritic knee. Dr. Khan also generally defended his practice of prescribing Flexeril for dental conditions and Pantoloc for acid reflux caused by NSAIDs. However, Dr. Khan acknowledged that his recordkeeping practices were deficient in relation to charting prescriptions and his rationales for issuing the prescriptions in question.

Decision to Refer

25. The ICRC decided to refer allegations of professional misconduct against Dr. Khan to the Discipline Committee in June 2014. The allegations are set out in the Notice of Hearing dated July 24, 2014.

Recordkeeping Regulation

26. *Regulation 547: Dentistry*, section 38, provides that a member in the practice of dentistry "... shall exercise generally accepted standards of practice of procedures in the performance of professional services...". Under section 38(b), a dentist is required "... to make and keep clinical and financial records respecting his or her patient ..." which must include:

- the patient's history;
- the examination procedures used;
- the clinical findings obtained;

- the treatment prescribed and provided; and
- the dentist's fees and charges.

The records must be retained for a period of at least 10 years after the date of the last entry.

27. The *Benzodiazepines and Other Targeted Substances Regulations* (under the federal *Controlled Drugs and Substances Act*), s. 60 requires practitioners to keep records regarding all transactions involving a clinic (emergency) supply of a targeted substance such as Lorazepam.

Admissions of Professional Misconduct

28. Dr. Khan admits that he committed acts of professional misconduct as alleged in the Notice of Hearing dated July 24, 2014.

29. In particular, Dr. Khan admits that:

- he contravened a standard of practice or failed to maintain the standards of practice of the profession with respect to prescribing excessive quantities of narcotic pain medication and Pantoloc for his mother, S.K., and for prescribing Flexeril (cyclobenzaprine) and Pantoloc (Pantoprazole) for the patients, T.D., B.F. and R.M., with no charted rationale for doing so or for prescribing such quantities, as alleged in paragraph 1 of the Notice of Hearing;
- he failed to keep records as required by the Regulations regarding the patients, J.C., T.D., B.F., J.H., S.K., A.L., R.M., K.N. and L.R., and the clinic supply of Lorazepam, as alleged in paragraph 3 of the Notice of Hearing; and
- he engaged in conduct or performed an act or acts that, having regard to all circumstances, would reasonably be regarded by members as unprofessional with respect to prescribing excessive quantities of narcotic pain medication and Pantoloc for S.K., and for prescribing Flexeril and/or Pantoloc for the patients, T.D., B.F. and R.M., when there was no rationale charted for prescribing these medications or the quantities prescribed for these patients in the patient records.

30. With leave of the Discipline Committee, the College withdraws the allegation in paragraph 2 of the Notice of Hearing, and the particulars in the allegations in paragraphs 1, 2 and 4 regarding excessive prescribing of narcotics for patients other than S.K.

DECISION

Having considered the evidence and submissions of the parties, the Panel finds that the Member committed professional misconduct as alleged in the allegations contained in the Notice of Hearing. Specifically, the panel finds that the Member committed acts of professional misconduct as provided by s. 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that he:

1. contravened a standard of practice or failed to maintain the standards of practice of the profession relative to patients T.D., B.F., S.K. and R.M. in respect of his prescribing practices as particularized in Allegation 1 in the Notice of Hearing;

2. failed to keep records as required relative to nine patients in 2012 and 2013 as particularized in Allegation 3 in the Notice of Hearing; and

3. engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical, as particularized in Allegation 4 in the Notice of Hearing. We agreed with counsel that this conduct would reasonably be regarded by members to be unprofessional.

REASONS FOR DECISION

The Panel was of the view that the evidence in the Agreed Statement of Facts clearly substantiated the three allegations of professional misconduct. It demonstrated the Member's disregard for his patients' well-being and for the College's standards of practice.

Dr. Khan admits:

- He contravened the profession's standard of practice with respect to prescribing excessive quantities of narcotic pain medication and prescribing other medications with no charted rationale for doing so.

- He failed to keep adequate records as required by the Regulations regarding various patients and office drug supplies.

- He engaged in conduct or performed an act or acts that, would reasonably be regarded by members as unprofessional with respect to prescribing excessive quantities of narcotic pain medications and other medications with no charted rationale for doing so.

The Panel found Dr Kahn's conduct was unprofessional due to his persistent disregard for a professional obligation but the conduct in this case, having regard to all the circumstances, was not viewed as disgraceful, dishonourable or unethical.

PENALTY EVIDENCE

The Member submitted further evidence in the form of a brief of documents containing his curriculum vitae, reference letters and letters of support from peers and patients, including some of the patients identified in the Notice of Hearing.

PENALTY AND COSTS SUBMISSIONS

The parties jointly submitted that the Panel ought to make an order as follows:

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 two (2) months. The suspension shall commence 30 days following the Order becoming final, or on a date selected by the Member provided that such date is within six (6) months of this Order becoming final, 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 continue until the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served, namely:

    a. while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office when patients are present, save and except for unforeseen non-patient related emergencies.

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 that 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"), namely:

a. the Member shall successfully complete, at his own expense, and within eight (8) months following this Order becoming final or such additional time as may be permitted by the Registrar, the following remedial courses:

i. the College's course on Recordkeeping for Ontario Dentists or equivalent, as approved by the Registrar;

ii. a course on prescribing practices, including management of dental pain and appropriate use of narcotics, as approved by the Registrar; and

iii. the ProBE Program on Ethics for Healthcare Professionals, to be completed with an unconditional pass;

b. the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine during the twenty-four (24) months following written confirmation to the Registrar that the Member has completed all of the courses referred to in sub-paragraph 4(a) above. The Member shall cooperate with the College during the inspections and, further, shall pay to the College in respect of the cost of monitoring, the amount of $600.00 per inspection, such amount to be paid immediately after completion of each of the inspections;

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

d. the Conditions imposed by virtue of clause (b) of paragraph 4 shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clause (b) of paragraph 4 above have been completed successfully.

5. Ordering the Member to pay costs to the College in the amount of $15,000 no later than 30 days following this Order becoming final.

DECISION ON PENALTY AND COSTS

The panel of the Discipline Committee accepted the joint submission from the parties and imposed the following penalty upon the Member:

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

2. The Registrar is directed to suspend the Member's certificate of registration for a period of two (2) months. The suspension shall commence 30 days following the Order becoming final, or on a date selected by the Member provided that such date is within six (6) months of this Order becoming final, and shall run without interruption.

3. The Registrar is directed to impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served, namely:

   a. while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office when patients are present, save and except for unforeseen non-patient related emergencies. 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 that 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. The Registrar is directed to impose the following additional terms, conditions and limitations on the Member's certificate of registration (the "Conditions"), namely:

   a. the Member shall successfully complete, at his own expense, and within eight (8) months following this Order becoming final or such additional

time as may be permitted by the Registrar, the following remedial courses:

i. the College's course on Recordkeeping for Ontario Dentists or equivalent, as approved by the Registrar;

ii. a course on prescribing practices, including management of dental pain and appropriate use of narcotics, as approved by the Registrar; and

iii. the ProBE Program on Ethics for Healthcare Professionals, to be completed with an unconditional pass;

b. the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine during the twenty-four (24) months following written confirmation to the Registrar that the Member has completed all of the courses referred to in sub-paragraph 4(a) above. The Member shall cooperate with the College during the inspections and, further, shall pay to the College in respect of the cost of monitoring, the amount of $600.00 per inspection, such amount to be paid immediately after completion of each of the inspections;

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

d. the Conditions imposed by virtue of clause (b) of paragraph 4 shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clause (b) of paragraph 4 above have been completed successfully.

5. The Member shall pay costs to the College in the amount of $15,000 no later than 30 days following this Order becoming final.

REASONS FOR PENALTY DECISION

After deliberation, the Panel concluded that the proposed penalty was appropriate in all circumstances of this case. It therefore accepted the Joint Submission and ordered its terms be implemented.

The Panel was satisfied that a reprimand and a two month suspension of the Member's certificate of registration are warranted in this situation due to the Member's failure to abide by standards of the profession, including those set out in Regulation 547 to the *Drug and Pharmacies Regulation Act*.

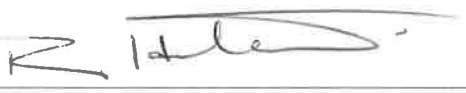
The costs ordered and the time away from his practice will act as specific deterrents to the Member and a general deterrent to the whole profession. These standards are meant for public protection and when they are not adhered to, patients and the public are subjected to significant risk.

The terms, limitations and conditions on the Member's certificate of registration include courses in recordkeeping, prescribing practices and management of dental pain, and a ProBE Program on Ethics for Healthcare Professionals. These courses will help remediate the Member. Practice monitoring for 24 months at his expense will act to protect the public.

The Panel considered the Member's high level of educational training, sense of remorse and cooperation throughout the hearing as mitigating factors. The Member has not appeared before a Discipline Panel in the past.

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

I, Dr. Richard Hunter, sign these Reasons for Decision as Chairperson of this Discipline Panel.



Chairperson

Jan 17, 2017

Date