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. MARK SHANKMAN,** of the City of Dundas 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
Dr. William Coyne, Professional Member
Dr. Nancy Di Santo, Professional Member
Dr. Edelgard Mahant, 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
- and -	)	Surgeons of Ontario
	)	
	)	Ms. Emily Lawrence
	)	for the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. MARK SHANKMAN	)	No representation
	)	for Dr. Shankman

Hearing held on January 5, 2016.

REASONS FOR DECISION

This matter came on for hearing before a panel of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on January 5, 2016.

PUBLICATION BAN

On the request of the parties, the panel made an order banning the broadcasting or publication of the names of any clients referred to in the hearing, including in the exhibits; the name of the dental facility referred to in the hearing, including in the exhibits; and the name of the associate dentist referred to in the hearing, including the exhibits.

THE ALLEGATIONS

The allegations in the Notice of Hearing dated November 4, 2014 concerning Dr. Mark Shankman (the "Member") are as follows.

TAKE NOTICE THAT 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 the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation 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 11 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A-G., M.	2011
A., A.	2012
B., T.	2011
B., K.	2011
B., M.	2012
B., J.	2012
B., D.	2011, 2012
B., A.	2012
B., D.	2011
B., R.	2011
B., M.	2012
B., J.	2011

B., C.	2012
B., S.	2013
C., J.	2011
C., D.	2011
C., A.	2011
D., B.	2011, 2012
D., S.	2011
D., W.	2012
D., R.	2011
E., E.	2012
E., S.	2011
F., T.	2011
F., T.	2011
F., M.	2011
F., L.	2011
F., H.	2012
G. A.	2011
G., J.	2012
G., B.	2011
G., K.	2011
G., D.	2011
H., J.	2012
H., S.	2011
H., D.	2011
H., M.	2011, 2012
H., M.	2011, 2012
J., J.	2012
K., T.	2011
K., R.	2011
K., T.	2011
L., R.	2011
L., M.	2012
M., T.	2012
M., Z.	2012
M., D.	2012
M., I.	2013
M., J.	2011
M., S.	2011
M., J.	2011
M., C.	2011
M., M.	2011, 2012
M., S.	2011

P., S.	2013
P., T.	2011
P., M.	2011
P., Z.	2011
P., T.	2011
R., T.	2012
R., K.	2011
R., W.	2011
R., N.	2011, 2012, 2013
R., N.	2012
R., D.	2012
S., M.	2011
S., R.	2011
S., M.	2012
S., T.	2011
S., S.	2011
S., B.	2011
S., D.	2012
S., A.	2012
W., E.	2011
W., N.	2011, 2012
W., S.	2011, 2012
W., D.	2011
W., D.	2012
W., K.	2012, 2013
W., S.	2011
Y., M.	2011
Z., M.	2013
Z., S.	2011

Particulars:

- Dr. Shankman failed to keep a drug log book in respect of in-office supplies of triazolam and midazolam;
- Dr. Shankman failed to keep the information required by the College's Guidelines *Use of Sedation and General Anesthesia in Dental Practice* (2009) and Standard of Practice *Use of Sedation and General Anesthesia in Dental Practice* (2012) with respect to patients identified as receiving sedation/ anaesthesia services in his office;
- Dr. Shankman failed to keep clinical progress notes or anaesthesia/sedation records in respect of nine patients (K. B., M. B., C. B., A. G., R. M., Z. M., D. M., Z. P., T. R.).

2. 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)
A-G., M.	2011
A., A.	2012
B., T.	2011
B., K.	2011
B., M.	2012
B., J.	2012
B., D.	2011, 2012
B., A.	2012
B., D.	2011
B., R.	2011
B., M.	2012
B., J.	2011
B., C.	2012
B., S.	2013
C., J.	2011
C., D.	2011
C., A.	2011
D., B.	2011, 2012
D., S.	2011
D., W.	2012
D., R.	2011
E., E.	2012
E., S.	2011
F., T.	2011
F., T.	2011
F., M.	2011
F., L.	2011
F., H.	2012
G., A.	2011
G., J.	2012
G., B.	2011
G., K.	2011
G., D.	2011

H., J.	2012
H., S.	2011
H., D.	2011
H., M.	2011, 2012
H., M.	2011, 2012
J., J.	2012
K., T.	2011
K., R.	2011
K., T.	2011
L., R.	2011
L., M.	2012
M., T.	2012
M., Z.	2012
M., D.	2012
M., I.	2013
M., J.	2011
M., S.	2011
M., J.	2011
M., C.	2011
M., M.	2011, 2012
M., S.	2011
P., S.	2013
P., T.	2011
P., M.	2011
P., Z.	2011
P., T.	2011
R., T.	2012
R., K.	2011
R., W.	2011
R., N.	2011, 2012, 2013
R., N.	2012
R., D.	2012
S., M.	2011
S., R.	2011
S., M.	2012
S., T.	2011
S., S.	2011
S., B.	2011
S., D.	2012
S., A.	2012
W., E.	2011
W., N.	2011, 2012

W., S.	2011, 2012
W., D.	2011
W., D.	2012
W., K.	2012, 2013
W., S.	2011
Y., M.	2011
Z., M.	2013
Z., S.	2011

Particulars:

- Dr. Shankman failed to keep a drug log book in respect of in-office supplies of triazolam and midazolam;
- Dr. Shankman failed to keep the information required by the College's Guidelines *Use of Sedation and General Anesthesia in Dental Practice* (2009) and Standard of Practice *Use of Sedation and General Anesthesia in Dental Practice* (2012) with respect to patients identified as receiving sedation/ anaesthesia services in his office;
- Dr. Shankman failed to keep clinical progress notes or anaesthesia/sedation records in respect of nine patients (K. B., M. B., C. B., A. G., R. M., Z. M., D. M., Z. P., T. R.).

3. 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, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A-G., M.	2011
A., A.	2012
B., T.	2011
B., K.	2011
B., M.	2012
B., J.	2012
B., D.	2011, 2012
B., A.	2012
B., D.	2011
B., R.	2011

B., M.	2012
B., J.	2011
B., C.	2012
B., S.	2013
C., J.	2011
C., D.	2011
C., A.	2011
D., B.	2011, 2012
D., S.	2011
D., W.	2012
D., R.	2011
E., E.	2012
E., S.	2011
F., T.	2011
F., T.	2011
F., M.	2011
F., L.	2011
F., H.	2012
G., A.	2011
G., J.	2012
G., B.	2011
G., K.	2011
G., D.	2011
H., J.	2012
H., S.	2011
H., D.	2011
H., M.	2011, 2012
H., M.	2011, 2012
J., J.	2012
K., T.	2011
K., R.	2011
K., T.	2011
L., R.	2011
L., M.	2012
M., T.	2012
M., Z.	2012
M., D.	2012
M., I.	2013
M., J.	2011
M., S.	2011
M., J.	2011
M., C.	2011

M., M.	2011, 2012
M., S.	2011
P., S.	2013
P., T.	2011
P., M.	2011
P., Z.	2011
P., T.	2011
R., T.	2012
R., K.	2011
R., W.	2011
R., N.	2011, 2012, 2013
R., N.	2012
R., D.	2012
S., M.	2011
S., R.	2011
S., M.	2012
S., T.	2011
S., S.	2011
S., B.	2011
S., D.	2012
S., A.	2012
W., E.	2011
W., N.	2011, 2012
W., S.	2011, 2012
W., D.	2011
W., D.	2012
W., K.	2012, 2013
W., S.	2011
Y., M.	2011
Z., M.	2013
Z., S.	2011

Particulars:

- Dr. Shankman failed to keep a drug log book in respect of in-office supplies of triazolam and midazolam;
- Dr. Shankman was unable to account for more than one hundred tablets of triazolam that had been prescribed for office use.

THE MEMBER'S PLEA

The Member orally admitted the allegations of professional misconduct. He also made admissions in writing in the Agreed Statement of Facts, which was signed by the Member. In the Agreed Statement of Facts the Member expressly admitted the facts as set out in the Notice of Hearing, and that these facts 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 (without exhibits) provides as follows.

Background

1. Dr. Shankman has been registered with the College as a general dentist since 2003.

2. At the relevant times, he worked at the clinic in Dundas, Ontario ("the Facility"). Dr. J. F. also worked at the Facility.

3. At the relevant times, Dr. Shankman was authorized to administer oral sedation, and the Facility held a Facility Permit to offer sedation services. In July 2015, the College rescinded the Facility's permit to provide sedation services.

4. Dr. Shankman commenced a voluntary leave of absence from the Facility from March 2013 due to a health condition. The Registrar commenced a health inquiry regarding his suspected incapacity to practise.

5. Dr. Shankman was interim suspended by the Inquiries, Complaints and Reports Committee ("ICRC") between June 2013 and June 2015, pending the final disposition of his incapacity proceedings. In 2013, Dr. Shankman was referred to the Fitness to Practise Committee of the College in respect of his health condition. As set out below, Dr. Shankman is now in stable recovery from his health condition, and has returned to the practice of dentistry, subject to posted public terms, conditions and limitations.

The Notice of Hearing

6. The allegations of professional misconduct against the Member are set out in a Notice of Hearing, dated November 4, 2014 (Exhibit 1). The allegations arose from a Registrar's investigation into Dr. Shankman's oral sedation practices.

7. The College and Dr. Shankman have agreed to resolve the allegations on the basis of the facts and admissions set out below.

Facts and Admissions

8. The facts giving rise to the allegations of professional misconduct in H140023 came to the attention of the College during routine facility inspections (and re-inspections) conducted under the College's Sedation and/or General Anesthesia Inspection Program.

9. Among other things, the inspectors noted that the Facility's sedation records were incomplete, that Dr. J. F. had performed four oral moderate sedation cases without requisite registration and training, and that Dr. Shankman had ordered tablets of triazolam (a benzodiazepine and controlled substance) in quantities that were not accounted for in stock or as administered to patients.

10. The Registrar of the College appointed an investigator to inquire into the complaint regarding Dr. Shankman's conduct pursuant to the Health Professions Procedural Code, section 75(1)(c).

11. The College's investigator sought, received and analyzed charts from a total of 72 of the Facility's patients who had treatment between February 2011 and August 2013, and obtained printouts of Dr. Shankman's billings for oral sedation treatment (a total of 92 sedations) and the clinical records for sedation procedures performed by Dr. J. F.

12. The Facility did not have a drug log book prior to June 2013, but Dr. Shankman's practice was to record the administration of oral sedation in the patient's progress notes.

13. The investigator also obtained the complete pharmacy records for all prescriptions by Dr. Shankman for controlled substances between February 1, 2011 and August 2013. Based on a review of the administration of oral

sedation noted in the patients' charts, the prescriptions for oral sedation made by Dr. Shankman to the pharmacy, and the stock of oral sedation at the Facility, the College's investigation revealed that Dr. Shankman had ordered tablets of triazolam (a benzodiazepine and controlled substance) in quantities that were not accounted for as administered to patients or otherwise in the Facility's stock.

A. Breach of Standards and Failure to Keep Records as Required

14. The College's Guideline on the Use of Sedation and General Anaesthesia in Dental Practice and its Standard of Practice on Use of Sedation and General Anesthesia in Dental Practice ("Sedation Guidelines") contain protocols respecting the administration of sedation and anesthesia to patients. These protocols include strict requirements governing the evaluation, monitoring and documenting of information about patients receiving sedation while undergoing dental treatment.

15. The Sedation Guidelines require that dentists monitor by clinical observation a patient's level of consciousness and assessment of vital signs before, during and after the procedure for minimal sedation.

16. The Sedation Guidelines also require all facilities offering oral sedation services to have a drug log/register to account for all narcotics, and controlled and targeted substances kept on-site.

(i) Failure to Keep Sedation Records (Allegations 1 and 2)

17. The College's investigation identified recordkeeping violations with respect to the patient files it reviewed, and in particular:

    a. in all of his oral sedation documentation, Dr. Shankman did not document that he had monitored by clinical observation his patients' level of consciousness and assessment of vital signs before, during and after the procedure for minimal sedation as required by the Sedation Guidelines;

    b. for two patients, (B. D. (2011), and D. H. (2011)), no progress notes existed in the chart;

    c. for four cases (R. B. (2001), A. C. (2011x2), and R. K. (2011)), the progress notes did not record of the type/dose provided; and

d. for nine patients (K. B., M. B., C. B., A. G., R. M., Z. M., D. M., Z. P., and T. R.), each of which was billed for oral sedation on one or more occasions, Dr. Shankman initially failed to provide any clinical records whatsoever. When these charts were eventually produced, only two had chart entries on the dates billed for, six had progress notes for the treatment provided on the day the treatment was claimed to have been provided, and none had sedation entries.

18. Dr. Shankman admits that his charting was inadequate and/or incomplete and that his documentation practices were deficient. He acknowledges that he breached his professional, ethical and legal responsibilities that required him to maintain a complete record documenting all aspects of each patient's dental care for oral sedation.

19. If Dr. Shankman were to testify, he would state that he did monitor the level of consciousness of his patients, but admits that he did not document this monitoring. Moreover, Dr. Shankman would state that his documentation practices were negatively impacted by his then untreated health condition.

20. Therefore, Dr. Shankman admits that he:

a. contravened the standards of practice, as published by the College, in relation to inducing general anesthesia or conscious sedation, in that he failed to keep information as required by the Sedation Guidelines (including documenting his patients' level of consciousness and assessment of vital signs before, during and after the procedure for minimal sedation and other progress or clinical records) contrary to paragraph 11 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing; and

b. failed to keep records as required and to keep information as required by the Sedation Guidelines (including documenting his patients' level of consciousness and assessment of vital signs before, during and after the procedure for minimal sedation and other progress or clinical records), contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing.

(ii) Drug Log (Allegations 1, 2 and 3)

21. The College's investigation identified that Dr. Shankman and the Facility did not have a drug log/drug register in respect of in-office supplies of triazolam and midazolam between February 2011 and June 2013. In June 2013, Dr. J. F. created a drug log, after he was advised to do so at the facility inspection.

22. Dr. Shankman admits that he did not have and maintain a drug log book in respect of in-office supplies of triazolam and midazolam between February 2011 and June 2013.

23. Dr. Shankman acknowledges that a drug log book is an integral part of dental record-keeping in facilities that offer sedation services, to ensure that sedation medication is handled safely and is not diverted for non-clinical use. Dr. Shankman admits that his failure to have a drug log book demonstrates a lack of diligence in his practice, and led to a systemic problem in his practice such that he cannot account for oral sedation medication dispensed to him, as set out below.

24. Therefore, Dr. Shankman admits that in failing to have and maintain a drug log book of in-office oral sedation supplies, he:

    a. contravened the standard of practice, as published by the College, in relation to inducing general anesthesia or conscious sedation, contrary to paragraph 11 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing;

    b. failed to keep records as required by the Sedation Guidelines, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing; and

    c. engaged in conduct or performed an act or acts that would reasonably be regarded as disgraceful, dishonourable, unprofessional and unethical, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

B. Failure to account for In-Office Supplies of Oral Sedation (Allegation 3)

25. The College's investigation revealed that between February 1, 2011 and August 22, 2013, the local pharmacy had dispensed to Dr. Shankman, for office use, a total of:

    a. 584 tablets of triazolam (234 at 0.125mg and 350 at 0.25mg); and

    b. Three bottles of 84ml of 3mg/ml of midazolam oral suspension.

26. The College's investigation revealed that between February 1, 2011 and August 22, 2013:

a. of the 234 tablets of 0.125mg strength prescribed for in-office use, Dr. Shankman administered 96 and Dr. J. F. administered 21 between February 1, 2011 and August 22, 2013. 117 tablets were unaccounted for;

b. of the 350 tablets at 0.25mg strength prescribed for in-office use, Dr. Shankman administered 112 and Dr. J. F. administered 29 between February 1, 2011 and August 22, 2013. 209 tablets were unaccounted for. One referenced the administration of triazolam at 0.25mg strength, reducing the unaccounted for tablets of triazolam at 0.25mg strength to 207;

c. although Dr. Shankman recorded administering 0.50mg tablets to some of his patients (10 tablets total), the local pharmacy has no record of dispensing this strength to him between February 1, 2011 and August 22, 2013; and

d. for the oral suspension, Dr. Shankman administered a total of 190mg of suspension to sixteen patients.

27. Two of the staff members reported seeing triazolam tablets on Dr. Shankman's desk in the basement of the office.

28. If Dr. Shankman were to testify, he would state that:

a. the College's investigator's calculations regarding the unaccounted for tablets were correct, but due to his documentation deficiencies, his patient records under-represented the tablets actually administered and/or discarded;

b. his documentation practices were negatively impacted by his then untreated health condition;

c. the oral suspension was thrown out when it expired;

d. any blister packs on his desk were there temporarily before being returned to the locked box; and

e. he did not use any of the oral sedation medication personally nor did he divert these medications.

29. Dr. Shankman acknowledges and admits he had a professional obligation to be extremely conscientious in his record-keeping and medication storage practices, and that his record-keeping and medication storage practices were

grossly inadequate between 2011 and 2013. He further acknowledges that he ought to have known that his stock supply was being diverted, and failed to take steps to prevent such diversion.

30. Therefore, Dr. Shankman admits that his failure to account for over one hundred tablets of triazolam is conduct that would reasonably be regarded as disgraceful, dishonourable, unprofessional and unethical, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

Fitness to Practise Proceedings

31. In June 2015, the Fitness to Practise Committee made findings that Dr. Shankman is incapacitated as defined by the Health Professions Procedural Code, section 1, and ordered that Dr. Shankman's certificate of registration be subject to public terms, conditions and limitations, including that he:

- shall not administer or have access to opiates or benzodiazepines in his dental practice, and shall only prescribe these substances if approved by another approved dentist for one year from the date of this Decision or until approved by his addiction specialist and the Registrar
- shall not engage in the practice of dentistry alone and must practice in the presence of a workplace monitor(s);
- shall be under the care of a physician who will report to the College; and
- shall limit practice schedule to 40 hours per week.

32. Dr. Shankman has compiled with these terms.

33. Dr. Shankman has also provided the College with an undertaking and agreement that should he breach or fail to comply with the terms, conditions and limitations he will be immediately suspended on an interim basis until such time as the matter at issue is dealt with by the Fitness to Practise Committee or Discipline Committee (as the case may be) hears and determines the alleged breach. The Undertaking is attached as Appendix "A".

Prior History

34. Dr. Shankman has no past findings of professional misconduct.

35. Dr. Shankman was cautioned by the ICRC in 2008 for inconsistent record-keeping. In 2011, he was cautioned again by the ICRC for inappropriate communication over social media with young women. In 2012, he was again

cautioned for his lack of professionalism and his failure to cooperate with a former client's lawyer who was attempting to obtain clinical records for a civil matter.

36. In 2014, the ICRC reviewed a complaint about Dr. Shankman made by a client alleging deficient prosthodontic care in 2012 and 2013. Dr. Shankman provided an Undertaking/Agreement that, within three months of his return to practice, he would retain a mentor to assess the adequacy of his crown and bridge treatment and to follow the recommendations of the mentor, including further training with respect to his prosthodontic treatment and/or record-keeping, and be subject to monitoring by College through inspections for twenty-four months. Dr. Shankman had retained an appropriate mentor.

37. In 2014, the ICRC reviewed a complaint about Dr. Shankman made by a client alleging deficient implant treatment in 2011 and 2012. Dr. Shankman provided an Undertaking/Agreement that he would (1) not initiate any implant treatment, including both the surgical placement of implants and the prosthetic restoration of implants, unless and until, he completed a comprehensive hands-on course in Implant Therapy and retained a mentor to assess the adequacy of his implant treatment and (2) be subject to monitoring by College through inspections for twenty-four months. Dr. Shankman had retained an appropriate mentor and completed the required coursework.

38. In August 2015, the ICRC reviewed a complaint about Dr. Shankman made by a client alleging treatment deficiencies, improper sedation monitoring and excessive billing from 2011 to March 2013. The ICRC noted its concerns regarding Dr. Shankman's clinical documentation (including informed consent) and record-keeping and his financial record-keeping. It did not have concerns regarding Dr. Shankman's oral sedation practices relating to this patient. The ICRC cautioned Dr. Shankman and ordered that he complete a specified continuing education or remediation program ("SCERP"), namely the College's course in Recordkeeping, including informed consent and financial recordkeeping within six months of its order. It also ordered that he be subject to monitoring by College through inspections for twenty-four months. Dr. Shankman completed this course on September 25, 2015.

39. The above-referenced decisions are attached as Appendices "B" to "G".

Post-Conduct Course Work and Remediation

40. As noted above, Dr. Shankman completed the following remediative coursework and mentoring:

a. he completed the College's course on Recordkeeping for Ontario Dentists on September 15, 2014; and

b. he completed the College's course on Recordkeeping for Ontario Dentists on September 25, 2015, (as a SCERP);

c. he completed a comprehensive hands-on course in Implant Therapy on November 19, 2015;

d. he has retained an appropriate mentor, Dr. K. H., in respect of his crown and bridge treatment and his implant therapy. He completed the crown and bridge mentoring in November 2015, and the Implant mentoring is ongoing.

41. Dr. Shankman acknowledges that he would benefit from taking a course in relation to inducing general anesthesia or conscious sedation prior to seeking any application for authorization to administer oral sedation or any application for a facility permit to provide sedation services at a facility at which the Member practices. Dr. Shankman further acknowledges that completion of this course is a precondition to any application to administer oral sedation, but not a guarantee that the College will authorize him to administer oral sedation or grant an application a facility permit to provide sedation services at a facility at which he practices.

DECISION

Having considered the evidence and submissions of the parties, the panel finds that the Member committed professional misconduct as alleged in the Notice of Hearing.

With respect to allegation #3, the panel finds that the Member engaged in conduct or performed acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

REASONS FOR DECISION

The panel was of the view that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations and demonstrated the Member's disregard for his patients well-being, the College's Guidelines *Use of Sedation and*

General Anesthesia in Dental Practice and the College's Standard of Practice related to the *Use of Sedation and General Anesthesia in Dental Practice*.

Dr Shankman admits that:

- He contravened the standards of practice as published by the College in relation to inducing general anesthesia or conscious sedation to one or more patients during the years 2011-2013.
- He failed to keep a drug log book in respect to in-office supplies of sedative agents.
- He is unable to account for hundreds of tablets of sedative agents during the years 2011-2013.

The members of the panel unanimously found the Member guilty of professional misconduct as set out in the Notice of Hearing. The conduct was serious enough that it amounted to conduct that would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

PENALTY AND COSTS SUBMISSIONS

The parties presented a joint submission which requested that this panel make an order follows.

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

2. The Registrar shall 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 shall 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 shall 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, a remedial course in relation to inducing general anesthesia or conscious sedation approved by the Registrar, as a precondition to any application for authorization for the Member to administer oral sedation, or any application for a facility permit to provide sedation services at a facility at which the Member practices, within the six (6) months immediately preceding such application;

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 thirty-six (36) months following the completion of the Member's suspension referred to in paragraph 2 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 $7,500 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 shall appear before the Panel of the Discipline Committee to be reprimanded, on a date to be fixed by the Registrar.

2. The Registrar shall 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 shall 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 shall 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, a remedial course in relation to inducing general anesthesia or conscious sedation approved by the Registrar, as a precondition to any application for authorization for the Member to administer oral sedation, or any application for a facility permit to provide sedation services at a facility at which the Member practices, within the six (6) months immediately preceding such application;

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 thirty-six (36) months following the completion of the Member's suspension referred to in paragraph 2 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 $7,500 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 the circumstances of this case. It therefore accepted the Joint Submission and ordered it its terms be implemented.

The panel was satisfied that a reprimand and a two-month suspension are warranted in this situation due to the Member's failure to abide by the College's Guidelines and Standard of Practice for *Use of Sedation and General Anesthesia in Dental Practice*. Both the time away from his practice and the costs awarded to the College will act as a specific deterrent to the Member and a general deterrent to the whole profession. The College's published 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 completing a course in general anesthesia or conscious sedation to help remediate him, and practice monitoring by the College for 36 months at the Member's expense. These will act to protect the public.

The panel considered the Member's preexisting medical condition and cooperation throughout the hearing as mitigating factors. He has also attended remedial courses as set out under the terms, limitations and conditions on the Member's Certificate of Registration. 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 when they are combined with the Undertaking the Member has given the College relating to his health condition. To the extent that the Member's previously untreated health condition caused or contributed to his professional misconduct, the provisions of the Undertaking will ensure that the public is protected should the Member's health become unstable or compromised in any way. The Undertaking was a key consideration in the panel's decision to accept the Joint Submission.

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

Chairperson	Date