DECISION 3

Dr. William Motruk
633 Norris Crt #3
Kingston, Ontario

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Notice of Hearing #1:

- Contravened the standards of practice in relation to inducing general anesthesia or conscious sedation (para. 11)
- Charged an excessive or unreasonable fee (para. 31)
- Failed to provide accurate information to the College (para. 57)
- Failed to keep records as required by the regulations (para. 25)

Notice of Hearing #2:

- Contravened a term, condition or limitation on his certificate of registration (para. 2)
- Contravened the standards of practice in relation to inducing general anesthesia or conscious sedation (para. 11)
- Contravened a standard of practice or failed to maintain the standards of practice of the profession (para. 1)
- Disgraceful, dishonourable, unprofessional or unethical conduct (para. 59)

BRIEF SYNOPSIS OF FACTS

Notice of Hearing #1:

- During an inspection, his mobile sedation equipment and drugs were not in full compliance with the College's Standard of Practice for the Use of Sedation and General Anesthesia in Dental Practice, including:
  - > Expired parenteral diphenhydramine, expired parenteral corticosteroid and expired bags of intravenous fluid
  - > No parenteral vasopressor (e.g. ephedrine)
  - > No spare bulb for the laryngoscope was available
- Despite the findings of the inspection, Dr. Motruk's emergency drug kit still did not have a parenteral vasopressor at the time of the subsequent investigation of his practice.
  - > His recordkeeping, in respect of his administration of sedation and anesthesia, was inadequate and failed to include information required by the standard, including ASA classification, medical history review, NPO Status, monitors used, anesthesia start and end times, start procedure and end procedure times to recovery room time, vital signs recording, discharge criteria, discharge time, written/verbal post-sedation instructions.
- He performed parenteral conscious sedation in the absence of a sedation assistant in more than 20 separate cases, although he originally told the College investigator that it was only on one instance.
- He administered nitrous oxide in addition to an intramuscular sedative agent in 11 cases of parenteral conscious sedation, despite being limited to the administration of a single sedative agent.
- He performed parenteral conscious sedation on six separate occasions at his office and 27 separate occasions as a mobile practitioner without a current HCP Level CPR certification.

Notice of Hearing #2:

- As a result of the matter set out in Notice of Hearing #1, the member was bound by an interim order which imposed restrictions on the member's administration of sedation, namely allowing him to perform minimal sedation only.
- As a result of a facility inspection in another practitioner's office, it was determined that the member provided oral moderate sedation in breach of the interim order in nine cases. Moreover, in five of the nine cases, the triazolam dose was at the maximum dosage published by the College (0.75mg) which is above the suggested dose range for oral moderate sedation and in some cases also combined with oral midazolam.
- The member did not hold the permits or authorizations required by the College's Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice to administer oral moderate sedation in all nine cases.
- The member admitted that providing oral moderate sedation in breach of the interim order would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

DECISION

1. Finding

The member pleaded guilty to the allegations above as set out in both notices of hearing, with the exception of failing to provide accurate information to the College, as alleged in Notice of Hearing #1. The member was found guilty with respect to all of the above allegations of professional misconduct, including the contested allegation.

2. Penalty

- Reprimand
- Suspension of certificate of registration for 12 months (July 24, 2016 – July 23, 2017)
- Permanently restricted from providing sedation services of any kind or nature, including minimal, moderate, deep and general anesthesia
- Permanently restricted such that he may not hold a sedation facility permit at any practice location
- Course in professional ethics
- Practice to be monitored for 36 months following completion of courses

3. Costs/Publication

- Costs awarded to College in the amount $25,000
- Member to pay monitoring costs
- Pursuant to the legislation, publication of this matter includes the member's name and address

PANEL'S REASONING

With respect to Finding:

- The panel accepted the member's guilty plea to seven of the eight allegations.
- For the contested allegation of failing to provide accurate information to the College, the panel accepted the member's explanation that he was "frazzled" when questioned by the College investigator. However, the panel rejected the notion that this excused the member's claim that he had only performed one intramuscular (IM) sedation case in three years when the records clearly show that he had actually treated more than 20 patients with IM sedation during that time period. The panel found it inconceivable that he could only remember one. The panel concluded that this was a deliberate attempt by the member to mislead the College investigator as part of an attempt to minimize the seriousness of the member's actions.

With respect to Penalty:

- The penalty was a joint submission reached following a pre-hearing conference.
- The reprimand and the 12-month suspension will act as a specific deterrent to the member and a general deterrent to the membership, and sends the message that subjecting patients to significant risk and charging excessive fees are not tolerated by the profession.
- The terms, conditions, limitations and conditions that restrict the member from performing any sedation procedures in the future, in addition to the ethics course and practice monitoring, both remediate the member and protect the public.
- The aggravating factors include the member's deliberate attempt to mislead the College and his lack of effort to obtain a sedation assistant when required. His expired CPR certification and outdated emergency drug kit left him ill-equipped to handle any sedation related emergency. The panel also made note of a prior finding of professional misconduct made by the Discipline Committee in respect of Dr. Motruk, approximately seven years ago.
- The mitigating factors include the member's admission to seven of the eight allegations of professional misconduct, and that he acknowledged his wrongdoing and the need for improvement, as well as the fact that he was cooperative and no harm was caused to any patient.