H140029
H160001

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 (*"Code"*) respecting one **DR. WILLIAM MOTRUK**, 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").

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. Harpaul Anand
Dr. David Mock
Dr. Edelgard Mahant
Mr. Manohar Kanagamany

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Marie Henein and Mr. Matthew Gourlay
- and -	)	For the Royal College of Dental Surgeons of Ontario
DR. WILLIAM MOTRUK	)	Mr. Matthew Wilton For Dr. Motruk

) Mr. Brian Gover
) Independent Counsel for the
) Discipline Committee of the
) Royal College of Dental
) Surgeons of Ontario

Hearing held on May 16 and 24, 2016.

DECISION AND REASONS

Introduction

On May 16, 2016, a panel of the Discipline Committee (the "Discipline Panel" or the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") convened to hear allegations of professional misconduct made against Dr. William Motruk (the "Member"). The allegations against Dr. Motruk were set out in Notice of Hearing H140029 (**Exhibit 1**) and Notice of Hearing H160001 (**Exhibit 2**), each of which contained four (4) allegations. Complete versions of **Exhibit 1** and **Exhibit 2** are attached as **Appendix "A"** and **Appendix "B"**, respectively. At the outset of the hearing, the Panel made an order pursuant to subsection 45(3) of the *Health Professions Procedural Code*[1] (the "*Code*"), banning publication of any patients' names and identifying information.

The Member admitted professional misconduct in relation to three (3) of the four (4) allegations set out in **Exhibit 1.** The allegations which the Member admitted (Allegations #1, #2 and #4) 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 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.[2]

2. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the *Code*, in that, you charged a fee that was excessive or unreasonable in relation to the service performed relative to one or more of the following patients during the year and/or one or more of the years specified opposite that

[1] Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c 18.
[2] Sixty-six patients were named in relation to this allegation, which referred to the years 2013 and 2014 and sometimes to both regarding the same patient. Seven detailed particulars were set out in connection with this allegation.

patient's name, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.[3]

4. 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.[4]

The Member admitted professional misconduct in relation to all four (4) allegations set out in **Exhibit 2.** The allegations admitted by the Member 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, commencing on December 22, 2014 onwards, you contravened a term, condition or limitation imposed on your certificate of registration relative to the following patients, contrary to paragraph 2 of the Dentistry Act Regulation.[5]

2. 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.[6]

3. 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.[7]

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[3] Fifteen patients were named in relation to this allegation, which referred to the years 2012, 2013 and 2014. In relation to one patient, it referred to two years, 2013 and 2014. Three detailed particulars were set out.

[4] Twenty-four patients were named in this allegation, which referred to the years 2011, 2012, 2013 and 2014. In relation to two patients, it referred to three years, 2011, 2012 and 2013. In relation to one patient, it referred to all four years. Seventeen detailed particulars were set out.

[5] Nine patients were named in this allegation, which referred to dates in April, May and September, 2015. Four detailed particulars were set out. The Discipline Panel notes that at College Counsel's request, the words "and may fall into the category of deep sedation" were deleted from the fourth particular.

[6] The same 9 patients were names in this allegation as were named in Allegation #1 of **Exhibit 2**. This allegation also referred to dates in April, May and September, 2015. While there were initially three particulars in relation to this allegation, the Discipline Panel notes that at the request of College Counsel, the words "and may fall into the category of deep sedation" were deleted from the second particular, and that the third particular was deleted entirely.

[7] Once again, the same 9 patients were named as were named elsewhere in **Exhibit 2** and reference was made to the same dates in April, May and September, 2015. While there were initially two particulars in relation to this allegation, the Discipline Panel notes that at the request of College Counsel, the words "and may fall into the

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 the following patients, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.[8]

A number of additional items were exhibited on consent.

Exhibit 3 was an Agreed Statement of Facts regarding Notice of Hearing H140029 (**Exhibit 1**). It consisted of 140 paragraphs and included 15 attachments. The text of the **Exhibit 3** is attached as **Appendix "C"**.

Exhibit 4 was an Agreed Statement of Facts relating to Notice of Hearing H160001 (**Exhibit 2**). Exhibit 4 is attached as **Appendix "D"**.

A two volume Joint Document Book was also exhibited. This was marked as **Exhibits 5A** and **5B**.

Hearing of the Contested Allegation (Exhibit 1, Allegation #3)

A contested hearing ensued in respect of the allegation denied by the Member (Allegation #3 in **Exhibit 1**). It was as follows:

3. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the *Code*, in that, during the years 2013 and 2014, you failed to take reasonable steps to ensure that any information provided by you or on your behalf to the College was accurate, contrary to paragraph 57 of Section 2 of the Dentistry Act Regulation.[9]

The College and the Member each called one witness.

Dr. Christopher Swayze was called by College Counsel. During his testimony, Dr. Swayze described the process by which investigations authorized under s. 75 of the *Code*

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category of deep sedation" were deleted from the first particular, and that the second particular was deleted entirely.

[8] Once again, the same 9 patients were named as were named elsewhere in **Exhibit 2** and reference was made to the same dates in April, May and September, 2015. Six particulars were set out, but the Discipline Panel notes that there was no admission by the Member in relation to the sixth particular, which alleged that the Member is "ungovernable in that (he has) a frequent conduct history with the College spanning many years with recurring concerns regarding sedation and anesthesia, which have not been rehabilitated despite a discipline hearing, reprimand, a suspension, a remedial course, an assessment and practice monitoring." In addition to making no admission in relation to this particular, the Member submitted that no facts were adduced to support it.

[9] Fourteen patients were named in this allegation. In relation to one patient, it referred to both 2013 and 2014. Two detailed particulars were set out.

are conducted, which can include unannounced visits to members' offices. In cross-examination, Dr. Swayze acknowledged that dentists who are the targets of unannounced office visits by College investigators can find this experience to be shocking and stressful. He also testified, "As part of the investigation, we don't give the whole background (to those who are under investigation)."

Dr. Swayze also explained the terms "parenteral" and "conscious" sedation. Parenteral sedation encompasses all sedation that is not administered orally; in other words, it includes nasal, intravenous (IV) and intramuscular (IM) sedation. Dentists administering parenteral sedation require the assistance of a sedation assistant (typically a nurse, but possibly a respiratory therapist, dentist or physician). Conscious sedation entails that the patient is still breathing on his or her own. He or she may have no recollection of the appointment, but it is not as deep as the general sedation that is administered at hospitals.

Dr. Swayze testified about his unannounced visit to the Member's office in Kingston on April 16, 2014. This visit was not prompted by a patient complaint and was not preceded by an adverse patient outcome. All of the issues that prompted it related to sedation, and not the Member's general dentistry or his periodontal practice. Prior to going there, he reviewed the College's Field Inspector's report arising out of a September 19, 2013 routine 1-year re-inspection of the Member's "mobile" sedation equipment and drugs for administration of Oral Moderate Sedation and Parenteral Conscious Sedation – single sedative only facility. The Field Inspector had identified three cases in which parenteral sedation was administered without a sedation assistant being present. Dr. Swayze was aware that the Member had administered intramuscular sedation to those three patients, and Dr. Swayze knew the patients' names. He was also aware that the report identified two issues: a lack of spare bulbs and a lack of emergency drugs. Dr. Swayze decided to take custody of the five patient charts identified in the Field Inspector's report.

It was Dr. Swayze's evidence that his visit to the Member's Kingston office lasted approximately two hours. During that visit, the Member said he "wanted to come clean". The Member said that he only performed oral sedation, but that his lifesaving course had lapsed and he did not have a current cardiopulmonary resuscitation (CPR) certificate. The Member indicated that he encountered difficulty in finding a nurse to act as a sedation assistant at his Kingston office.

When they discussed whether the Member performed parenteral sedation at his Kingston office, the Member told Dr. Swayze that he did so in one case. The patient, a nurse (J.C.) became agitated and the Member administered intramuscular sedation. However, during the office visit, the Member's receptionist printed a list naming approximately 50 patients who had received intramuscular sedation at the Kingston office since 2011.[10] Dr.

[10] Exhibit 3, Tab 2

Swayze requested 10 patients' charts. Dr. Swayze also obtained a production summary that identified all of the procedures that were used.[11]

Dr. Swayze testified that toward the conclusion of his April 16, 2014 visit to the Member's office, the Member said that he would seek to have the facility permit for his Kingston office withdrawn. Dr. Swayze admitted in cross-examination that by the end of the visit, he knew that: (1) that the Member did not have a sedation assistant; (2) the Member had administered intramuscular, but not intravenous sedation; (3) that intramuscular sedation was administered without a sedation assistant being present; and (4) there were approximately 50 patient charts that reflected intramuscular sedation having been administered.

The Member testified that he was "very nervous and scared" when Dr. Swayze showed up unexpectedly at his office on April 16, 2014, that he was "frazzled" and "blurted out whatever" when he spoke with Dr. Swayze in the staff room. However, as Dr. Motruk admitted in cross-examination, he did not tell Dr. Swayze that he was nervous.

It was the Member's evidence that "probably within the first 15 to 20 minutes", he told Dr. Swayze that he had performed one intramuscular sedation, naming the patient (J.C.). At that point, the Member testified, he was not himself and was not thinking straight. In cross-examination by College Counsel (Ms. Henein), the Member admitted that he provided details: he administered the sedation because the patient, who was a nurse, was very agitated. It was an emergency. He agreed that he was not so confused that he could not remember why he gave the patient an intramuscular injection.

When he was taken to the production summary[12] in cross-examination, the Member admitted that he had administered intramuscular sedation to 65 patients and had billed for approximately 100 hours of sedation. When asked whether it was his evidence that he had forgotten about 100 hours of sedation, the Member insisted that he had spoken to Dr. Swayze without thinking and "was not logical in (his) thought processes". He agreed with College Counsel that he knew it was important to be completely honest with Dr. Swayze and that he did not in any way seek to qualify his answer that he had administered intramuscular sedation on one occasion.

After his conversation with Dr. Swayze in the staff room, the Member instructed his receptionist to assist Dr. Swayze. That is how the list of patients[13] and the further production summary[14] were generated and provided to Dr. Swayze.

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[11] Exhibit 3, Tab 3
[12] Exhibit 3, Tab 3
[13] Exhibit 3, Tab 2
[14] Exhibit 3, Tab 3

The essence of the Member's testimony was that the College was not misled by his statement that he had performed only one intramuscular sedation. In that respect, he referred to a number of subsequent communications with the College, including the following items:

- Dr. Swayze's subsequent letter to him, dated May 7, 2014, which included reference to 15 patients on whom intramuscular sedation had been performed;[15]
- An email exchange dated July 17, 2014 in which Dr. Swayze noted a number of cases in which intramuscular midazolam had been administered, and inquired whether a sedation assistant was present during those procedures[16] and Dr. Motruk's receptionist confirmed that no sedation assistant was present for them;[17]
- Dr. Motruk's July 28, 2014 letter to Dr. Swayze, in which among other things, Dr. Motruk admitted that he had performed intramuscular sedation without a nurse being present;[18] and
- Dr. Motruk's October 7, 2014 telephone message, advising that he would not be providing a response to the Inquiries, Complaints and Reports Committee, that he had said everything in his first letter, he had "made a mistake" and "owned up to it".[19]

In her submissions, College Counsel argued that the only question for the Discipline Panel to determine was whether the Member's evidence that he was "frazzled" or "nervous" was an excuse. She submitted that it was not credible. It defies credibility, Ms. Henein asserted, that the Member would have forgotten hours and hours of administering sedation without a sedation assistant being present. Similarly, it defied credibility that someone so frazzled or nervous would remember the details of the time he administered the intramuscular sedation to J.C. Ms. Henein emphasized the importance of the College's ability to rely on the honesty and integrity of its members. She argued that being "nervous and frazzled" was no excuse for misleading Dr. Swayze (even if only temporarily) and that it was no excuse in law.

Mr. Wilton, the Member's counsel pointed out that the inaccurate information was provided about 15 minutes after Dr. Swayze's arrival at the Member's Kingston office. At that point, Mr. Wilton argued, the Member had not been afforded an opportunity to take reasonable steps. Mr. Wilton submitted that by the end of Dr. Swayze's unannounced visit, he had accurate information, including the fact that the Member had never employed a sedation assistant. He contended that Dr. Swayze had not been misled.

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[15] Exhibit 5A, Tab 3
[16] Exhibit 5A, Tab 14
[17] Exhibit 5A, Tab 15
[18] "... You pointed out that I was in error for doing IM sedation without a Nurse present. For this I will plead myself guilty for failing to follow the guidelines as you pointed out. For this fault I am in remorse for this action and have no one to blame but myself": Exhibit 5A, Tab 20.
[19] Exhibit 5A, Tab 28

Both Mr. Wilton and Ms. Henein referred to section 2, paragraph 57 of the Dentistry Act Regulation,[20] which provides as follows:

> **2.** The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:
>
> . . .
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> 57. Failing to take reasonable steps to ensure that any information provided by or on behalf of the member to the College is accurate.

Mr. Wilton submitted that this provision anticipates a process being undertaken. Ms. Henein highlighted that this creates an obligation to provide accurate information (through use of the word "ensure") and submitted that to give meaning to paragraph 57, lying to a College representative could never amount to a "reasonable step".

The Panel reserved its decision and deliberated on whether to make a finding of professional misconduct in relation to Allegation #3 in **Exhibit 1**.

Findings of Professional Misconduct

Subsequently, by Notice of Decision dated May 18, 2016, the Panel informed the parties that it had made findings of professional misconduct against the Member with respect to all four (4) allegations as set out in Notice of Hearing H140029 (**Exhibit 1**) and all four (4) allegations as set out Notice of Hearing H160001 (**Exhibit 2**).[21] The hearing was adjourned to May 24, 2016, for submissions to be heard as to the appropriate penalty order.

Reasons for Findings of Professional Misconduct

In relation to the uncontested allegations (i.e., Allegations #1, #2 and #4 on **Exhibit 1** and Allegations #1 through #4 on **Exhibit 2**), the Discipline Panel was mindful of our obligation imposed by section 49 of the *Code* to decide the case based on the evidence before us and that the two Agreed Statements of Fact (**Exhibit 3** and **Exhibit 4**) constituted the evidence for the purposes of the hearing. The Panel was satisfied that coupled with the Member's admissions of professional misconduct, these two detailed Agreed Statements of Fact constituted sufficient bases for making findings of professional misconduct in relation to each of the uncontested allegations.

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[20] O.Reg. 853/93.

[21] In making findings of professional misconduct in relation to **Exhibit 2**, the Discipline Panel took into account the deletions to the various particulars that are described in notes 5, 6 and 7, above. Further, and having regard to the circumstances outlined in note 9, the Discipline Panel did not find that the Member is ungovernable, as was alleged in the final particular set out in connection with Allegation #4.

After deliberation, the Discipline Panel also made a finding of professional misconduct in connection with the contested allegation (Allegation #3 in **Exhibit 1**). Its reasons for making that finding of professional misconduct are as follows.
The Discipline Panel considered whether the Member failed to take reasonable steps to ensure that any information he provided to the College during the years 2013 and 2014 was accurate as is required by section 2, paragraph 57 of the Dentistry Act Regulation.

The Panel accepted the Member's explanation of being "frazzled" when questioned by the College investigator but rejected the notion that this excused the Member's claim that he had performed only one intramuscular (IM) sedation case in approximately 3 years. The Member's office records clearly showed that he had actually treated 65 patients with IM sedation in the time period and 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.

Joint Submission – Penalty and Costs

When the hearing reconvened on May 24, 2016, the parties advised the Discipline Panel that they had formulated a joint submission on penalty and costs. A document entitled "Joint Submission with Respect to Penalty and Costs" (the "Joint Submission") was filed as **Exhibit 6**.

It provided as follows:

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

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

    (b) directing the Registrar to suspend the Member's certificate of registration for a period of twelve (12) months, to run consecutively, such suspension to commence within two (2) months of this Order becoming final;

    (c) that the Registrar impose the following terms, conditions and limitations on the Member's certificate of registration ("Conditions"), which Conditions

shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 1(b) above has been fully served, namely:

(i) 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;

(ii) 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;

(iii) 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;

(iv) 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

(v) the Conditions imposed in subparagraphs 1(c)(i)-(iv) above shall be removed at the end of the period that the Member's certificate of registration is suspended.

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

(i) effective immediately, the member's certificate of registration shall be permanently restricted such that will not be permitted to provide sedation services of any kind or nature, including: minimal, moderate, deep sedation and general anaesthesia; and shall not be permitted to hold a Sedation Facility Permit at any practice location;

(ii) the Member shall successfully complete, at his own expense, the ProBe Program for Professional/Problem based Ethics, and provide proof of successful completion and an unconditional pass in writing to the Registrar within six (6) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(iii) 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, with advance notice to the Member, during the period commencing upon completion of the Member's suspension and ending thirty-six (36) months thereafter, or until a panel of the Inquiries, Complaints and Reports Committee is satisfied that monitoring is no longer necessary and has advised the Member of this in writing;

(iv) that the Member shall cooperate with the College during the inspection(s) and further, 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;

(v) that the representative or representatives of the College shall report the results of those inspections to the Inquiries, Complaints and Reports Committee of the College and the Inquiries, Complaints and Reports Committee may, if deemed warranted, take such action as it considers appropriate;

(e) that the Member pay costs to the College in the amount of $25,000.00 in respect of this discipline hearing, such costs to be paid in full within six (6) months of this Order becoming final.

2. The College and the Member further submit that pursuant to the *Regulated Health Professions Act*, 1991, as amended, the results of these proceedings must be recorded on the Register of the College and publication of the Decision of the panel would therefore occur with the name and address of the Member included.

The parties made submissions in support of the Joint Submission.

In her submissions, Ms. Henein referred to the Member's discipline history, which is reflected in a decision dated January 13, 2009 (**Exhibit 7**). In 2006, the Member over-

prescribed Ativan to a three year old patient and falsified his records after the over-prescription was discovered. He admitted professional misconduct and the agreed upon penalty included a reprimand, suspension of his certificate of registration for a period of three (3) consecutive months, and imposition of terms, conditions and limitations thereafter. Ms. Henein also referred to the conduct proven in this case: improper use of anesthetics and a failure to maintain the standards of the profession; an attempt to mislead the College's investigator, Dr. Swayze; and breaching the interim order on 9 occasions by administering "moderate sedation" when he was limited to administering "mild sedation".

College Counsel also adverted to the goals of specific and general deterrence and to the mitigating and aggravating factors in this case. The mitigating factors included the Member's admissions to 7 or the 8 allegations, his contrition and cooperation, his awareness and recognition of his failures, and the fact that there was no evidence of harm having been suffered by patients as a result of his professional misconduct. The aggravating factors included his breach of an interim order, his action in misleading College staff (albeit only briefly), his repeated failures to maintain the standards of practice and his discipline history.

In his submissions, Mr. Wilton acknowledged that the Member has a deficit relating to sedation. He emphasized that there was no evidence that any patients had been harmed and submitted that the public safety issues regarding sedation are addressed by the Joint Submission.

Decision as to Penalty and Costs

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

Reasons for Decision as to Penalty and Costs

The Discipline Panel's reasons for accepting the Joint Submission are as follows. The Panel noted that on November 18, 2008 Dr. Motruk had pleaded guilty to four (4) allegations of professional misconduct related to administration of sedation in his practice. This was of concern to the Panel because of the similar nature of the allegations before it.

The Panel was satisfied that a reprimand and a 12 month suspension are warranted in this situation due to the Member's failure to abide by the College's Guidelines for Use of Sedation and General Anesthesia in Dental Practice (2012). Both the time away from his practice and the costs awarded to the College will act as specific deterrents to the

Member and a general deterrent to other members of the profession who may otherwise be inclined to engage in similar acts of professional misconduct. Subjecting his patients to significant risk and charging excessive fees are not to be tolerated by the profession.

Public protection is provided by the Terms, Limitations and Conditions that restrict the Member from performing any sedation procedures in the future. His practice will be subjected to office monitoring for 36 months and the Member will have to complete the ProBe (ethics) course as specified by the College.

Restricting the Member's Certificate of Registration for sedation procedures and requiring the Member to take a course in ethics will serve to remediate the Member and his practice. The inability to perform these procedures will serve to ensure that the Member does not engage in similar infractions.

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 mitigating factors include the Member's admission to 7 of the 8 allegations before him. He was cooperative and no harm was caused to any patient. Finally, the Member acknowledged his wrongdoing and accepted the need for improvement.

Administration of Reprimand

At the conclusion of the hearing, the Member signed a waiver of appeal (**Exhibit 8**) and the Discipline Panel administered the oral reprimand called for by the Joint Submission. The reprimand was administered in public and on the record.

June 27, 2016

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

Dr. Harpaul Anand, Member
Dr. David Mock, Member
Dr. Edelgard Mahant, Member
Mr. Manohar Kanagamany, Public Member