H170017

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. RANDALL DARE TEMPLEMAN,** of the City of Beeton, 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: Susan Davis, Chair
Elliott Gnidec
Carol Janik
Margaret Dunn
Benjamin Lin

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS	)	Appearances:
OF ONTARIO	)	
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
	)	Surgeons of Ontario
- and -	)	
	)	Ms. Megan Shortreed
	)	For the Royal College of Dental
		Surgeons of Ontario
	)	
DR. RANDALL TEMPLEMAN	)	No one appearing for Dr. Randall
	)	Templeman

Hearing held on March 29, 2018

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on March 29, 2018.

The Panel was advised that while Dr. Templeman was aware of the hearing time and location, he was not expected to attend. After receiving confirmation that the Member had adequate notice of the hearing, the Panel proceeded in the Member's absence.

PUBLICATION BAN

On the request of the College, the Panel made an order banning the publication or broadcasting of the names of any patients referred to in the hearing, including in the Notices of Hearing and/or the Agreed Statement of Facts and/or any of the exhibits, as well as an order banning the publication or broadcasting of any information that would identify those patients.

THE ALLEGATIONS

The allegations against Dr. Templeman (the "Member") were contained in the Notice of Hearing, dated October 5, 2017. The allegations against the Member were as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that, during the following years, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to the following patients, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patients	Years
S.Y.	1993 to 2015
R.J.	1998 to 2015
S.Y.J.	1998 to 2015
J.Y.	1993 to 2015

<u>Particulars:</u>

S.Y.:

- In or about the years 1993 to 2015, you failed to properly manage your patient's treatment needs and did not provide her with appropriate and needed dental care. S.Y. has been your patient for more than 25 years and despite regular visits to your office, the state of her dentition deteriorated under your care and amounted to supervised neglect.
- In or about the year 2015, you failed to diagnose and/or treat decay and/or recurrent caries on teeth 21, 22, 23, 24, 25, 26, 12, 13, and 17.
- In or about the year 2015, you failed to diagnose and/or treat endodontic issues on teeth 23 and 26.
- You failed to perform periodontal evaluations of S.Y.'s teeth at any point during the time she was your patient in or about the years 1993 to 2015.
- S.Y.'s patient record does not contain diagnoses or treatment plans with respect to any of the treatment you performed.

R.J.:

- In or about the years 1998 to 2015, you failed to properly manage your patient's treatment needs and did not provide him with appropriate and needed dental care. R.J. has been your patient since 1998 and despite regular visits to your office, the state of his dentition deteriorated under your care and amounted to supervised neglect.
- In or about the year 2015, you failed to diagnose and/or treat generalized periodontal disease and severe periodontal bone loss of the patient's maxillary and mandibular anterior teeth, including heavy calculus and deep pockets.
- You failed to adequately examine your patient clinically and radiographically in that the patient record does not contain any radiographs of the patient's anterior teeth since you began treating him in or about the year 1998.
- You failed to perform periodontal evaluations of R.J.'s teeth at any point during the time he was your patient in or about the years 1998 to 2015.
- R.J.'s patient record does not contain diagnoses or treatment plans with respect to any of the treatment you performed.

S.Y.J.:

- In or about the years 1998 to 2015, you failed to properly manage your patient's treatment needs and you did not provide him with

appropriate and needed dental care. S.Y.J. has been your patient since 1998 and despite regular visits to your office, the state of his dentition deteriorated under your care and amounted to supervised neglect.

- You failed to treat caries on teeth 24, 25, 14 and 15, despite documentation in the patient record of the presence of caries on these teeth on or about February 25, 2013, and despite the fact that the patient was under your care until on or about June 9, 2015.
- You failed to perform periodontal evaluations of S.Y.J.'s teeth at any point during the time he was your patient in or about the years 1998 to 2015.
- S.Y.J.'s patient record does not contain any treatment plans with respect to any of the treatment you performed.

J.Y.:

- In or about the years 1993 to 2015, you failed to properly manage your patient's treatment needs and did not provide her with appropriate and needed dental care. J.Y. has been your patient for more than 25 years, and despite regular visits to your office, the state of her dentition deteriorated under your care and amounted to supervised neglect.
- In or about the year 2015, you failed to diagnose and/or treat deep decay and/or recurrent decay on teeth 22, 23, 27 and 28.
- In or about the year 2015, you failed to diagnose and/or treat endodontic issues on tooth 26.
- In or about September 2007, you removed the bridge from tooth 44 to 47 as tooth 44 was decayed and could no longer support the bridge. You subsequently prepared and placed a bridge from tooth 43 to 47 and failed to remove the root of tooth 44. You did not inform the patient of this.
- In or about May 2011, you extracted tooth 24 and left the root of tooth and placed a cantilever bridge from tooth 26 to 23 over the remaining root. You did not inform the patient of this.
- You failed to perform periodontal evaluations of J.Y.'s teeth at any point during the time she was your patient in or about the years 1993 to 2015.
- J.Y.'s patient record does not contain diagnoses or treatment plans with respect to any of the treatment you performed.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the following years, you failed to keep records as required by the Regulations relative to the following patients, contrary to

paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended

Patients	Years
S.Y.	1993 to 2015
R.J.	1998 to 2015
S.Y.J.	1998 to 2015
J.Y.	1993 to 2015

Particulars:

- In or about the years 1993 to 2015, you failed to document adequate detail in your patient records as required of you in respect of your patient Ms. S.Y.:
    - The patient record does not document diagnostic findings or rationales for the treatment you performed.
    - The patient record does not include diagnoses or treatment plans.
    - The patient record does not contain periodontal evaluations.
    - The patient record does not include notations that informed consent was obtained prior to commencing treatment.
    - The patient records lacks detail with respect to the treatment provided, including materials and drugs used, and where appropriate, the outcome of treatment.
- In or about the years 1993 to 2015, you failed to document adequate detail in your patient records as required of you in respect of your patient Ms. J.Y.:
    - The patient record does not document diagnostic findings or rationales for the treatment you performed.
    - The patient record does not include diagnoses or treatment plans.
    - The patient record does not contain periodontal evaluations.
    - The patient record does not include notations that informed consent was obtained prior to commencing treatment.
    - The patient record lacks detail with respect to the treatment provided, including materials and drugs used, and where appropriate, the outcome of treatment.
- In or about the years 1998 to 2015, you failed to document adequate detail in your patient records as required of you in respect of your patient R.J.:
    - The patient record does not document diagnostic findings or rationales for the treatment you performed.
    - The patient record does not include diagnoses or treatment plans.

    - The patient record does not contain periodontal evaluations.
    - The patient record does not include notations that informed consent was obtained prior to commencing treatment.
    - The patient record lacks detail with respect to the treatment provided, including materials and drugs used, and where appropriate, the outcome of treatment.
- In or about the years 1998 to 2015, you failed to document adequate detail in your patient records as required of you in respect of your patients S.Y.J.:
    - The patient record does not document diagnostic findings or rationales for the treatment you performed.
    - The patient record does not include diagnoses or treatment plans.
    - The patient record does not contain periodontal evaluations.
    - The patient record does not include notations that informed consent was obtained prior to commencing treatment.
    - The patient record lacks detail with respect to the treatment provided, including materials and drugs used, and where appropriate, the outcome of treatment.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the following years, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to the following patients, contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patients	Years
S.Y.	1993 to 2015
R.J.	1998 to 2015
S.Y.J.	1998 to 2015
J.Y.	1993 to 2015

Particulars:

- In or about the years 1993 to 2015 you failed to obtain informed consent prior to commencing treatment with respect to your patient Ms. S.Y.:
    - The patient record does not document that you discussed with your patients, at any point in the years that you treated her,

the nature of the treatment proposed, the expected benefits of treatment, the material risks and side effects of treatment, taking into account the individual circumstances of the patient, or the alternatives to treatment, as is required of you.

- In or about the years 1993 to 2015 you failed to obtain informed consent prior to commencing treatment with respect to your patient Ms. J.Y.:
  - The patient record does not document that you discussed with your patient, at any point in the years that you treated her, the nature of the treatment proposed, the expected benefits of treatment, the material risks and side effects of treatment, taking into account the individual circumstances of the patient, or the alternatives to treatment, as is required of you.
- In or about the years 1998 to 2015 you failed to obtain informed consent prior to commencing treatment with respect to your patient Mr. R.J.:
  - The patient record does not document that you discussed with your patient, at any point in the years you treated him, the nature of the treatment proposed, the expected benefits of treatment, the material risks and side effects of treatment, taking into account the individual circumstances of the patient, or the alternatives to treatment, as is required of you.
- In or about the years 1998 to 2015 you failed to obtain informed consent prior to commencing treatment with respect to your patient S.Y.J.:
  - The patient record does not document that you discussed with your patient, at any point in the years you treated him, the nature of the treatment proposed, the expected benefits of treatment, the material risks and side effects of treatment, taking into account the individual circumstances of the patient, or the alternatives to treatment, as is required of you.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2008, 2009, 2010, 2011, and 2012 you prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs relative to one of your patients, namely J.Y., contrary to paragraph 10 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On or about December 8, 2008, April 9, 2009, December 3, 2010, June 10, 2011, and March 6, 2012, you prescribed lorazepam to your patient, J.Y., without justification and without indication of how much was prescribed.
- In a phone call with the College investigator, on or about September 2, 2016, you indicated that you prescribed lorazepam to your patient, J.Y., for a non-dental purpose after the passing of a member of her family, and that you continued to prescribe the drug over an extended period of time.

THE MEMBER'S PLEA

The Member signed a written plea and plea inquiry, which was included in the Agreed Statement of Facts, described below. The Member pleaded guilty to all of the allegations set out in the Notice of Hearing, except that he did not agree to the facts as set out in the second bullet under allegation #4.

The Panel was satisfied 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 that substantiated the allegations. The Agreed Statement of Facts (without exhibits) provides as follows:

1. Dr. Templeman has been registered with the College as General Dentist since April 19, 1974. He worked out of 3 different practice locations in Beeton, Bolton and Angus, Ontario, until in or around 2013 when he started working exclusively in the Beeton practice.
2. Dr. Templeman has no history of findings by the Discipline Committee of the College, but was the subject of a complaint in 2009 relating to prosthodontic treatment. The complaint was resolved in January 2011 when the ICRC issued a caution in respect of concerns regarding the adequacy of the treatment (both prosthodontic and endodontic treatment), as well as recordkeeping and informed consent. To address the ICRC's concerns, Dr. Templeman voluntarily signed an Undertaking/Agreement dated January 7, 2011, to take and complete a course on prosthodontics and recordkeeping, including informed consent, and to have his practice monitored for 2 years.
3. In respect of the current complaint, the ICRC issued an Interim Order which took effect on July 28, 2017, directing the Registrar to suspend

Dr. Templeman's certificate of registration as it was of the opinion that Dr. Templeman exposes or is likely to expose his patients to harm or injury.

The Notice of Hearing

4. Dr. Templeman was served with a Notice of Hearing dated October 5, 2017. These allegations arose following a complaint by S.Y., a patient, and a resulting investigation under s. 75(1)(c) of the Code.

5. The College and the Member have agreed to resolve the allegations on the basis of the facts and admissions agreed to and set out below.

Facts and Admissions

i. Dr. Templeman's treatment of the Y-J Family

6. The allegations in this matter relate to the care and treatment of a family consisting of a wife (S.Y.), a husband (R.J.), their son (S.Y.J.), and S.Y.'s mother (J.Y.), all of whom were all patients of Dr. Templeman's general practice, which included Dr. Templeman as well as other providers.

7. The Notice of Hearing alleges that Dr. Templeman treated S.Y and J.Y. from 1993 to 2015, and R.J. and S.Y.J. from 1998 to 2015. In fact, Dr. Templeman was the primary care dentist for each of the patients as follows:

a. S.Y. was a patient of the practice since 1986. She was not treated by Dr. Templeman in 1993. She was treated by Dr. Templeman on a few occasions in 1994 (one occasion) and 1995 (two occasions). For 1993 to 1995, her appointments were mainly with other providers in this and other practices. S.Y. was treated by Dr. Templeman under his responsibility as her primary care provider in the following periods:

    i. 1996 to 1998,
    ii. the year 2000,
    iii. from 2002 to 2006, and
    iv. from 2012 to 2015, although seen by Dr. Templeman on only one occasion in early 2015.

b. R.J. was a patient of the practice since 1998. He was not treated by Dr. Templeman in 1998. He was treated by Dr. Templeman on a few occasions in 2001 (one occasion) and 2002 (one occasion). He was not treated by Dr. Templeman from 2003 to 2012, during which period he was treated by other dentists in the practice. R.J. was treated by Dr. Templeman under his responsibility as his primary care provider from 2013 to 2015.

c. S.Y.J. was a patient of the practice since 1998. From 1998 to 2010, his appointments were mainly with other providers in this and possibly other practices. He was treated by Dr. Templeman on two occasions in 2002, and once in 2006. S.Y.J. was treated by Dr.

Templeman under his responsibility as his primary care provider from 2011 to 2013, during which period he was a university student and only attended dentist appointments during his breaks from school.

d. J.Y. was a patient of the practice since 1986. She was treated nearly exclusively by Dr. Templeman, under his responsibility as her primary care provider from 1993 to 2015.

8. A list of appointments for the four patients for which Dr. Templeman identified himself as the treatment provider is attached at Tab 1.

9. Dr. Templeman only admits professional misconduct in respect of the facts below for the periods during which he was the primary care provider for each of the patients.

10. Further, if he were to testify, Dr. Templeman would say that in the latter years of his treatment of the Y-J family, he was suffering from illness, and was not properly focused on the care that should have been provided to the family.

ii. Allegation 1 – failure to meet the standards of practice

11. Dr. Templeman admits that he failed to meet the standards of practice in respect of his treatment, diagnosis, and documentation for the Y-J family, as follows:

a. Respecting S.Y., in the periods during which he was her primary care provider, Dr. Templeman:

i. failed to properly manage the patient's treatment needs and did not provide her with appropriate and needed dental care. Despite regular visits to his office, the state of her dentition deteriorated under his care and amounted to supervised neglect;

ii. failed to diagnose and/or treat decay and/or recurrent caries on teeth 21, 22, 23, 24, 25, 26, 12, 13, and 17;

iii. failed to diagnose and/or treat endodontic issues on teeth 23 and 26;

iv. failed to perform periodontal evaluations of the patient's teeth at any point during the time she was his patient; and

v. failed to properly document in the patient's record diagnoses or treatment plans with respect to any of the treatment he performed.

b. Respecting R.J., in the periods during which he was his primary care provider, Dr. Templeman:

   i. failed to properly manage the patient's treatment needs and did not provide him with appropriate and needed dental care. Despite regular visits to Dr. Templeman's office, the state of his dentition deteriorated under his care and amounted to supervised neglect;

   ii. failed to diagnose and/or treat generalized periodontal disease and severe periodontal bone loss of the patient's maxillary and mandibular anterior teeth, including heavy calculus and deep pockets;

   iii. failed to adequately examine the patient clinically and radiographically, in that the patient record does not contain any radiographs of the patient's anterior teeth;

   iv. failed to perform periodontal evaluations of the patient's teeth at any point during the time he was his patient; and

   v. failed to properly document in the patient's record diagnoses or treatment plans with respect to any of the treatment he performed.

c. Respecting S.Y.J., in the periods during which he was his primary care provider, Dr. Templeman:

   i. failed to properly manage the patient's treatment needs and did not provide him with appropriate and needed dental care. Despite regular visits to Dr. Templeman's office, the state of his dentition deteriorated under his care and amounted to supervised neglect;

   ii. failed to treat caries on teeth 24, 25, 14 and 15, despite documentation in the patient record of the presence of caries on these teeth on February 25, 2013, and despite the fact that the patient was under his care for at least 3 further appointments in 2013;

   iii. failed to perform periodontal evaluations of the patient's teeth at any point during the time he was his patient; and

   iv. failed to properly document in the patient's record any treatment plans with respect to any of the treatment he performed.

d. Respecting J.Y., in the periods during which he was her primary care provider, Dr. Templeman:

i. failed to properly manage the patient's treatment needs and did not provide her with appropriate and needed dental care. Despite regular visits to Dr. Templeman's office over 20 years, the state of her dentition deteriorated under his care and amounted to supervised neglect;

ii. failed to diagnose and/or treat deep decay and/or recurrent decay on teeth 22, 23, 27 and 28;

iii. failed to diagnose and/or treat endodontic issues on tooth 26;

iv. removed the bridge from tooth 44 to 47 as tooth 44 was decayed and could no longer support the bridge, in or about September 2007, and subsequently prepared and placed a bridge from tooth 43 to 47 without removing the root of tooth 44. Dr. Templeman did not inform the patient of this;

v. extracted tooth 24 and left the root of tooth and placed a cantilever bridge from tooth 26 to 23 over the remaining root, in or about May 2011. Dr. Templeman did not inform the patient of this;

vi. failed to perform periodontal evaluations of the patient's teeth at any point during the time she was his patient; and

vii. failed to properly document in the patient's record diagnoses or treatment plans with respect to any of the treatment he performed.

12. By failing to provide proper treatment, diagnosis and documentation as set out above, Dr. Templeman admits that his conduct contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 in the Notice of Hearing.

iii. Allegation 2 – failure to keep records as required

13. Dr. Templeman admits that he failed to keep records as required in relation to all four members of the Y-J family. In particular, Dr. Templeman failed to document adequate detail in the patient records for the patients, as follows:

a. the patient records do not document diagnostic findings or rationales for the treatment performed;

b. the patient records do not include diagnoses or treatment plans;

c. the patient records do not contain periodontal evaluations;

d. the patient records do not include notations that informed consent was obtained prior to commencing treatment; and

e. the patient records lack detail with respect to the treatment provided, including materials and drugs used, and where appropriate, the outcome of treatment.

14. Dr. Templeman acknowledges that with respect to the facts set out above, his recordkeeping was not in accordance with the regulations, or the standards of practice of the profession. Dr. Templeman 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, per the College's Dental Recordkeeping Guideline, and s. 38 of Regulation 547.

15. Therefore, Dr. Templeman admits that he failed to keep records as required by the Regulations, contrary to paragraph 25 of section 2 of the Dentistry Act Regulation, as set out in Allegation 2 in the Notice of Hearing.

iv. Allegation 3 – failure to obtain informed consent

16. Dr. Templeman admits that he failed to obtain informed consent prior to commencing significant treatment for all four patients.

17. The patient records do not document that Dr. Templeman discussed with his patients, at any point in the years that he treated them, the nature of the treatment proposed, the expected benefits of treatment, the material risks and side effects of treatment, taking into account the individual circumstances of the patient, or the alternatives to treatment, as is required of him.

18. Dr. Templeman acknowledges that with respect to the facts set out above, he treated patients for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without documenting such a consent, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

v. Allegation 4 – improper prescription of lorazepam

19. Dr. Templeman admits that he on several occasions between 2008 and 2012, he prescribed lorazepam to J.Y. without justification and without indication of how much was prescribed.

20. If he were to testify, Dr. Templeman would say that J.Y. had a longstanding bruxism and temporo-mandibular joint disorder (TMD) which he had diagnosed and managed with a bruxism appliance (i.e., night guard) and prescription lorazepam. The patient records contain the following entries in this regard:

a. August 9, 1988: a progress note documents "discussed bite plate". No rationale or diagnosis is documented;

b. December 5, 1988: a progress note documents “Bite plate bruxism, build up in Jan”;

c. December 15, 1988: a progress note documents “Insert bite plate, good result”;

d. January 10, 1989: a progress note documents “bite plate o.k.”;

e. February 24, 1992: a progress note documents “TENS machine bite adj”. No rationale or diagnosis is documented;

f. March 3, 1992: a progress note documents “TENS ½ machine bite adj”. No rationale or diagnosis is documented;

g. September 12, 1996: a progress note documents “Lower bite plate”. No rationale or diagnosis is documented;

h. November 15, 1999: a progress note from documents “adj [adjust] bite plate”;

i. Undated entry (likely 2002-2006): Dr. Templeman documented “Stress clenching terrible. Son very ill - Sister passed away, husband ill”;

j. December 4, 2003: a progress note documents “Bite–Rite”. No rationale or diagnosis is documented; and

k. August 21, 2006: a progress note documents that the patient is wearing her Bite–Rite regularly.

21. Specifically, prior to 2008, there is no indication in the patient’s record of management of the bruxism issue with lorazepam. Starting from December 2008, the following notations appear in the chart:

a. December 8, 2008: a progress note documents that Dr. Templeman prescribed 1mg of lorazepam for the patient. No rationale or diagnosis is documented. A copy of the prescription is not maintained on file;

b. April 9, 2009: a progress note documents that Dr. Templeman repeated his prescription for 1mg of lorazepam for the patient. No rationale or diagnosis is documented. A copy of the prescription is not maintained on file;

c. June 10, 2011: a progress note documents that Dr. Templeman prescribed 1mg of lorazepam for the patient. No rationale or diagnosis is documented. A copy of the prescription is not maintained on file;

d. July 12, 2011: a progress note from Dr. Templeman documents that a “lower bite plate” (i.e., bruxism appliance);

e. November 1, 2011: a medical history questionnaire notes that the patient is already taking lorazepam. No rationale, diagnosis, or follow-up questions are documented; and

f. March 6, 2012: a progress note documents that the patient is already taking lorazepam. No rationale or diagnosis is documented.

22. In a phone call with the College investigator, on or about September 2, 2016, Dr. Templeman indicated that he prescribed lorazepam to J.Y. after the passing of a member of her family, and that he continued to prescribe the drug over an extended period of time. Dr. Templeman maintains that the death of J.Y.’s husband exacerbated her TMD and, for that reason, he prescribed lorazepam. He denies that he prescribed the drug for a non-dental purpose, but admits that he did so without justification noted in her chart, and without indication of how much was prescribed.

23. Therefore, Dr. Templeman acknowledges that during the years 2008, 2009, 2011, and 2012, he prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs relative to one of his patients, namely J.Y., contrary to paragraph 10 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 of the Notice of Hearing.

Summary

24. Dr. Templeman admits that the acts described above constitute professional misconduct and he now accepts responsibility for his actions and the resulting consequences.

25. Dr. Templeman’s admissions in this agreement and his plea to allegations 1, 2, 3 and 4 in the Notice of Hearing are voluntary, informed and unequivocal. Specifically, by signing this agreement, Dr. Templeman acknowledges that:

a. he understands the nature of the allegations that have been made against him;
b. he has no questions with respect to the allegations made against him;
c. he understands that by admitting the allegations, he is waiving the right to require the prosecution prove the case against him;
d. he understands the consequences of admitting to the allegations;
e. he is aware that there will be a record of his admission and that a penalty will be imposed;
f. he is aware that the penalty could include a fine, suspension or revocation of his certificate of registration;
g. he is aware that the results of this proceeding will be available to the public from the College’s register, and that the College must publish the panel’s decision and a summary of its reasons, including his name;
h. he voluntarily decided to admit the allegations against him;

i. he was not pressured in any way by a person in authority to admit the allegations;

j. he was not offered any bribe, or promised any reward to admit to the allegations;

k. he understands that any agreement between him and the College with respect to the issue of penalty does not bind the Discipline panel, and that the panel could order something different than what the parties have agreed to.

26. Dr. Templeman has had the opportunity to take independent legal advice with respect to his admissions and has done so.

DECISION

Having considered the evidence and submissions of the parties, the Panel found that the Member committed professional misconduct as alleged in the Notice of Hearing and more particularly at paragraph 7 of the Agreed Statement of Facts. The Panel made no finding with respect to the particular as set out in the second bullet under allegation #4.

REASONS FOR DECISION

The Member pled guilty to the allegations of professional misconduct as set out in the Notice of Hearing and did not dispute the facts presented in the Agreed Statement of Facts. The Panel is satisfied that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations professional misconduct against Dr. Templeman.

The evidence clearly established that Dr. Templeman failed to properly care for and treat four members of the same family: S.Y., R.J., S.Y.J. and J.Y. Although the years of treatment and number of visits for each family member varied, the facts clearly established that Dr. Templeman failed to meet the standard of practice in respect of his treatment, diagnosis and documentation for each of them. He failed to provide appropriate and needed dental care and despite regular visits the state of their dentition deteriorated under his care and amounted to supervised neglect. Dr. Templeman also failed to perform periodontal evaluations at any point during the time they were his patients and he failed to properly document diagnoses or treatment plans with respect to any of the treatment provided.

The Panel also considered allegations that were specific to individual family members:

With respect to S.Y., Dr. Templeman failed to diagnose and/or treat decay and/or recurrent caries on numerous teeth and failed to diagnose and/or treat endodontic issues on two teeth.

With respect to S.Y.J., Dr. Templeman failed to treat caries on four teeth despite documentation in the patient record of the presence of caries on these teeth on February 25, 2013 and despite the fact that the patient was under his care for at least three further appointments that year.

With respect to R.J., Dr. Templeman failed to diagnose and/or treat generalized periodontal disease and severe periodontal bone loss of the patient's maxillary and mandibular anterior teeth, including heavy calculus and deep pockets. He failed to adequately examine the patient clinically and radiographically. The patient record had no radiographs of the patient's anterior teeth.

With respect to J.Y., Dr. Templeman failed to diagnose and/or treat deep decay and/or recurrent decay on four teeth and failed to diagnose and/or treat endodontic issues on tooth 26. Dr. Templeman removed a bridge from tooth 44 to 47 as tooth 44 was decayed and could no longer support the bridge. He subsequently prepared and placed a bridge from tooth 43 to 47 without removing the root of tooth 44. He extracted tooth 24 and left the root of the tooth and placed a cantilever bridge from tooth 26 to 23 over the remaining root. Dr. Templeman failed to inform the patient of his failure to remove any of the roots outlined above.

The Panel found that these failures to provide proper treatment, diagnoses and documentation clearly establish a failure to maintain the standards of practice of the dental profession. The Panel also found that Dr. Templeman failed to keep proper patient records. He did not document diagnostic findings or rationales for the treatments performed, there were no diagnoses or treatment plans and the records did not contain periodontal evaluations. The records did not contain any notations that informed consent was obtained prior to commencing treatments. His record keeping was not in accordance with the regulations or the standards of practice of the profession.

The Panel found that Dr. Templeman failed to obtain informed consent prior to commencing significant treatment for all four patients. There is no documentation of any discussions of the proposed treatments, the risks and benefits of such treatments, the material risks and side effects of such treatments. Dr. Templeman admitted that this amounted professional misconduct in the circumstances. This was of concern to the panel as Dr. Templeman had already had additional training with respect to informed consent because of a prior ICRC order.

The Panel also found that Dr. Templeman prescribed lorazepam to J.Y. on several occasions between 2008 and 2012 without justification and without documenting how much was prescribed and acknowledged In the Agreed Statement of Facts that this was a breach of the Dentistry Act Regulation, paragraph 10, section 2.

PENALTY SUBMISSIONS

The College advised the Panel that the Member had entered into a voluntary undertaking in which he agreed to permanently resign his certificate of registration. The Acknowledgement and Undertaking, dated March 28, 2018, is attached to this decision at Appendix A.

As a result of the Member's decision to provide the Acknowledgement and Undertaking, the College and Member made the following proposal with respect to penalty and costs:

> **WHEREAS** Dr. Randall Templeman ("the Member") entered into a voluntary Acknowledgement and Undertaking dated March 28, 2018, as attached to this Joint Submission as Appendix A, in which he agreed to permanently resign his certificate of registration;
>
> **AND WHEREAS** this panel of the Discipline Committee has found that the Member is guilty of professional misconduct;
>
> **NOW THEREFORE** the Royal College of Dental Surgeons of Ontario ("College") and the Member jointly submit that this panel of the Discipline Committee make the following order:
>
> 1. Requiring the Member 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; and
>
> 2. Requiring the Member to pay costs to the College in the amount of $5,000 in respect of this discipline hearing, such costs to be paid within thirty (30) days of this Order becoming final or on a date to be fixed by the Registrar.

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

The College submitted that in light of the Acknowledgment and Undertaking, the proposed penalty was appropriate. The public will be adequately protected given that the Member will no longer be permitted to practice in the Province.

PENALTY DECISION

The Panel accepted the parties' submission and so ordered as follows:

1. That the Member 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; and

2. That the Member pay costs to the College in the amount of $5,000 in respect of this discipline hearing, such costs to be paid within thirty (30) days of this Order becoming final or on a date to be fixed by the Registrar.

REASONS FOR PENALTY DECISION

The Panel concluded that the proposed Joint Submission on Penalty is appropriate in all the circumstances of this case. The Panel is aware that joint submissions should be respected unless they fall so far outside the range of an appropriate sanction that they would bring the administration of justice into disrepute or are otherwise contrary to the public interest. In considering the appropriateness of the proposed penalty, the Panel reviewed the voluntary Acknowledgement and Undertaking pursuant to which Dr. Templeman resigned from the profession and undertook to never reapply already in effect.

This Acknowledgment and Undertaking ensures that the primary penalty goal of protection of the public is met as Dr. Templeman will never practice dentistry in this province again. The Panel also considered the fact that Dr. Templeman recognized the seriousness of his behavior, is 70 years old and at the end of his dental career. The reprimand ordered serves to express the Panel's disapproval and disappointment with Dr. Templeman's treatment of his patients and sends a clear signal to the profession that such behavior will result in no longer being able to practice dentistry.

COST SUBMISSIONS

The College sought $5,000.00 from the Member for a portion of its costs.

COST DECISION AND REASONS

Dr. Templeman agreed to the cost penalty of $5,000 in the Joint Submission. The Panel finds that this cost order is appropriate in the circumstances.

I, Susan Davis, sign these Reasons for Decision as Chairperson of this Discipline Panel.

Susan Davis
Chairperson

May 7, 2018
Date

SCHEDULE A

File No: H170017

ACKNOWLEDGEMENT AND UNDERTAKING

TO: **ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO**
6 Crescent Road, Toronto, Ontario M4W 1T1

WHEREAS, on September 28, 2017, a panel of the Inquiries, Complaints and Reports Committee ("ICRC") referred specified allegations of professional misconduct to the Discipline Committee;

AND WHEREAS the allegations of professional misconduct against me are set out in a Notice of Hearing was issued on October 5, 2017;

AND WHEREAS the ICRC issued an Interim Order which took effect on July 28, 2017, directing the Registrar to suspend my certificate of registration, and I have not practised dentistry since that date;

AND WHEREAS, I wish to retire from the practice of dentistry, and I am prepared to provide the College with an undertaking to resign my membership with the College and never practice dentistry again in Ontario;

NOW THEREFORE, I, Dr. Randall Templeman, do hereby undertake and agree as follows:

1. to resign my membership with the College, effective immediately, thus relinquishing my certificate of registration;

2. never to practice dentistry again in the province of Ontario;

3. not to apply to the College at any time for reinstatement of my certificate of registration; and

4. not to apply to the College at any time for a new certificate of registration.

I further agree that the terms of this undertaking, as well as a notation that I entered into this Acknowledgement and Undertaking while a hearing into allegations of professional misconduct was pending, including a summary of those allegations, will be placed on the College's public register, pursuant to subsection 23(2) of Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18.

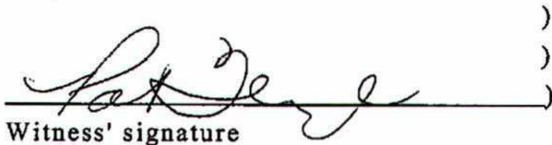
Without limiting the generality of the foregoing, it is understood and agreed that should the College determine that I have failed to abide by any of the terms of this Acknowledgement and Undertaking, a panel of the Inquiries, Complaints and Reports Committee may refer allegation(s) of professional misconduct to the Discipline Committee of the College in respect of my failure to abide by any of the terms of this Acknowledgement and Undertaking.

I, THE UNDERSIGNED, hereby acknowledge that I have been advised to obtain independent legal advice prior to signing this Acknowledgement and Undertaking and that I have done so.

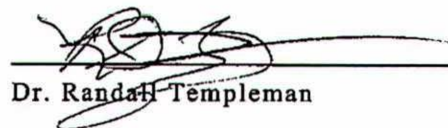
I am signing this document having read it and having understood it, of my own free will, voluntarily and without coercion.

SIGNED AND WITNESSED this 28th day of March, 2018.

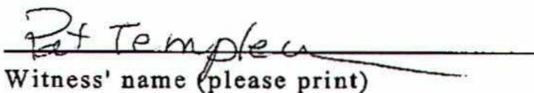
SIGNED, SEALED AND DELIVERED)
in the presence of)
)
)



Witness' signature



Dr. Randall Templeman



Witness' name (please print)