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. KEITH DA SILVA,** of the City of Etobicoke, 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
Dr. Bill Coyne
Margaret Dunn
Dr. Lisa Kelly

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Luisa Ritacca Independent Counsel for the Discipline Committee of the Royal College of Dental Surgeons of Ontario
- and -	)	
	)	Nick Coleman for the Royal College of Dental Surgeons of Ontario
DR. KEITH DA SILVA	)	
	)	Dr. Keith Da Silva, Self-Represented

Hearing held on June 21, 2018

PUBLICATION BAN

The Panel made an order banning the publication or broadcasting of the names of any patient referred to in the hearing, including in the Notice 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 the patient.

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 June 21, 2018.

THE ALLEGATIONS

The allegations against Dr. Da Silva (the "Member") were contained in the Notice of Hearing, dated February 1, 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 year 2015, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to two of your patients, namely V.P. and R.J., both minors, contrary to paragraph 33 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You submitted an account or charge to the City of Toronto, Department of Public Health, for restorative treatment on the following tooth surfaces of the following patients that you did not complete:
    - V.P.
        - Tooth 84 (lower right primary first molar) – Buccal
        - Tooth 83 (lower right primary cuspid) – Distal, Lingual, and Mesial
        - Tooth 55 (upper right primary second molar) – Occlusal, and Lingual
        - Tooth 53 (upper right primary cuspid) - Distal, Lingual, and Mesial
        - Tooth 64 (upper left primary first molar) – Distal, and Occlusal

- Tooth 65 (upper left primary second molar) – Occlusal, and Lingual
- Tooth 75 (lower left primary second molar) - Occlusal and Buccal

o R.J.

- Tooth 54 (upper right primary first molar) – Distal
- Tooth 55 (upper right primary second molar) – Occlusal and Lingual
- Tooth 65 (upper left primary second molar) – Occlusal and Lingual
- Tooth 63 (upper left primary cuspid) – Distal, Buccal, and Lingual
- Tooth 73 (lower left primary cuspid) – Distal, Buccal, and Lingual
- Tooth 83 (lower right primary cuspid) – Distal, Buccal, and Mesial

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, in the year 2015 you charged a fee(s) that was (were) excessive or unreasonable in relation to the service(s) performed relative to two of your patients, namely V.P., and R.J., both minors, contrary to paragraph 31 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You charged fees for restorative treatment on the following tooth surfaces of the following patients that you did not complete:

<u>V.P.</u>

- Tooth 84 (lower right primary first molar) – Buccal
- Tooth 83 (lower right primary cuspid) – Distal, Lingual, and Mesial
- Tooth 55 (upper right primary second molar) – Occlusal, and Lingual
- Tooth 53 (upper right primary cuspid) - Distal, Lingual, and Mesial
- Tooth 64 (upper left primary first molar) – Distal, and Occlusal
- Tooth 65 (upper left primary second molar) – Occlusal, and Lingual
- Tooth 75 (lower left primary second molar) - Occlusal and Buccal

<u>R.J.</u>

- Tooth 54 (upper right primary first molar) – Distal

- Tooth 55 (upper right primary second molar) – Occlusal and Lingual
- Tooth 65 (upper left primary second molar) – Occlusal and Lingual
- Tooth 63 (upper left primary cuspid) – Distal, Buccal, and Lingual
- Tooth 73 (lower left primary cuspid) – Distal, Buccal, and Lingual
- Tooth 83 (lower right primary cuspid) – Distal, Buccal, and Mesial

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 year 2015, 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 two of your patients, namely V.P., and R.J., both minors, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On or about April 27, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for V.P., when you did not perform such restorative treatment:

  o Tooth 84 (lower right primary first molar) – Buccal
  o Tooth 83 (lower right primary cuspid) – Distal, Lingual, and Mesial

- On or about May 25, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for V.P, when you did not perform such restorative treatment:

  o Tooth 53 (upper right primary cuspid) - Distal, Lingual, and Mesial

- On or about June 8, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for V.P., when you did not perform such restorative treatment:

  o Tooth 64 (upper left primary first molar) – Distal, and Occlusal

- Tooth 65 (upper left primary second molar) – Occlusal, and Lingual
- Tooth 75 (lower left primary second molar) - Occlusal and Buccal

- On or about September 14, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for R.J., when you did not perform such restorative treatment:

  - Tooth 54 (upper right primary first molar) – Distal
  - Tooth 55 (upper right primary second molar) – Occlusal and Lingual

- On or about September 24, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for R.J., when you did not perform such restorative treatment:

  - Tooth 63 (upper left primary cuspid) - Distal, Buccal, and Lingual
  - Tooth 65 (upper left primary second molar) - Occlusal and Lingual

- On or about September 28, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for R.J., when you did not perform such restorative treatment:

  - Tooth 83 (lower right primary cuspid) – Distal, Buccal, and Mesial

- On or about October 5, 2015, you represented to the patient and/or the patient's guardian, and/or the City of Toronto, Department of Public Health that you performed restorative treatment on the following tooth surfaces for R.J., when you did not perform such restorative treatment:

  - Tooth 73 (lower left primary cuspid) – Distal, Buccal, and Lingual

THE MEMBER'S PLEA

The Member admitted allegations 1, 2 and 3. The panel conducted a plea inquiry and was satisfied that the Member's plea was 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 provides as follows:

Allegations of Professional Misconduct

1. The allegations of professional misconduct against Dr. Keith Da Silva are set out in the Notice of Hearing, dated February 1, 2018 (Exhibit 1).

Background

2. Dr. Da Silva has been registered as a general dentist with the Royal College of Dental Surgeons of Ontario (the "College") since July 20, 2009. He is a certified specialist in pediatric dentistry.

3. At the time of the events described below, Dr. Da Silva owned his own dental practice. Since then, he has sold the practice. He has also completed a specialty degree in Dental Public Health at the University of Toronto.

4. Dr. Da Silva has no prior record of discipline at the College.

Complaint to the College

5. The College received a complaint regarding Dr. Da Silva on March 31, 2016. The complainant, Dr. H[redacted] S[redacted], is the [redacted] at [redacted].

6. The complaint concerned claims Dr. Da Silva had submitted to Toronto Public Health pursuant to the Children in Need of Treatment ("CINOT") dental program. The CINOT program provides publicly-funded dental care coverage for low-income children. Dr. St[redacted] was concerned that Dr. Da Silva had submitted claims and billed for services provided in 2015 to four of his minor patients and that, when those four patients were subsequently examined by Toronto Public Health, it was not evident that those services had actually been performed.

7. Dr. S[redacted] enclosed with her complaint copies of the claims Dr. Da Silva had submitted, as well as Toronto Public Health's patient charts, in respect of the four patients at issue.

Complaint Investigation

8. On April 11, 2016, pursuant to subsection 75(1)(c) of the Health Professions Procedural Code, the College appointed an investigator to investigate Dr. S[redacted]'s complaint.

9. The College investigator notified Dr. Da Silva regarding the complaint on April 13, 2016. Also on April 13, 2016, the College

investigator attended at Dr. Da Silva's office and obtained from Dr. Da Silva the patient records for the four patients Dr. S[redacted] had identified, as well as the names and contact information for several current and former staff members. In addition, following a request by the College, Dr. Da Silva provided the College investigator with radiographs for one of the four patients, as well as a typed verbatim transcript of his chart entries for all four patients.

10. The College investigator completed her Report of Section 75(1)(c) Investigation ("Report"). A copy of the Report was provided to Dr. Da Silva on June 3, 2016. Dr. Da Silva was invited to provide any response to Dr. S[redacted]'s complaint, together with any response to the Report, on or before July 8, 2016.

Dr. Da Silva's Response

11. Dr. Da Silva provided his response to Dr. S[redacted]'s complaint and the Report on June 25, 2016.

12. In his response, Dr. Da Silva attributed Dr. S[redacted]s concerns about "fraudulent billing practices" to his own poor record keeping and data flow management during a stressful period in his life. He indicated that his first child was born in April 2015 and his wife was very ill afterwards, requiring close to six months recovery and frequent hospital visits. During this period, Dr. Da Silva often had to rearrange his schedule on short notice and found himself overbooked on certain days. On such days, Dr. Da Silva would enter his chart notes and submit billing codes to his receptionist at the end of the day, rather than following each patient encounter. Dr. Da Silva acknowledged that errors may have been made during this period.

13. Dr. Da Silva also advised the College that, in approximately October 2015, he realized that the stress of managing his personal life and a full time sole practice was taking a toll on his health, and, as a result, he sold the majority interest in his practice. Dr. Da Silva indicated that he hoped that, once the sale and transition was completed in the summer of 2016, he would be able to focus solely on patient care, while another party could take care of the administrative and managerial duties associated with the practice.

ICRC Review

14. A panel of the Inquiries, Complaints, and Reports Committee ("ICRC") met to review the complaint against Dr. Da Silva. on July 18, 2017. The panel decided that it required further information.

Accordingly, it directed the College investigator to obtain the Toronto Public Health's complete original patient records, including all original radiographs and odontograms, in respect of the four patients at issue. The panel also asked Dr. Da Silva to answer specific questions, including with respect to the treatments he had provided to the patients, the process by which billings were recorded at his office and submitted to Toronto Public Health for those patients, and information with respect to the Recordkeeping course Dr. Da Silva indicated that he had taken.

15. Dr. Da Silva provided his response to the ICRC's questions on August 15, 2017. In his response, Dr. Da Silva provided the following comments:

    (a) With respect to what treatments he provided and when, Dr. Da Silva indicated that he could only rely upon his notes, which were recorded "in a hurry and sometimes the following day". He acknowledged that his notes and billing records indicated that restorations were performed for the patients that could not be identified when those same patients were examined by dentists and staff members at Toronto Public Health. According to Dr. Da Silva, he was not certain as to whether his notes were incorrect or whether the fillings had failed and fallen out by the time that the patients were examined at Toronto Public Health.

    (b) With respect to his office's billing practices, Dr. Da Silva advised that his usual practice was to write the codes for the treatments he has provided on a form for his receptionist to enter into the billing software. However, Dr. Da Silva indicated that, to the best of his recollection, he did not write down the treatment codes or complete his chart entries with respect to these four patients until the end of the day or the following morning. Dr. Da Silva stated that, as a result of these delays, he may have made errors in his record keeping and billing for these patients.

    (c) Dr. Da Silva also submitted a certificate of completion in respect of the course "Dental Recordkeeping – Back to the Basics", and advised that he had also completed the course "Jurisprudence and Ethics" and would also be forwarding the certificate of completion for that course when he received it.

16. Dr. Da Silva provided the College investigator with a certificate of completion for the course "Jurisprudence and Ethics" on August 25, 2017.

17. The College investigator also contacted Dr. S[redacted] and, on September 15, 2017, obtained original records from Toronto Public Health for each of the four patients at issue.

ICRC Concerns

18. On November 7, 2017, a panel of the ICRC met to review the information the College investigator had gathered and Dr. Da Silva's responses. The panel expressed concerns about Dr. Da Silva's billing and records with respect to two of his patients, R.J. and V.P. In particular, the panel was concerned that:

    (a) Dr. Da Silva had submitted bills and accepted payment for restorative treatments that did not appear to have been provided; and

    (b) Dr. Da Silva represented to his patients, their guardian(s), and/or Toronto Public Health that he had provided restorative treatments that did not appear to have been provided.

19. The panel formed an intention to refer specified allegations of professional misconduct to the Discipline Committee. Accordingly, on November 15, 2017, Dr. Da Silva was notified regarding the panel's concerns and intentions. The panel invited Dr. Da Silva to make further submissions in writing and/or in person at its meeting.

ICRC Decision

20. The panel of the ICRC met on December 13, 2017. Dr. Da Silva attended the meeting and provided oral submissions on his own behalf. During the course of his submissions, Dr. Da Silva acknowledged that, due to the stress of having a young family, he had not maintained best practices with respect to his recordkeeping and billing. He indicated that he took full responsibility for his actions, would return the payments received from Toronto Public Health, and was prepared to take the steps necessary to restore the faith of the profession and the community.

21. The panel of the ICRC decided to refer specified allegations of professional misconduct against Dr. Da Silva to the Discipline Committee. As noted above, the allegations of professional misconduct against Dr. Da Silva are set out in the Notice of Hearing, dated February 1, 2018 (Exhibit 1).

Restitution Payment

22. On May 2, 2018, Dr. Da Silva provided Toronto Public Health with a payment of $2,100, representing payment in full of the amounts received in respect of the patients, V.P. and R.J., plus interest.

23. On May 16, 2018, Dr. S[redacted] confirmed receipt of the same.

Admissions of Professional Misconduct

24. Dr. Da Silva admits that he committed the acts of professional misconduct during the year 2015, as alleged in paragraphs 1, 2, and 3 of the Notice of Hearing, dated February 1, 2018 (Exhibit 1).

25. In particular, Dr. Da Silva admits that, as described in the particulars to those allegations, he:

    (a) submitted an account or charge for dental services that he knew or ought to have known was false or misleading relative to two of his minor patients;

    (b) charged a fee that was excessive or unreasonable in relation to the service provided; and

    (c) 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 and unethical.

DECISION

Having considered the evidence as contained in the Agreed Statement of Facts and submissions of the parties, the Panel found Dr. DaSilva committed professional misconduct as alleged in paragraphs 1, 2, and 3 of the Notice of Hearing.

REASONS FOR DECISION

Dr. DaSilva admitted that he committed the acts of professional misconduct in 2015, as alleged in paragraphs 1, 2, and 3 of the Notice of Hearing. Specifically, he admitted that he:

- submitted and account or charge for dental services that he knew or ought to have known was false and misleading relative to two of his minor patients;
- charged a fee that was excessive or unreasonable in relation to the service provided; and

- 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.

Given the facts and admissions set out in the Agreed Statement of Facts, the Panel had no difficulty finding that the allegations of professional misconduct were clearly established.

PENALTY SUBMISSIONS

The College and the Member submitted that this Panel ought to make the following order:

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 four (4) months. The suspension shall commence thirty (30) days following this Order becoming final.
3. The Registrar shall impose the following terms, conditions and limitations on the Member's certificate of registration ("the Suspension 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 Suspension 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 "Practice Conditions"), namely:

(a) the College's course on recordkeeping, or equivalent, as approved by the Registrar, within six (6) months of this Order becoming final;

(b) the Member shall successfully complete, at his own expense, the ProBE Program on Professional/Problem-Based Ethics, to be completed with an unconditional pass within twelve (12) months of this Order becoming final;

(c) the Member's practice shall be monitored by the College by means of office visits 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 twenty-four (24) months following written confirmation to the Registrar that the Member has completed the course referred to in clause (a) of paragraph 4 above. The Member shall cooperate with the College during the monitoring visits and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per visit, such amount to be paid immediately after completion of each of the visits;

(d) the Practice Conditions imposed by virtue of clauses (a) and (b) of paragraph 4 above 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 described in clauses (a) and (b) of paragraph 4 above have been completed successfully; and

(e) the Practice Conditions imposed by virtue of clause (c) of paragraph 4 above 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 (c) of paragraph 4 above have been completed successfully.

5. The Member shall pay costs to the College in the amount of $5,000.00 no later than thirty (30) days following this Order becoming final.

PENALTY DECISION

The Panel ordered as 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 four (4) months. The suspension shall commence thirty (30) days following this Order becoming final.

3. The Registrar shall impose the following terms, conditions and limitations on the Member's certificate of registration ("the Suspension 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 Suspension 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 "Practice Conditions"), namely:

(a) the College's course on recordkeeping, or equivalent, as approved by the Registrar, within six (6) months of this Order becoming final;

(b) the Member shall successfully complete, at his own expense, the ProBE Program on Professional/Problem-Based Ethics, to be completed with an unconditional pass within twelve (12) months of this Order becoming final;

(c) the Member's practice shall be monitored by the College by means of office visits 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 twenty-four (24) months following written confirmation to the Registrar that the Member has completed the course referred to in clause (a) of paragraph 4 above. The Member shall cooperate with the College during the monitoring visits and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per visit, such amount to be paid immediately after completion of each of the visits;

(d) the Practice Conditions imposed by virtue of clauses (a) and (b) of paragraph 4 above 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 described in clauses (a) and (b) of paragraph 4 above have been completed successfully; and

(e) the Practice Conditions imposed by virtue of clause (c) of paragraph 4 above 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 (c) of paragraph 4 above have been completed successfully.

5. The Member shall pay costs to the College in the amount of $5,000.00 no later than thirty (30) days following this Order becoming final.

REASONS FOR PENALTY AND COSTS

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

The Panel was satisfied that the suspension, educational courses, monitoring provisions, the reprimand and the recording of the results of these proceedings on the College Register will act to deter Dr. Da Silva from ever behaving in this manner again. The educational courses and monitoring requirements of the Penalty Order will provide for the rehabilitation of the member. The Penalty Order also sends a very clear message to the profession that the submission of false or misleading fee claims will not be tolerated by the College. The Panel was satisfied that the goals of penalty have been met and that the public will be protected.

In considering the appropriateness of the 4-month suspension provision, the Panel was concerned that the length of this suspension is on the higher end of the range of possible suspensions given the facts of this case. However, the Panel is also 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 at the College into disrepute or are otherwise contrary to the public interest. In the circumstances, the Panel was not prepared to interfere with the proposed length of suspension, which was reasonable. The submission of false or misleading billings is a serious issue for the profession

and the penalty imposed reflects this fact. The Panel was ultimately satisfied that the suspension is within the range of appropriate penalties for professional misconduct arising from the submission of false billings for work not actually performed on patients.

The Panel acknowledges that Dr. Da Silva cooperated with the College at every interaction, fully accepted his misconduct and expressed his remorse for his actions. Restitution was made to Toronto Public Health in the amount of $2,100, representing payment in full of the amounts received in respect of the two patients plus interest.

At the conclusion of the Hearing, the Member waived his right to an appeal from the decision on liability and penalty. The Panel delivered its Reprimand, a copy of which is attached as Schedule "A".

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

Susan Davis
Chairperson

July 30, 2018
Date

Schedule A

Reprimand for Dr. Keith Da Silva June 21, 2018

Dr. Da Silva, as you know, the Discipline panel has ordered you to be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the seriousness of your misconduct.

The fact you have received this reprimand will be part of the public portion of the Register and as such, part of your record with the College.

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found you have engaged in acts of professional misconduct related to the submission of charges to the City of Toronto, Department of Public Health for restorative treatments on 2 patents that you did not in fact complete.

Your professional misconduct is a matter of concern. It is unacceptable to your fellow dentists and to the public. You have brought discredit to the profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged has involved billing for dental work not performed, to a publicly funded program providing access to dental care for underprivileged children. The panel recognizes your rehabilitation efforts to date and expects you will never find yourself before this Discipline Committee again.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is **not** an opportunity for you to debate the merits or the correctness of the decisions we have made.

Thank you for attending today. We are adjourned.