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. Nicholas Bekesch, of the City of Burlington, in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation").

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Peter Delean
Mr. Rod Stableforth

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 -	)	
	)	Megan Shortreed, Dr. Helene Goldberg
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. NICHOLAS BEKESCH	)	Mr. Symon Zucker
	)	For the Member

Hearing held by way of teleconference

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on August 25, 2020. This matter was heard electronically.

At the outset of the hearing, the College sought an order banning the publication of the name of the patient or any information that could be used to identify the patient. The Member consented to the request. The Panel granted the order, which extends to the exhibits filed, as well as to these reasons for decision.

THE ALLEGATIONS

The allegations against the Member were contained in the Notice of Hearing, dated December 2, 2019 (Exhibit 1).

> 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 years 2017, 2018 and/or 2019, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one or more of your patients, namely Person A, Person B, Person C, Person D, Person E, Person F and/or Person G, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.
>
> Particulars:
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> - You prescribed opioid medication to seven patients without justification in that you did not document an appropriate diagnosis or assessment of the patient's pain or that you had tried a non-opioid medication first:
>   - For Person A, you prescribed opioid medication on five occasions between April 10, 2018 and December 28, 2018, without proper justification.
>   - For Person B, you prescribed opioid medication on three occasions without proper justification between January 9, 2019 and January 21, 2019.
>   - For Person C, you prescribed opioid medication on four occasions without proper justification between January 4, 2019 and January 21, 2019.

- For Person C, you prescribed opioid medication on four occasions without proper justification between January 4, 2019 and January 21, 2019.
- For Person D, you prescribed opioid medication on 104 occasions without proper justification between January 6, 2017 and March 28, 2019.
- For Person E, you prescribed opioid medication on six occasions without proper justification between April 20, 2018 and May 28, 2018.
- For Person F, you prescribed opioid medication on four occasions without proper justification between February 13, 2017 and March 3, 2018.
- For Person G, you prescribed opioid medication on four occasions without proper justification between January 9, 2018 and April 3, 2018.

- You did not limit the number tablets of opioids dispensed to your patients according to the College's Guidelines The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice (November 2015) and you did not document a rationale as to why the recommended maximum was exceeded relative to two of your patients:
  - For Person C:
- On or about January 11, 2017 and January 14, 2017, you prescribed 30 tablets of Oxycocet (Percocet), which exceeds the recommended maximum by six tablets.
- On or about January 21, 2017, you prescribed 60 tablets of Oxycocet, which exceeds the recommended maximum by 36 tablets.
  - For Person D:
- You prescribed a total of 1515 tablets of Oxycocet in approximately a two year period between January 2017 and March 2019 and on 14 occasions in that period, you prescribed 30 tablets of Oxycocet, which exceeds the recommended maximum by 6 tablets.

- You did not prescribe opioids to your patients at an appropriate frequency according to the College's Guidelines in that you did not limit the number of consecutive prescriptions to a maximum of three and thereafter you did not consult with the patient's family doctor or dental specialist with expertise in pain management prior to prescribing additional opioids:

- For Person A, you provided four prescriptions for narcotic medication between April 10, 2018 and May 3, 2018.
- For Person C, you provided four prescriptions for narcotic medication between January 4, 2017 and January 21, 2017.
- For Person D, you provided a total of 104 prescriptions between January 6, 2017 and March 28, 2019.
- For Person E, you provided six prescriptions for narcotic medication between April 20, 2018 and May 28, 2018.
- For Person F, you prescribed four prescriptions for narcotic medication between February 13, 2017 and March 3, 2018.

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 years 2017, 2018 and 2019, 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 or more of your patients, namely Person A, Person B, Person C, Person D, Person F and/or Person G, contrary to paragraph 10 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - You prescribed narcotic medication for an improper purpose in that you prescribed narcotic medication for seven patients when it was not indicated based on the dental procedures performed or the patient's condition. You also prescribed narcotics when you did not render any treatment:
     - For Person A, you prescribed opioid medication on five occasions between April 10, 2018 and December 28, 2018, when the prescription was not indicated or when no treatment was rendered.
     - For Person B, you prescribed opioid medication on three occasions between January 9, 2019 and January 21, 2019, when the prescription was not indicated or when no treatment was rendered.

- For Person C, you prescribed opioid medication on four occasions between January 4, 2019 and January 21, 2019, when the prescription was not indicated or when no treatment was rendered.
- For Person D, you prescribed opioid medication on 104 occasions without proper justification between January 6, 2017 and March 28, 2019, when the prescription was not indicated or when no treatment was rendered.
- For Person E, you prescribed opioid medication on six occasions between April 20, 2018 and May 28, 2018, when the prescription was not indicated or when no treatment was rendered.
- For Person F, you prescribed opioid medication on four occasions between February 13, 2017, and March 3, 2018, when the prescription was not indicated or when no treatment was rendered.
- For Person G, you prescribed opioid medication on four occasions between January 9, 2018 and April 3, 2018, when the prescription was not indicated.

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 years 2017, 2018 and 2019, you failed to keep records as required by the Regulations relative to one or more of your patients, namely Person A, Person B, Person C, Person D, Person F and/or Person G, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You prescribed opioid medication to seven patients and did not document the prescription in the patient chart or retain a copy of the prescription in the patient record:
  - For Person A, on or about April 10, 2018, you prescribed Lenotec No. 3 and you did not record the prescription in the patient’s chart.

- For Person B, on or about January 21, 2019, you prescribed Oxycocet and you did not record the prescription in the patient's chart.
- For Person C, on or about January 14 and 21, 2017, you prescribed Oxycocet and you did not record the prescription in the patient's chart.
- For Person D, on 91 occasions between January 6, 2017, and March 28, 2019, you prescribed opioids and you did not record the prescription in the patient's chart.
- For Person E, on or about May 28, 2018, you prescribed Oxycocet and you did not record the prescription in the patient's chart.
- For Person F, on or about February 13, 2017 and March 27, 2017, you prescribed Lenotec No. 3 to your patient and did not record the prescription in the patient's chart.
- For Person G, on or about January 30, 2018, you prescribed Codeine and you did not record the prescription in the patient chart.

- You did not date prescriptions contained in patient charts for three patients:
  - For Person D, two undated prescriptions were found in the patient chart.
  - For Person F, one undated prescription was found in the patient chart.
  - For Person G, two undated prescriptions were found in the patient chart.

- You did not include required information in your patient chart notes for the prescription of opioid medication to seven patients, Person A, Person B, Person C, Person D, Person E, Person F and Person G, in that you did not document a justification for the prescription, your diagnosis of the patient's pain, a notation that you considered a non-opioid medication first, and/or instructions for the use of the medication prescribed.

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 2017, 2018 and 2019, 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 your patient, namely Person D, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- Based on the number and frequency of narcotic medication you prescribed to your patients, and in particular, Person D, you have not demonstrated reasonable professional judgment in your prescribing practices and you have not assumed the responsibility of limiting the potential for drug misuse, abuse and/or diversion.
- You have not demonstrated awareness of the potential harm that the over-prescription of opioid medication can have on your patient Person D [redacted]

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in the Notice of Hearing. The Member signed a Plea Inquiry, which was marked as Exhibit 2.

In addition, the Panel confirmed with the Member that he understood the effect of his plea and as such was satisfied that Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 3) which substantiated the allegations. A summary of the Agreed Statement of Facts is set out below:

Background

1. Dr. Nicholas Bekesch (the "Member") has been registered with the College as a general dentist since 1975.
2. At the material times, the Member was practicing at multiple locations owned by other dentists, as follows:

    - Dental Hygiene Clinic, 2333 Markham Road, Scarborough
    - Dr. Komal Jain, 1991 Danforth Ave, Scarborough
    - Dr. Komal Jain, 73 Dundas St West, Mississauga
    - Linwell Park Dental Centre, 142 Linwell Rd, St Catherines
    - Dundas Dental Hygiene Clinic, 4154 Dundas St West, Etobicoke
    - University Dental Hygiene Clinic, 258 King St N, Waterloo
    - Monarch Dental Centre, 650 Fairview St, Burlington
    - Dr. Anthony Cardelli, 650 Yonge Street, Toronto.

3. The Member is currently subject to an Interim Order made by the ICRC on April 12, 2019, following the report that led to the allegations in this case. It specifically imposes terms, conditions or limitations on Dr. Bekesch's certificate of registration that he shall not prescribe, for any purpose, to any person or for office use, narcotics and/or controlled substances.

The Notice of Hearing

4. The allegations of professional misconduct against the Member are set out in the Notice of Hearing dated December 2, 2019 (attached at Tab A).
5. The College and the Member have agreed to resolve the allegations on the basis of the facts and admissions set out below.

Facts and Admissions

6. The facts giving rise to the allegations of professional misconduct came to the attention of the College on March 18, 2019, when a Practice Advisor in the College's Quality Assurance Department received a telephone call from a pharmacist at Total Health Pharmacy, Samantha Aboelezz, who had concerns with respect to the Member's prescribing practices.

7. Ms. Aboelezz indicated that a patient had provided her with three prescriptions for Percocet that the Member had written in a single week. The patient was Person D [redacted]

[redacted]. Over the course of the previous two years, the Member had written 83 prescriptions for Person D, of which Ms. Aboelezz was aware. The prescriptions were written on different prescription pads, but were all authorized by the Member.

8. The ICRC authorized a s. 75(1)(a) investigation on March 27, 2019, with respect to whether the Member had committed an act of professional misconduct with respect to his prescribing practices.

9. Dr. Helene Goldberg, a College investigator, obtained patient records from the principal dentists in the offices where the Member worked. The investigator also obtained information from the Narcotic Monitoring System (NMS) regarding the Member, as well as from the pharmacy that initially reported the issue. The investigator also contacted Person D's family physician.

10. From the materials received, the investigator selected seven patient records to review in addition to Person D's records. One of those patient records was later removed when it became clear that there was an error in the documentation, and the Member had not prescribed that patient any narcotics. As a result, in addition to Person D, there were six additional patient charts reviewed in relation to this matter: Person F, Person G, Person A, Person C, Person E, and Person B.

11. After the investigator submitted her Report on Investigation ("ROI") to the ICRC, the Member provided a response for the ICRC's consideration on September 4, 2019. The ICRC considered the ROI and Dr. Bekesch's response. On November 25, 2019, it referred allegations of professional misconduct to the Discipline Committee.

A. Allegations 1 and 2 – Improper Prescribing Practices

12. An examination of the patient files revealed improper prescribing practices in respect of all seven patients between 2017 and 2019, as follows:

a. Dr. Bekesch did not document an appropriate diagnosis or assessment of the patient's pain or that he had tried a non-opioid medication first, for patients:

- Person A, on five occasions between April 10, 2018 and December 28, 2018;
- Person B, on three occasions between January 9, 2019 - January 21, 2019;

- Person C, on four occasions between January 4, 2019 - January 21, 2019;
- Person D, on 104 occasions between January 6, 2017-March 28, 2019;
- Person E, on six occasions between April 20, 2018 - May 28, 2018;
- Person F, on four occasions between February 13, 2017 - March 3, 2018; and
- Person G, on four occasions between January 9, 2018 - April 3, 2018.

b. Dr. Bekesch did not limit the number of tablets of opioids dispensed to his patients according to the College's Guidelines on The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice (the "Opioid Guidelines", attached at Tab B). Further, he did not document a rationale as to why the recommended maximum was exceeded for the following patients:

- Person C, on January 11 and 14, 2017 (prescribed 30 tablets each visit) and January 21, 2017 (prescribed 60 tablets); and
- Person D, between January 2017 and March 2019 (prescribed 1515 tablets total), including prescribing 30 tablets on 14 separate occasions.

c. Dr. Bekesch did not prescribe opioids at an appropriate frequency according to the Opioid Guidelines, by not limiting the number of consecutive prescriptions to a maximum of three, and not thereafter consulting with the patient's family doctor or specialist with expertise in pain management prior to prescribing additional opioids, for the following patients:

- Person A, by providing four prescriptions between April 10, 2018 and May 3, 2018;
- Person C, by providing four prescriptions between January 4, 2017 and January 21, 2017;
- Person D, by providing 104 prescriptions between January 6, 2017 and March 28, 2019;
- Person E, by providing six prescriptions between April 20, 2018 and May 28, 2018; and
- Person F, by providing four prescriptions between February 13, 2017 and March 3, 2018.

d. Dr. Bekesch prescribed narcotic medication when it was not indicated based on the dental procedures performed, the patient's

condition, and/or when he did not render any treatment, for the following patients:

- Person A, on five occasions between April 10, 2018 - December 28, 2018;
- Person B, on three occasions between January 9, 2019 and January 21, 2019;
- Person C, on four occasions between January 4, 2019 and January 21, 2019;
- Person D, on 104 occasions between January 6, 2017 and March 28, 2019;
- Person E, on six occasions between April 20, 2018 and May 28, 2018;
- Person F, on four occasions between February 13, 2017 and March 3, 2018; and
- Person G, on four occasions between January 9, 2018 and April 3, 2018.

13. The Opioid Guidelines set out the following requirements in respect of prescribing opioids:
    - Opioids should only be prescribed in appropriate cases, taking into consideration the diagnosis or clinical indication. Before prescribing an opioid, the dentist should consider whether the patient's pain is well documented, whether the patient is currently taking an opioid, and/or whether the patient's medical history suggests signs of substance misuse, abuse and/or diversion;
    - Before prescribing an opioid, dentists should consider alternatives, including NSAIDs;
    - Dentists who prescribe an opioid should place reasonable limits on their prescriptions and consider opportunities for collaborating with other health care professionals. If the use of an opioid is determined to be appropriate, the dentist should limit the number of tablets dispensed, generally as follows: codeine 15 mg, to a maximum of 36 tablets; codeine 30 mg, to a maximum of 24 tablets; oxycodone 5 mg, to a maximum of 24 tablets;
    - Dentists should also limit the number of consecutive prescriptions to a maximum of three; and
    - Long term use of such medication should be avoided, whenever possible.

14. The Member acknowledges that he prescribed opioids on numerous occasions without documenting the required consideration of

whether it was appropriate. He also did not limit the number of tablets (or document why the maximum was exceeded) on numerous occasions, nor prescribe at the appropriate frequency (i.e., he provided more than three consecutive prescriptions). He also prescribed opioids in cases where the medication was not indicated based on the treatment or condition, or where treatment was not rendered.

15. Therefore, the Member admits that he 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.

16. Further, the Member admits that he prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs, contrary to paragraph 10 of Section 2 of the Dentistry Act Regulation.

B. Allegation 3 – Failure to Keep Records as Required

17. An examination of the patient files revealed that the Member failed to keep records as required in respect of all seven patients between 2017 and 2019, as follows:

    a. Dr. Bekesch prescribed opioid medication but did not document the prescription in the patient chart or retain a cop of the prescription in the patient record, for the following patients:
        - Person A, on April 10, 2018 (Lenotec No. 3);
        - Person B, on January 21, 2019 (Oxycocet);
        - Person C, on January 14 and 21, 2017 (Oxycocet);
        - Person D, on 91 occasions between January 6, 2017 and March 28, 2019;
        - Person E, on May 28, 2018 (Oxycocet);
        - Person F, on February 13 and March 27, 2017 (Lenotic No. 3); and
        - Person G, on January 30, 2018 (Codeine).

    b. Dr. Bekesch did not date prescriptions contained in patient charts, for patients Person D (two undated prescriptions), Person F (one undated prescription), and Person G (two undated prescriptions).

18. The Member's professional, ethical and legal responsibilities dictate that he maintain a complete record documenting all aspects

of each patient's dental care, pursuant to the Dental Recordkeeping Guidelines (May 2008), and s. 38 of Regulation 547. In particular, the College's Dental Recordkeeping Guidelines state that the progress notes for each visit should provide a concise and complete description of all services rendered and include any drugs prescribed, dispensed or administered, including the quantity and dose of each. Dentists must also document the patient's condition, a diagnosis and treatment plan, and justification for treatment recommendations (which would include medication prescriptions).

19. In addition, the Opioid Guidelines require dentists to document the following information when issuing a prescription: name of the patient, full date (day, month and year), name of the drug, drug strength and quantity or duration of therapy, full instructions for use of the drug, refill instructions, if any, printed name of prescriber, address and telephone number of dental office where the patient's records are kept, signature of pre scriber or appropriate electronic identifier.

20. The Member acknowledges that he did not document a prescription, or retain a copy, on numerous occasions. In other cases, he did not date the prescription and/or did not include the required information about the prescription, including not documenting a justification for the prescription, his diagnosis of the patient's pain, a notation that he considered a non-opioid medication first, and/or instructions for the use of the medication prescribed.

21. The Member 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 Guidelines, and s. 38 of Regulation 547.

22. Therefore, the Member admits that he failed to keep records as required by the Regulations relative to the patients listed above, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

C. Allegation 4 – Lack of Professional Judgment

23. The Opioid Guidelines require dentists to exercise reasonable professional judgment to determine whether prescribing an opioid is the most appropriate choice for a patient, including consideration of the high susceptibility of these drugs to misuse, abuse, and/or diversion, and the possibility of harm.

24. The Member acknowledges that he failed to demonstrate reasonable professional judgment in his prescribing practices with respect to Person D, in light of the high number and frequency of narcotics prescribed to her (104 prescriptions for Percocet over a two year period, totaling 1515 tablets). He also did not demonstrate any awareness of the potential of harm to her [redacted]

25. If the Member were to testify, he would state that Person D had an allergy to codeine [redacted]. She had tried to get coverage [redacted] to pay for medications other than Percocet, but no other medications were approved. He would say that Person D had chipped and broken teeth and a number of her teeth required root canal treatment. Person D could not pay for the required treatment, which was why she needed to be kept on pain killers and antibiotics. Dr. Bekesch would testify that he did not believe Person D was addicted, although he acknowledges that he did not consult directly with her family physician and relied only on Person D's account.

26. The Member admits that he did not demonstrate reasonable professional judgment in prescribing practices and did not assume the responsibility of limiting the potential for drug misuse, abuse and/or diversion, based on the number and frequency of narcotic medication prescribed to his patient.

27. Given that he was prescribing Person D at least 2 tablets per day, he further admits that he did not demonstrate awareness of the potential harm that the over-prescription of opioid medication could have on his patient [redacted].

28. Therefore, the Member admits that he 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, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Past History

29. The Member has no prior findings of professional misconduct. However, in February 1994, he received a caution from the ICRC related to charting results of specific exams and patient consultations in greater detail (attached at Tab C).

General

30. Dr. Bekesch admits that the acts described above constitute professional misconduct and he now accepts responsibility for his actions and the resulting consequences.
31. Dr. Bekesch has had the opportunity to take independent legal advice with respect to his admissions.

DECISION

The Panel finds that the Member engaged in professional misconduct as admitted in the Agreed Statement of Facts. The Member's conduct would reasonably be regarded by other members of the College as disgraceful, dishonourable and unprofessional.

REASONS for DECISION

The Panel was of the view that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations and demonstrated the Member's disregard for his patient's wellbeing and the profession as a whole.

Dr. Bekesh admits to:

- Improper prescribing practices in respect to seven patients between 2017 and 2019. The Member did not record an appropriate diagnosis or assessment of the patient's pain, he did not limit the number of tablets of opioids dispensed as recommended in the College Guidelines, he prescribed opioids at an improper frequency and he prescribed narcotic medication when it was not indicated based on the procedure performed.

- Failing to keep records as required in respect to all seven patients between 2017 and 2019. Specifically, Dr. Bekesh did not document the prescription in the patient chart or retain a copy of the prescription.

- Clearly displaying a lack of professional judgment by prescribing opioid analgesics with an unreasonable frequency, quantity and without justification in certain instances. He contravened the College's Guidelines on the Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice. This conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical conduct.

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission with respect to Penalty & Costs (Exhibit 4), which provides as follows.

1. Requiring the Member to appear before the Panel of the Discipline Committee to be reprimanded, on the date of this Order becoming final.
2. Directing the Registrar to suspend the Member's certificate of registration for a period of four (4) months. The suspension shall commence on the date of this Order becoming final, and shall run without interruption.
3. Directing that 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 immediately inform the following people about the suspension:
        i. staff in the offices or practices in which the Member works, including other regulated professionals and administrative staff
        ii. dentists with whom the Member works, whether the Member is a principal in the practice or otherwise associated with the practice
        iii. dentists or other individuals who routinely refer patients to the Member
        iv. faculty members at Faculties of Dentistry, if the Member is affiliated with the Faculty in an academic or professional capacity
        v. owners of a practice or office in which the Member works
        vi. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Member may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

b. while suspended, the Member must not engage in the practice of dentistry, including but not limited to:
    i. acting in any manner that suggests the Member is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Member must ensure that administrative or office staff do not suggest to patients in any way that the Member is entitled to engage in the practice of dentistry
    ii. giving orders or standing orders to dental hygienists
    iii. supervising work performed by others
    iv. working in the capacity of a dental assistant or performing laboratory work
    v. acting as a clinical instructor;
c. while suspended, the Member must not be present in offices or practices where the Member works when patients are present, except for emergencies that do not involve patients. The Member must immediately advise the Registrar in writing about any such emergencies;
d. while suspended, the Member must not benefit or profit, directly or indirectly from the practice of dentistry.
    i. The Member may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Member may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.
    ii. The Member is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.
    iii. The Member must not sign insurance claims for work that has been completed by others during the suspension period;
e. the Member shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Member has complied with the Suspension Conditions. The Member must provide the College with access to any records associated with the practice that the College may require to verify that the Member has not engaged in the practice of dentistry or profited during the suspension; and

f. the Suspension Conditions imposed by virtue of subparagraphs 3(a)-(e) above shall be removed at the end of the period that the Member's certificate of registration is suspended.

4. Directing that the Registrar also impose the following additional terms, conditions and limitations on the Member's certificate of registration (the "Practice Conditions"), namely:

a. the Member shall be restricted permanently from prescribing narcotic drugs and preparations or controlled drugs and preparations;

b. the Member shall successfully complete, at his own expense, the following courses approved by the Registrar:

i. the Pro BE Program for Professional/Problem- Based Ethics (must obtain an "unconditional pass" grade);

ii. the College course on Recordkeeping for Ontario Dentists; and

iii. a comprehensive course on appropriate prescribing of drugs, including narcotics or other controlled substances as well as non- narcotic analgesics, for dental pain management;

such courses to be completed within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

c. the Member's practice shall be monitored by the College by means of periodic inspection(s) or periodic chart review(s) by a representative or representatives of the College at such time or times and in such manner as the College may determine, during the twenty- four (24) months following the date he returns to practice following the suspension in paragraph 2 above;

d. the Member shall cooperate with the College during the inspections and/or chart reviews and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per inspection or chart review, such amount to be paid immediately after completion of each inspection or review;

e. the representative or representatives of the College shall report the results of the inspections and/ or chart reviews 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;

f. the Practice Conditions imposed by virtue of clause (b) of paragraph 4 shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses have been completed successfully;and

g. the Practice Conditions imposed by virtue of clauses (c), (d) and (e) of paragraph 4 shall be removed from the Member's certificate of registration 24 months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clauses (c), (d) and (e) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

5. The Member shall pay costs to the College in the amount of $10,000.00, in five (5) monthly installments of $2,000.00 each, commencing on February 1, 2021 and ending on June 1, 2021.

The College and the Member further submit that pursuant to the Code, as amended, the results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and address of the Member included.

PENALTY DECISION

The Panel agreed and accepted the Joint Submission on Penalty and so makes the following order:

1. The Member is required to appear before the Panel of the Discipline Committee to be reprimanded, on the date of this Order becoming final.
2. The Registrar is directed to suspend the Member's certificate of registration for a period of four (4) months. The suspension shall commence on the date of this Order becoming final, and shall run without interruption.
3. The Registrar shall impose the following terms, conditions and limitations on the Member's certificate of registration (the "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 immediately inform the following people about the suspension:
    i. staff in the offices or practices in which the Member works, including other regulated professionals and administrative staff
    ii. dentists with whom the Member works, whether the Member is a principal in the practice or otherwise associated with the practice
    iii. dentists or other individuals who routinely refer patients to the Member
    iv. faculty members at Faculties of Dentistry, if the Member is affiliated with the Faculty in an academic or professional capacity
    v. owners of a practice or office in which the Member works
    vi. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Member may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

b. while suspended, the Member must not engage in the practice of dentistry, including but not limited to:
    i. acting in any manner that suggests the Member is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Member must ensure that administrative or office staff do not suggest to patients in any way that the Member is entitled to engage in the practice of dentistry
    ii. giving orders or standing orders to dental hygienists
    iii. supervising work performed by others
    iv. working in the capacity of a dental assistant or performing laboratory work
    v. acting as a clinical instructor;

c. while suspended, the Member must not be present in offices or practices where the Member works when patients are present, except for emergencies that do not involve patients. The Member must immediately advise the Registrar in writing about any such emergencies;

d. while suspended, the Member must not benefit or profit, directly or indirectly from the practice of dentistry.
    i. The Member may arrange for another dentist to take over their practice during the suspension period. I f another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Member may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.
    ii. The Member is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.
    iii. The Member must not sign insurance claims for work that has been completed by others during the suspension period;
e. the Member shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Member has complied with the Suspension Conditions. The Member must provide the College with access to any records associated with the practice that the College may require to verify that the Member has not engaged in the practice of dentistry or profited during the suspension; and
f. the Suspension Conditions imposed by virtue of subparagraphs 3(a)-(e) above shall be removed at the end of the period that the Member's certificate of registration is suspended.

4. Directing that the Registrar also impose the following additional terms, conditions and limitations on the Member's certificate of registration (the "Practice Conditions"), namely:

a. the Member shall be restricted permanently from prescribing narcotic drugs and preparations or controlled drugs and preparations;
b. the Member shall successfully complete, at his own expense, the following courses approved by the Registrar:
    i. the Pro BE Program for Professional/Problem- Based Ethics (must obtain an "unconditional pass" grade);
    ii. the College course on Recordkeeping for Ontario Dentists; and
    iii. a comprehensive course on appropriate prescribing of drugs, including narcotics or other controlled substances as well as non-narcotic analgesics, or dental pain management;

such courses to be completed within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

c. the Member's practice shall be monitored by the College by means of periodic inspection(s) or periodic chart review(s) by a representative or representatives of the College at such time or times and in such manner as the College may determine, during the twenty- four (24) months following the date he returns to practice following the suspension in paragraph 2 above;

d. the Member shall cooperate with the College during the inspections and/or chart reviews and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per inspection or chart review, such amount to be paid immediately after completion of each inspection or review;

e. the representative or representatives of the College shall report the results of the inspections and/ or chart reviews 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;

f. the Practice Conditions imposed by virtue of clause (b) of paragraph 4 shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses have been completed successfully; and

g. the Practice Conditions imposed by virtue of clauses (c), (d) and (e) of paragraph 4 shall be removed from the Member's certificate of registration 24 months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clauses (c), (d) and (e) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

5. The Member shall pay costs to the College in the amount of $10,000.00, in five (5) monthly installments of $2,000.00 each, commencing on February 1, 2021 and ending on June 1, 2021.

REASONS FOR PENALTY DECISION

The Panel heard submissions from Counsel for the College and from Counsel for the Member in support of the Joint Submission on Penalty.

College Counsel submitted that the proposed penalty appropriately meets the principles of general deterrence, specific deterrence and public protection. The Panel accepted that the penalty was within the appropriate range for misconduct of this nature.

The Panel was satisfied that the reprimand, a four (4) month suspension, restriction of Dr. Bekesh's certificate of registration from prescribing any narcotic medication and publication of the results of these proceedings on the College register will provide adequate specific and general deterrence. The imposed penalty clearly sends a message to the profession that the College will not tolerate misconduct of this nature

Office monitoring for 24 months at the Member's expense, mandatory courses in Professional/Problem-Based Ethics, Recordkeeping and a Comprehensive course on the appropriate prescribing of drugs for pain management will assist with the Member's remediation.

The Panel accepted the Member entered a plea agreement with the College preventing a lengthy and more costly hearing and the fact Dr. Bekesh has not appeared before the Discipline Committee before as mitigating factors.

The Panel considered the apparent lack of remorse and the serious nature of the misconduct as aggravating factors. Seven (7) patients were prescribed large quantities of narcotics with little to no documentation of why these drugs were prescribed. The number of tablets prescribed were excessive and far too frequent. The risk of addiction and overdose can not be understated.

The Panel confirmed that its order would come into effect on September 1, 2020.

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

September 9, 2020

Richard Hunter — Date

Dr. Peter Delean
Mr. Rod Stableforth

REPRIMAND

Dr. Bekesch, as you know, this Discipline panel has ordered you 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 that 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 that you have engaged in multiple acts of professional misconduct. The misconduct related to series breach of the practice standards, including improperly prescribing opioids to patients and failing to properly record such prescriptions. You failed to demonstrate reasonable professional judgment in your conduct. The cumulative effect of your conduct would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire 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 numerous deficiencies in documenting and prescribing narcotic analgesics to a number of your patients.

You have shown a blatant disregard for your patients' well being and the College's Practice Guidelines for Prescribing Narcotics. The Panel is concerned that you do not fully appreciate the potential harm that you might have caused your patients.

While the Panel appreciates you admitted the allegations, the Panel notes that your conduct during the course of the hearing reveals an apparent lack of remorse and a disdain for your Regulator.

We expect more from a senior member of the profession.

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.