DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Bacchus ONRCDSO 1

Date: 2024-06-06

File Nos.: H190012, H200006, 21-0187, 21-0188, 21-0432

IN THE MATTER OF: A Hearing 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"*)

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 Statues of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Kevin Bacchus

REASONS FOR DECISION

PANEL MEMBERS
Ms. Judy Welikovitch, Public Member, Chair
Dr. Carol Janik, Professional Member
Dr. Nancy Di Santo, Professional Member
Dr. Ian Brockhouse, Professional Member
Mr. Brian Smith, Public Member

APPEARANCES
Ms. Linda Rothstein, Ms. Glynnis Hawe and Ms. Lauren Rainsford, for the College
Ms. Jasmine Ghosn, for the Registrant
Ms. Luisa Ritacca and Mr. Paul Le Vay, Independent Legal Counsel

Heard: October 12, 14, 17, 18, November 14, 15, 16, 2022, January 23, March 6, 7, 8, 23, 27, 28, April 3, May 25 and 29, 2023 by way of videoconference
Decision Date: June 6, 2024
Release of Written Reasons: June 6, 2024

REASONS FOR DECISION

INTRODUCTION

This matter came on for a hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on October 12, 2022, and continued for seventeen (17) days throughout 2022 and 2023. This matter was heard by way of videoconference.

PUBLICATION BAN

At the commencement of this hearing, counsel for the College requested that a publication ban directing that no person publish or broadcast the identity of any patients of the Registrant, Dr. Kevin Bacchus, or any information that could disclose the identity of any patients who are named in the Notices of Hearing and/or the Agreed Statement of Facts in this matter. This Order was granted on October 12, 2022, pursuant to Section 45(3) of the Ontario *Health Professions Procedural Code* [1].

OVERVIEW

This matter proceeded before the Panel on five separate Notices of Hearing. At the outset of the hearing, the parties confirmed their consent to having the allegations set out in the five Notices of Hearing heard together.

Notice of Hearing H190012 and Notice of Hearing 21-0188 (Exhibits 1 and 4 respectively) relate primarily to allegations that the Registrant, Dr. Kevin Bacchus, submitted or caused to be submitted, false or misleading statements to an insurer, namely Green Shield Canada (GSC). The allegations in both Notices also relate more generally to Dr. Bacchus' record keeping, and in Notice of Hearing 21-0188 there are additional allegations relating to Dr. Bacchus' over-

[1] Ontario *Health Professions Procedural Code*, O. Reg. 262/18

prescribing of opioids or prescribing opioids without having documented a proper justification or reason.

Notices of Hearing H200006, 21-0187 and 21-0432 (Exhibits 2, 3 and 5 respectively) address allegations of sexual abuse and other improper behaviour by Dr. Bacchus as it relates to three former staff members, who were also allegedly patients at the time of the misconduct.

The College sought findings of professional misconduct against Dr. Bacchus as set out in each of the Notices of Hearing, save for certain specific allegations relating to five patients named in Notice of Hearing 21-0188 (Exhibit 4).

THE ALLEGATIONS

The specified allegations as set out against the Registrant are found in the Notices of Hearing marked as Exhibits 1 through 5 in these proceedings and are attached to the end of these Decision and Reasons.

THE REGISTRANT'S PLEA

The Registrant denied the allegations of professional misconduct as set out in all five Notices of Hearing.

DECISION

For the reasons set out below, the Panel finds that the Registrant engaged in professional misconduct as alleged in Notice of Hearing H200006 (Exhibit 2) and Notice of Hearing 21-0187 (Exhibit 3) in their entirety. The Panel makes no finding of misconduct with respect to the allegations set out in Notice of Hearing 21-0432 (Exhibit 5).

With respect to Notice of Hearing H190012 (Exhibit 1), the Panel finds that Dr. Bacchus engaged in professional misconduct as alleged in paragraphs 1 and 2.

Finally, the Panel finds that Dr. Bacchus engaged in professional misconduct as alleged in Notice of Hearing 21-0188 (Exhibit 4), except for the allegations described in paragraph 5, paragraphs 3 and 4 in relation to Patient RM, paragraphs 3 and 9 in relation to Patients JO and BT, paragraphs

7 and 8 in relation to obtaining informed consent for Patient AG, and paragraph 8 in relation to Patient TH.

BURDEN AND STANDARD OF PROOF

In assessing the evidence, the Panel notes that the College bears the burden of proving the allegations set out in the Notices of Hearing. Dr. Bacchus has no burden of disproving the allegations. The College must prove the allegations on a balance of probabilities standard.

This means that, after considering all the evidence, the Panel had to decide whether it was "more probable than not" that the Registrant engaged in the conduct as alleged. In reaching our decision, the Panel scrutinized the evidence carefully and where findings were made, we were satisfied that the evidence presented was sufficiently clear, convincing, and cogent.

EVIDENCE

Overview

Shortly following his graduation from the University of Western Ontario's dental school in 1995, Dr. Bacchus began working for his father, Dr. John Bacchus' four dental practices in Sarnia, Dresden, Corunna, and Forest, Ontario. In January 1996, Dr. Bacchus and his father opened a new office in Wallaceburg, Ontario at the County Fair Mall. Dr. Bacchus testified that from approximately 1996 until 2003 he worked principally in the Wallaceburg practice. He said that he would also occasionally work at Corunna and Forest, but never in Sarnia, Ontario.

Dr. Diane Roussy, Dr. Bacchus' then-romantic partner, joined the Wallaceburg practice in April 1996. According to Dr. Bacchus, Dr. Roussy worked no more than a couple of days a week in Wallaceburg from April 1996 to June 2002. In June 2002, Dr. Roussy went on maternity leave with her and Dr. Bacchus' first child. Dr. Roussy did not return to the Wallaceburg practice after June 2002.

In 2003, Dr. Bacchus' father retired from practice. Dr. Bacchus sold his father's Sarnia practice to Dr. Lenny Slipacoff.

Dr. Bacchus testified that he thereafter continued to work full-time in the Wallaceburg practice. In December 2009, Dr. Bacchus sold that practice to Dr. Omar Sarhan. He continued to work there as an associate until March-April 2010.

From January 1, 2014, to June 30, 2014, Dr. Bacchus' certificate of registration was suspended by the College's Discipline Committee[2]. Dr. Bacchus testified that once he had served his suspension, he returned to practice, part-time, one day a week at Family Dental Centre Sarnia ("Family Dental Centre") on July 1, 2014.

Dr. Bacchus testified that he sold that practice to Dr. Azim Parekh, although he continued at the practice there as an associate. The practice was also staffed by Dr. Rob Sottosanti, Dr. Stacey Cornelius, and Dr. Ali Ahmed.

On January 7, 2015, GSC advised Dr. Bacchus that his assignment privileges with them had been revoked. This meant that GSC would no longer reimburse him directly for treatment or services he provided to patients who were also GSC plan members. Reimbursement for Dr. Bacchus' patients would only be issued to plan members upon receipt of a standard dental claim form and valid confirmation of payment by debit or credit card.

Dr. Sottosanti left the practice in or around April 2015 and at around the same time, Dr. Bacchus returned to practice full time at the Family Dental Centre until March 2017, when Dr. Parekh locked him out of the practice and terminated his employment.

In March 2017, Dr. Bacchus opened Wallaceburg Family Dental and in September 2017, he opened Cathcart Dental in Sarnia. These practices were sold in December 2022.

Credibility of Witnesses

In weighing the evidence presented, the Panel considered both the reliability and credibility of the witnesses who testified, including Dr. Bacchus.

The Panel assessed the credibility of the witnesses on a principled basis. We considered the following factors in our assessment:

1. Did the witness seem honest?
2. Did the witness have an interest in the outcome of the case, or any reason to give evidence that was more favourable to one side than to the other?

[2] Dr. Bacchus has appeared before the College's ICRC and has been the subject of a previous discipline hearing prior to these matters being addressed. Dr. Bacchus' prior complaints and discipline history related, in part, to issues regarding billing for services not performed, inadequate record keeping, submitting claims to insurers that were inaccurate, and performing unnecessary services on a number of patients.

3. Did the witness seem able to make accurate and complete observations about the event? Did he or she have a good opportunity to make those observations? What were the circumstances in which those observations were made? What was the condition of the witness at that time? Was the event that was observed or witnessed unusual or routine?
4. Did the witness seem to have a good memory? Did the witness have any reason to remember the things about which he or she testified?
5. Did any inability or difficulty that the witness had in remembering events seem genuine, or did it seem made up as an excuse to avoid answering questions?
6. Did the witness seem to be reporting what they saw or heard, or simply putting together an account based on information obtained from other sources – i.e., what they may have heard from other witnesses – rather than personal observations?
7. Did the witness' testimony seem reasonable and consistent as they gave it? Was it similar to or different from what other witnesses said about the same events? Did the witness say or do something different on an earlier occasion?
8. Did any inconsistencies in the witness' evidence make the main points of the testimony more, or less, believable, and reliable? Was the inconsistency about something important, or a minor detail? Did it seem like an honest mistake? Was it a deliberate lie? Was the inconsistency because the witness said something different, or because he or she failed to mention something? Was there any explanation for it? Did the explanation make sense?

Lastly, the Panel notes that all evidence referred to in this decision and reasons was examined by the members of the Panel unless otherwise indicated.

The Allegations set out in Notice of Hearing H190012 (Exhibit 1)

Evidence and the Panel's Findings

It is alleged in Notice of Hearing H190012 that Dr. Bacchus submitted or caused to be submitted insurance claims for Patient GD to GSC which were inaccurate and/or misleading. Much of the evidence the Panel received with respect to these allegations was not in dispute.

The primary issue in dispute is whether Dr. Bacchus was responsible for the inaccurate submissions made to GSC regarding the care received by Patient GD in August and September 2016.

As described above, on January 7, 2015, GSC notified Dr. Bacchus that his assignment privileges had been revoked. This meant that his patients, who were GSC plan members, would have to pay for the service directly and then seek reimbursement from GSC on their own.

Patient GD attended an appointment with Dr. Bacchus on August 8, 2016. According to the medical records and testimony received, GD wanted to discuss an implant bridge for Tooth 12 with Dr. Bacchus. At that appointment, Dr. Bacchus took two periapical x-rays and a panoramic x-ray.

Family Dental Centre submitted a “pay provider” claim to GSC for the exam and x-rays. The “pay provider” claim is used so that the dental office can be reimbursed directly by the insurer, rather than have the patient pay the office and then get reimbursed themselves. Given the decision made by GSC in January 2015 to revoke his assignment privileges, Dr. Bacchus was prohibited from making these claims himself.

In this instance, the Family Dental Centre submitted the claim listing another dentist, Dr. Ahmed, as the treatment provider. This was corroborated by the documentary evidence before the Panel. There is no dispute in the evidence presented that Dr. Ahmed did not treat Patient GD on August 8, 2016, or at any other time. Ultimately, however, the claim was rejected because GD had reached his annual maximum of $1500.00 for basic dental services.

When asked to review the progress note in the patient’s chart relating to the work performed by him on August 8, 2016, Dr. Bacchus denied that the note was in his handwriting. He acknowledged that he reviewed these notes “most” of the time. When asked whether he considered this to be a best practice, he admitted that it was not.

At the conclusion of his appointment on August 8, 2016, Dr. Bacchus told GD that he would submit a predetermination request to GSC to see how much of the bridge work would be covered by his plan. Dr. Bacchus testified that a hardcopy predetermination request was printed and submitted to GSC by Person B, his employee.

On August 22, 2016, GSC received via surface mail a manual predetermination request for a 3-unit bridge for Teeth 11-13 for Patient GD. The request was submitted under Dr. Parekh’s name, even though Dr. Parekh did not treat GD. The predetermination was approved for up to $1000.00 for major treatment, the plan maximum, which meant that the Patient would have to pay any difference. Dr. Bacchus testified that the Patient indicated that his union would pay a further

$1000.00 towards the cost of this treatment. The Patient, who testified before the Panel, gave no evidence in this regard.

Patient GD attended an appointment with Dr. Bacchus on August 31, 2016, to begin bridge preparatory work.

On September 2, 2016, the Patient called Family Dental Centre to report that he was experiencing pain. The progress notes document only that a prescription was called in to the pharmacy at a "Superstore" for these medications "per KB." In his own evidence, Dr. Bacchus confirmed that he did not see Patient GD that day and that he had not made any progress notes which would explain why he had prescribed penicillin and Tylenol #3 for the Patient.

The Patient could not recall having received a prescription for these medications, nor could he recall being in pain.

The Patient attended to see Dr. Bacchus on September 6, 2016, for a further appointment at which time the Registrant documented in his chart notes that the patient had pain in his upper right molar, Tooth 16. Dr. Bacchus advised GD that he needed a root canal on Tooth 16. While not documented by Dr. Bacchus, a periapical x-ray was taken and a "pay provider" claim was submitted to GSC on the same day. The claim was denied because GD had reached his plan maximum and because Dr. Bacchus was prohibited from submitting "pay provider" claims[3].

Patient GD attended at the Family Dental Centre the next day, on September 7th. Dr. Bacchus performed a root canal on Tooth 16. Dr. Bacchus did not document this appointment in GD's progress notes. No submission was made to GSC for the root canal on September 7, 2016, or at anytime in 2016.

On September 15, 2016, Dr. Bacchus again attended to Patient GD to complete the three-unit bridge on Teeth 11-13. Family Dental Centre submitted a "pay provider" claim to GSC the same day. The claim was submitted with Dr. Ahmed identified as the provider. GSC approved the claim and paid $1000.00 to the Family Dental Centre. Dr. Bacchus did not dispute that Dr. Ahmed had not treated Patient GD.

The office staff who worked for the Family Dental Centre at the time, namely NMM, AW, and MS, were helpful to the Panel. The Panel found that they each provided their evidence in a fair and

[3] Exhibit 41

objective manner. Much of their evidence was corroborated by the documents tendered by the College. Overall, their evidence was both internally consistent and was reasonable and logical, and made sense in the circumstances.

NMM provided the following evidence with respect to the allegations contained in Exhibit 1, as follows:

1. She was a bookkeeper at the Family Dental Centre at the relevant time. She began working there when it was still owned by Dr. Bacchus.
2. Over the time of her tenure, her responsibilities evolved: at first, she was the bookkeeper for the entire practice and also did some personal bookkeeping for Dr. Bacchus.
3. She later moved into the position of practice lead until the practice was sold by Dr. Bacchus in or about January 2015.
4. NMM explained that the practice uses Tracker, a software program that organizes scheduling and invoicing; that it can generate invoices through a treatment plan by manually entering treatment codes. As she described it, “Tracker keeps track of everything”.
5. With respect to GSC, the practice was able to submit claims electronically.
6. She said it was “not normal for the practice to print out blank (claim) forms without the codes”. Nevertheless, NMM was able to point College counsel to blank GSC insurance documents that were printed out on August 23, 2016, and again on January 17, 2017, in relation to Patient GD.
7. Internally, the bookkeeping treatment of patient records produced by Tracker has more information than does the submission to GSC. With this system, the practice was able to distinguish between the “responsible provider” – i.e. the dentist under whose name and provider number the claim form was submitted to GSC – and the “main provider” – i.e. name of the dentist who actually performed the work and would receive payment therefor.
8. In this case, the records that were reviewed and analyzed by the Panel delineate the “responsible provider” of the services as either Dr. Parekh or Dr. Ahmed. The internal records also identified the “main provider”, being the dentist/hygienist who actually provided the work as being Dr. Bacchus.
9. In Tracker, the payment goes to the “main provider.” In other words, as described by the witnesses, all payments received from GSC for work performed by Dr. Bacchus but wrongly billed under the names and provider numbers of other dentists in the practice were credited to Dr. Bacchus in the usual course.

10. During her tenure, and after Dr. Bacchus' billing privileges had been suspended by GSC, NMM was asked by Dr. Bacchus to bill his claims under other providers; that she was aware that Dr. Bacchus' claims were sent to GSC under Dr. Ahmed, Dr. Parekh, and Dr. Adam, although the majority of these claims were submitted under Dr. Ahmed's name.

NMM's evidence was particularly detailed and precise. With respect to GD's care, NMM testified that Dr. Bacchus explicitly instructed her to submit the bill for the September 15, 2016 appointment to GSC under Dr. Ahmed's name, so that it could be sent to the insurer without the patient having to pay in advance. NMM's evidence was also consistent with the documentary evidence presented to the Panel which showed that after the office received the payment from GSC, employee MJD reversed the record of GD having paid upfront for the appointment.

AW, who worked in administration at Family Dental at the relevant time, also provided evidence with respect to billing practices more generally, and the billing practices of Dr. Bacchus once GSC revoked his privilege to submit "Pay Provider" claims under his own name and provider number. She testified to the following:

1. She is a Level II dental assistant and is thus able to do intra-oral duties, including rubber dam placement.
2. She began working for Dr. Bacchus after March 2015; that she worked for him approximately twenty (20) times.
3. As part of her duties, she played a role in documenting care.
4. She was not responsible for entering billing codes. Rather, she took the patient charts up to the front desk for billing.
5. She said that sometimes Dr. Bacchus would direct that the chart be given to certain staff – namely NMM and MS - because he wanted the bills to be submitted under the names and provider numbers of different dentists in the practice.
6. At one point, Dr. Rob Sottosanti spoke to her and said that if anything was being put through by Dr. Bacchus under Dr. Sottosanti's name, to let him know.

The Panel also heard from MS, who worked at the practice as a dental hygiene coordinator. She began working in September 2008 at the McNaughton Avenue practice in Wallaceburg. She worked there until February 2010 when that practice was sold, and Dr. Bacchus opened a new practice on Michigan Avenue in Sarnia. She took maternity leave from May 2013 to June 2014.

She was also on leave from August 2014 to March 2015 due to a personal injury. She resigned from that practice in April 2015. MS provided the following evidence:

1. When she returned from maternity leave in June 2014, MS was notified by the office manager that Dr. Bacchus' assignment privileges had been revoked by GCS.
2. Some of Dr. Bacchus' patients were disgruntled to the point of threatening to leave the practice; that they were used to not having to pay out-of-pocket.
3. Dr. Bacchus suggested that a way to have the fees for his patients who were members of the GSC plan come directly to the practice was to bill under Dr. Parekh's name and provider number.
4. She was asked by Dr. Bacchus to do this, and she said "no".
5. There were times when she would be inputting payments for GSC, that she would open the Explanation of Benefits page and she observed that the office was being paid on invoices where Dr. Bacchus had done the work, but that Dr. Parekh's name and provider number had been used.
6. All the administrative staff sat in the "same kind of common area" and that while sitting there she said, "what I would hear would be, 'just send it under Azim (Parekh).'" When asked who said this, she responded that it was Dr. Bacchus who would provide such instructions.

With respect to the dental work done for Patient GD specifically, the Panel received excerpts from the Family Dental Centre's Tracker system, which showed that on January 17, 2017, GSC paid the clinic $1000.00 towards Patient GD's bridge work. Employee MJD entered this payment into the Tracker system and at the same time adjusted the office's record of the transaction. While the ledger had previously reflected that the Patient had paid $1458.00 up front, MJD reversed that payment and credited the amount back to the patient, leaving the balance owing for the Patient at $0.00.

Also on January 17, 2017, MH entered a progress note in Patient GD's chart which documented the root canal as having been performed that day, instead of on the day on which it was actually performed, being September 7, 2016. The progress note is extensive and detailed. It includes the methods and materials used in the procedure. Dr. Bacchus conceded that the content of the progress note could only have been dictated by a dentist, and not by an assistant or hygienist. MH testified that she was likely asked to complete the progress note by someone, and that she understood that Dr. Bacchus had performed the treatment. Dr. Bacchus' initials are included in

the note but appear to have been crossed out and replaced with MH's. She confirmed that she had not crossed out Dr. Bacchus' initials because the handwriting was not her own.

There was no dispute in the evidence that Patient GD's root canal that was performed by Dr. Bacchus did not take place on January 17, 2017, and that as result the progress note entered into evidence was fabricated.

Family Dental Centre submitted a manual claim form to GSC for Patient GD's root canal indicating that the root canal was performed on January 13, 2017 (not the date of the service or the date in the progress note, being September 7, 2016). This claim form was prepared and submitted by MJD.

The January 13, 2017 claim was not paid by GSC because the claim form did not include the tooth numbers. Because of this missing information, GSC called Family Dental Centre and spoke with the clinic's then-practice manager, NMM. NMM told GSC that she did not see a record of treatment for Patient GD on January 13, 2017. This caused GSC to initiate an investigation, which resulted in its report to the College.

With respect to the allegations relating to Patient GD, Dr. Bacchus testified that he had no knowledge that false claims were made to GSC on his behalf for his treatment of GD.

Dr. Bacchus admitted that the content of the progress note transcribed by MH on January 17, 2017, must have come from him. He acknowledged that it was his practice to dictate to his assistants the care he was providing during the procedure and that the content in the note required the knowledge and skill of a dentist. Despite this acknowledgement, Dr. Bacchus claimed that he had no idea why the progress note was not entered on or about September 7, 2016, when he performed the root canal, and why instead it was entered several months later.

It is important to note that following the September 7th root canal, Dr. Bacchus saw Patient GD two weeks later to install a bridge. Dr. Bacchus apparently did not notice that there was nothing in Patient GD's chart about the root canal completed two weeks earlier. Dr. Bacchus said that it was not his practice to review or approve his charts after appointments, even when preparing for a follow-up or subsequent visit by the same patient.

In cross-examination, Dr. Bacchus suggested that perhaps his assistant wrote the September 7, 2016 progress note he dictated onto a sticky note and then entered it months later, although this suggestion was not put to MH or any of the other staff witnesses. Dr. Bacchus' evidence in this

regard was purely speculative and in the Panel's view, was intended to deflect responsibility away from himself.

The Panel's Findings

Having considered the evidence relating to Patient GD, the Panel finds that Dr. Bacchus engaged in professional misconduct as alleged. The Panel does not accept that Dr. Bacchus had no knowledge of the submissions for payment to GSC on a "pay provider" basis under the names and provider numbers of the other dentists, or that he was not aware that Patient GD's progress notes were only completed in January 2017, some months after the actual date of the root canal.

In that regard, the Panel prefers the evidence of the staff members who explained how submissions were generally made to insurers and how, once Dr. Bacchus's billing privileges were revoked by GSC, he instructed some staff to make submissions for treatment he provided to his patients under the names of other dentists and using those dentists' provider numbers. This finding is consistent with the records provided and with the oral evidence of the staff.

Contrary to Dr. Bacchus' suggestion that it was of no concern to him that his patients had to pay him directly and that it essentially made no difference to him if he could not make a submission for payment directly to GSC, the evidence from staff made clear that many of Dr. Bacchus' patients were upset about having to pay up front for services (particularly when they were used to not having to do so). The Panel thus concluded, on a balance of probabilities standard, that Dr. Bacchus was motivated to find some way to receive payment without having to inconvenience his patients, including Patient GD.

With respect to the issue of poor record-keeping, the College's Guideline on Record Keeping, which was approved by the RCDSO Council in November 2019, states the following in the first paragraph of the document:

> "Dentists have professional, legal and ethical responsibilities to maintain a *complete* record of each patient's dental care. Clear, accurate and up-to-date patient records are essential to the delivery of high-quality care." [*Emphasis added*]

The Guideline has thus established a requirement that all dentists are required to maintain a record of each patient's dental care in a complete and up-to-date manner.

The Panel finds that Dr. Bacchus was or ought to have been aware of his professional obligation, particularly given both his considerable complaints and disciplinary history with the College, which, among other things, addressed his failure to maintain the standards of practice of the profession with regard to the maintenance of his patient records and his billing practices.

Specifically, the Panel was referred to four (4) decisions of the College's ICRC and one (1) decision of the RDCSO's Discipline Committee, in which Dr. Bacchus had variously been ordered to take courses in recordkeeping and ethics, have his practice monitored, and, in connection with his prior discipline case, have his practice suspended for a period of 6-months.

Dr. Bacchus' evidence regarding his ignorance of the submission of false claims to GSC, and timing of the root canal entry into Patient GD's chart, was simply not believable. It was contradicted by the more reasonable and reliable evidence of the staff members who testified, as set forth above, and by the documentary evidence tendered by the College in support of this allegation. For these reasons, the Panel finds, on a balance of probabilities, that Dr. Bacchus is guilty of the misconduct as alleged in Notice of Hearing H190012.

Allegations set out in Notice of Hearing 21-0188 (Exhibit 4)

Evidence and Findings

Insurance Claims Made Using the Name and Provider Number of Other Dentists

On June 4, 2018, Dr. Helene Goldberg was appointed by the Registrar of the College to conduct a Registrar's investigation into Dr. Bacchus' practice, and whether he had potentially committed an act or acts of professional misconduct.

Dr. Goldberg provided very detailed evidence of her process for the review. She led the Panel through her comparison of the patient charts for some of Dr. Bacchus' patients, the corresponding treatment claim forms submitted by Family Dental, and the records that she obtained from Family Dental and from GSC.

One of the concerns that she investigated was that Dr. Bacchus was submitting, or causing to be submitted, insurance claims for his patients using the names and provider numbers of Dr. Ahmed and Dr. Parekh.

From her review of records at Dr. Bacchus' practice, Dr. Goldberg was able to determine that Dr. Parekh only worked at the Family Dental Centre on the third Saturday of each month and that Dr. Ahmed only worked there on Mondays and Tuesdays.

Dr. Goldberg obtained records of all claim submissions made to GSC by Family Dental Centre for Dr. Parekh on weekdays between July 2014 to March 2017, and for Dr. Ahmed for Wednesdays, Thursdays, and Fridays between June 2015 and March 2017, being the days of the week when neither of the dentists were at Family Dental Centre.

Further, Dr. Goldberg explained that she requested copies of 17 patient charts from Family Dental Centre for those patients who had both received narcotic prescriptions from Dr. Bacchus and had claims submitted for their care to GSC in the name of either Dr. Parekh or Dr. Ahmed.

Dr. Goldberg then analysed the information she received and prepared a report on her findings with respect to Dr. Bacchus' prescription of narcotics, billing submissions to GSC and recordkeeping.

Dr. Goldberg's evidence was that her analysis of Dr. Bacchus' charts as compared to the claims made to GSC revealed that in some instances claims were made for services rendered by Dr. Bacchus in other dentists' names and in other instances, claims were submitted to GSC for services performed on one date when in fact they were performed on another.

By way of example, Dr. Goldberg reviewed the progress notes for Patient FA. On November 13, 2015, Patient FA received treatment from Dr. Bacchus. This was recorded in the Patient's progress notes as well as Dr. Bacchus' appointment schedule. The claim submitted to GSC for Patient FA's dental services, including an examination, radiographs, restorations, and scaling, was made using Dr. Parekh's name and provider number. More specifically, the Family Dental Centre's Explanation of Benefits, which is a record generated internally by the practice, lists Dr. Bacchus as the treating dentist for FA, but the claim to GSC was submitted under Dr. Parekh's provider number and name.

Similarly, for Patient DE, the progress notes and appointment schedule show that the patient received care for Tooth 37 by Dr. Bacchus on October 27, 2016. He is listed as the treating dentist on the Explanation of Benefits; however, Dr. Ahmed's name and provider number were submitted on the claim form to GSC.

Patient BB's progress notes and appointment schedule show that the patient received care on September 30, October 4, and November 1, 2016. For each visit, the Centre's records show Dr. Bacchus as the treating dentist and, at least for the September appointment, the appointment schedule shows that the patient was to be seen by Dr. Bacchus. However, in two of these instances, the provider name and number used was Dr. Ahmed's and in the third instance it was Dr. Adam's.

With each of the 17 patient charts reviewed, Dr. Goldberg's testified that she was able to identify multiple claims that were submitted to GSC under the names and provider numbers of either Dr. Parekh or Dr. Ahmed, where the patient charts and the appointment schedule show that treatment was in fact provided by Dr. Bacchus.

There was no dispute that the charts reviewed by Dr. Goldberg were charts for Dr. Bacchus' patients and there was no dispute that it was Dr. Bacchus who provided the treatment as set out in the charts. Dr. Bacchus did dispute that he was in any way involved in submitting false or misleading claims to GSC.

Dr. Bacchus argued that he was not responsible for "submitting" or "arranging for the submission" of false or misleading insurance forms. He argued that there was not one single certificate, report or other document presented to the Panel which was purportedly "signed" or "issued" by him. Similarly, he argued that there was no evidence that he submitted any of the claims to GSC himself.

Dr. Bacchus explained that at the time his billing privileges were revoked by GSC, he was no longer in charge of the office staff and that if errors were made in the submissions, it was Dr. Parekh's responsibility and not his own.

The Panel's Findings

The Panel considered the evidence provided by Dr. Goldberg, the documents tendered, the evidence from staff and Dr. Bacchus' explanations in reaching its decision on the allegations contained in Notice of Hearing 21-0188. As set out above, the Panel was persuaded that each of the staff members who testified provided clear, objective, and reasonable evidence to the Panel. Further, their collective evidence was supported by the documents obtained and analyzed by Dr. Goldberg. The Panel finds, on a balance of probabilities, that the evidence before it disclosed a clear pattern: Dr. Bacchus provided services to his patients, and those services were

then billed to GSC under the names and provider numbers of other dentists. The staff members who testified about this issue confirmed that this was done on Dr. Bacchus' instruction.

The Panel does not accept Dr. Bacchus' assertion that, as the practice owner, all billing practices were the responsibility of Dr. Parekh. The evidence was clear that Dr. Parekh did not work at the Family Dental Centre except on one Saturday per month. Dr. Ahmed worked there two days per week. Dr. Bacchus was the dentist on-site, he exercised a degree of authority over the staff in the Family Dental Centre, and they did as he instructed – except for MS, who refused.

Further, in his own testimony, Dr. Parekh specifically rejected the suggestion that he directed his staff to make false or misleading submissions to GSC. His evidence was corroborated by the staff witnesses and was not rigorously challenged by Dr. Bacchus.

In these circumstances, the Panel is satisfied that the College has established, on a balance of probabilities, that Dr. Bacchus engaged in professional misconduct in that he caused claims for work provided by himself to be submitted to GSC (by directing staff to do so) under the names and provider numbers of Drs. Parekh and Ahmed, in circumstances where only he would benefit from the misconduct.

Insurance Submission Made for Services Rendered on a Date Different than the Date of the Actual Service

In addition to identifying instances where submissions were made under another dentist's name and provider number, Dr. Goldberg identified that on at least one occasion it appears that a claim was made to GSC for services rendered on a date that differed from the date of the actual service. Dr. Gizzarelli, the College's expert, reached the same conclusion upon his review of the records.

Based on the records reviewed, Dr. Goldberg and Dr. Gizzarelli each found that on March 11, 2016, Dr. Bacchus performed a five-surface restoration and inserted one post on Tooth 46 for Patient JO. The Patient was charged that day for the service. The Family Dental Centre generated a manual claim form for Patient JO to submit to GSC so that she would be reimbursed directly. The credible and reliable evidence before the Panel was that generating a manual claim form was not the usual practice of the Family Dental Centre; almost all forms were generated and sent electronically. In this instance, the manual claim was issued under Dr. Bacchus' name and provider number, but for the restoration only.

Dr. Goldberg's evidence, which was based upon her review of the records as described, established that the Family Dental Centre submitted an electronic claim submission regarding Patient JO to GSC on August 4, 2016, under Dr. Ahmed's name and provider number. The claim was for a five-surface restoration and a post on Tooth 46. The records confirm that Dr. Ahmed did not work at the practice that day and that Patient JO was not his patient. Further, there were no progress notes in the Patient's chart completed by any dentist for August 4, 2016. Dr. Bacchus did insert a chart entry in Patient JO's progress notes the following day but did not document that he had performed a restoration or a post on Tooth 46.

Dr. Bacchus denied any involvement in the submission of the August 2016 claim to GSC under Dr. Ahmed's name and provider number for services he provided to Patient JO. In closing submissions, counsel for Dr. Bacchus argued that it was NMM who would have done the submission in Dr. Ahmed's name and provider number on her own initiative, without Dr. Ahmed's consent and without direction from Dr. Bacchus. There was, however, no evidence to this effect.

The Panel finds this submission to lack credibility. As we found above, the submission of claim forms under a different dentist's name and provider number for work done by Dr. Bacchus would benefit only Dr. Bacchus.

Upon a consideration of the oral and documentary evidence, the Panel is satisfied that the College has established, on a balance of probabilities, that Dr. Bacchus engaged in professional misconduct in that he made a claim (by directing staff to do so) to GSC for services on a date different than when the services were actually provided. The Panel does not accept the suggestion that NMM made this submission without the knowledge of or at the direction of Dr. Bacchus.

Opioid Prescriptions

Dr. Goldberg testified that during her investigation she requested and received data from the Province's Narcotic Monitoring System ("NMS") for all monitored drugs prescribed by Dr. Bacchus from January 1, 2014, to June 12, 2018.

It is alleged by the College that Dr. Bacchus committed acts of professional misconduct when (a) he prescribed opioid medication for six (6) patients without a documented justification or reason; and (b) he prescribed opioid medication for an improper purpose when he prescribed the

medication when it was not indicated based on the dental procedures performed or the patient's condition.

Prescribing Opioids without Proper Justification

As described above, part of Dr. Goldberg's investigation included a review of Dr. Bacchus' opioid prescriptions for the period from 2014 through to June 2018 as recorded in NMS. Dr. Goldberg testified that, based on her review of the information that she received, Dr. Bacchus appeared to have prescribed opioids to patients in excess of the amounts permitted by the RCDSO's Opioid Guidelines, and without documenting why he had exceeded the Guidelines. Moreover, in some instances, she found that he prescribed opioids at a frequency that exceeded the Opioid Guidelines.

The Panel received evidence that the Opioid Guidelines[4] were introduced by the College in November 2015. They were passed by the College's council on November 19th and distributed to the membership by email on November 23, 2015. In other words, the Guidelines were in force for most of the period covered by Dr. Goldberg's review.

Among other things, the Opioid Guidelines set out the circumstances under which an opioid can be prescribed and how such prescription must be documented, the Opioid Guidelines sets the standards, as follows:

1. The Guidelines make clear that an appropriate dose of an NSAID[5] should manage the majority of moderate to severe pain experienced by dental patients.
2. The Guidelines direct that opioids be prescribed only in a small minority of situations and that dentists must always first consider prescribing an NSAID.
3. The Guidelines further direct that if a patient experiences severe pain, that the dentist should first consider a higher dose of an NSAID, an anesthetic block, or combining codeine or oxycodone with an NSAID, before prescribing opioids alone.
4. Further, they direct that before prescribing an opioid, dentists are required to consider the following in exercising their professional judgement:
    a. Is the patient's pain well-documented?
    b. Is the patient currently taking an opioid?

[4] The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice
[5] Nonsteroidal Anti-Inflammatory Drug

c. Does the patient's medical history suggest signs of substance misuse, abuse and/or diversion?
d. Given the efficacy of non-opioids, do the benefits of prescribing an opioid outweigh the risks?

The Opioid Guidelines also set out limits to the number of opioid tablets that should be dispensed at any given time, depending on the dosage. If a dentist decides to exceed the maximum number of tablets, they are expected to document the reason for doing so in the patient's chart.

In addition to the Opioid Guidelines, the Panel received evidence of the Dental Recordkeeping Guidelines ("Recordkeeping Guidelines"), which provide dentists with guidance as to how they should exercise their professional judgement in prescribing opioids and how those prescriptions should be documented in the patient chart.

The College tendered Dr. Gino Gizzarelli as an expert in the areas of pain management and prescription of opioids in a dental practice, dental recordkeeping, and general dentistry.

Dr. Bacchus' Counsel did not question Dr. Gizzarelli's experience or expertise but did challenge the College's request to tender him as an expert on the basis that Dr. Gizzarelli did not practice general dentistry like Dr. Bacchus.

Since 2004, Dr. Gizzarelli has practiced as a mobile anesthesia dentist. He travels to different dental offices to sedate patients who require deep sedation or general anesthesia for dental care. Prior to 2004, Dr. Gizzarelli worked as a general dentist. Prior to becoming a dentist, Dr. Gizzarelli worked as a clinical pharmacist at Toronto General Hospital. He testified that he continues to engage in pharmacy work from time to time.

The Panel was satisfied that Dr. Gizzarelli was appropriately qualified to provide the opinion evidence as described by the College. Dr. Gizzarelli is very familiar with the College's Recordkeeping Guidelines and the Opioid Guidelines and, given his experience as a treating dentist and as a pharmacist, the Panel determined that he was well positioned to provide opinion evidence regarding the role of opioids in the management of pain in dental patients and regarding recordkeeping and informed consent more generally.

Dr. Gizzarelli testified that in his opinion and based upon his review of the records available to him, Dr. Bacchus contravened the standards of practice by prescribing opioid medications without documenting a justification or reason for the prescription and/or without documenting that he

considered prescribing a non-opioid medication first. Dr. Gizzarelli identified this concerning pattern with regard to Patients FA, BB, JD, DE, JO, and JU.

Patient JU, for example, received a root canal from Dr. Bacchus on June 3, 2016. The chart notes indicated that the tooth had an infection, and that the nerve was necrotic. Dr. Gizzarelli opined that there was no indication for prescription of an opioid in these circumstances. The infection was removed by the root canal and over-the-counter analgesics should have been sufficient. If Dr. Bacchus determined that opioids were necessary, Dr. Gizzarelli explained that it was incumbent upon Dr. Bacchus to document the reason why in the patient's chart.

Dr. Bacchus testified that it was not his practice to document that he considered whether an alternative to an opioid for pain management would be appropriate before prescribing an opioid. Dr. Bacchus further testified that in the patient records before this Panel, he has a documented a justification for prescribing an opioid in each case. Dr. Bacchus asserted that the treatment described (i.e. "root canal") provides the justification for the prescription and that no further documentation was required. In her closing submissions, Dr. Bacchus' counsel argued that neither the Opioid Guidelines nor the Recordkeeping Guideline required Dr. Bacchus to set out his rationale for prescribing an opioid as Dr. Gizzarelli suggested.

With respect to the six patient records reviewed by Dr. Gizzarelli, the Panel considered the records and Dr. Bacchus' explanation in turn:

Patient FA: On November 26, 2015, three days after the College's dissemination of the Opioid Guidelines to the profession, Patient FA had six front teeth extracted. He was given a prescription for an antibiotic and Tylenol #3. His medical history was clear, and he had no stated contraindication to an NSAID.

Dr. Gizzarelli opined that the extractions do not, standing alone, justify the prescription of opioids. Further, he testified that if, in Dr. Bacchus's opinion, opioids were warranted for this patient, he was required to document that justification. Dr. Gizzarelli testified that such justification could include an assessment of the patient's pain, complications in the procedure, or the reason why a non-opioid was contraindicated.

In his own evidence, Dr. Bacchus conceded that the only thing he documented with respect to the prescription of an opioid for FA in this case was the procedure that Patient FA underwent; and

that the procedure was itself the justification for the prescription of opioid medication. There is nothing in FA's chart that specifically indicates why an opioid was prescribed in this case.

Upon a consideration of the patient chart for Patient FA, the College's Guideline with respect to Recordkeeping and the Opioid Guidelines (together the "Guidelines"), the oral evidence of Dr. Gizzarelli and of Dr. Bacchus, the Panel is satisfied, on a balance of probabilities, that Dr. Bacchus failed to comply with the College's Guidelines. The Panel thus finds that Dr. Bacchus committed misconduct when (a) he failed to keep proper records and (b) that he prescribed a drug for an improper purpose with regard to Patient FA.

Patient BB: On December 30, 2015, BB had a deep filling done by Dr. Bacchus. BB's medical history included asthma, but there was nothing in the record to suggest its severity. Dr. Gizzarelli testified that except in the case of severe asthma, most asthmatic patients can take NSAIDs for a certain period.

The evidence established that Dr. Bacchus did not document whether the patient could or did take NSAIDs. Dr. Gizzarelli testified that in his opinion, prescription painkillers are not required for deep restorations of teeth. If pain medication is required, extra strength Tylenol or Advil is sufficient. Further, it was his opinion that if Dr. Bacchus concluded that an opioid prescription was warranted, he was required to document his justification for doing so. He failed to do so. Dr. Bacchus conceded that none of the factors that informed his professional judgment when prescribing an opioid were documented in BB's progress note or patient chart.

Upon a consideration of the patient chart for Patient BB, the College's Guidelines, the oral evidence of Dr. Gizzarelli and of Dr. Bacchus, the Panel is satisfied, on a balance of probabilities, that Dr. Bacchus failed to comply with those Guidelines. The Panel thus finds that Dr. Bacchus committed misconduct when (a) he failed to keep proper records for Patient BB and (b) he prescribed a drug for an improper purpose.

Patient JDA: On May 20, 2016, Dr. Bacchus performed a root canal on JDA's Tooth 25. There was nothing in his medical history to suggest that NSAID painkillers were contraindicated.

Dr. Gizzarelli testified that in his opinion, a root canal does not, as a matter of course, warrant the prescription of opioids. Dr. Bacchus agreed that not all root canals require prescription opioids, but he failed to document in Patient JDA's records why they were appropriate in this case.

Upon a consideration of the patient chart for Patient JDA, the College's Guidelines, the oral evidence of Dr. Gizzarelli and of Dr. Bacchus, the Panel is satisfied, on a balance of probabilities, that Dr. Bacchus committed professional misconduct when he failed to comply with the College's Guidelines in that: (a) he failed to keep proper records and to document why, in his professional judgment, an opioid was necessary for Patient JDA, and (b) that he thereby prescribed a drug for an improper purpose.

Patient DE: The records indicate that on October 25, 2016, DE reported pain in his lower left posterior teeth. Dr. Bacchus prescribed antibiotics and twenty (20) tablets of Tylenol #3, despite going on to resolve the issue with a filling two days later. The chart notes indicate that the patient took Tylenol and Advil, meaning there were no contraindications for these NSAIDs for Patient DE. Dr. Bacchus's progress notes do not explain why, if the patient could manage their pain with Tylenol, that they could not continue to do so. Once again, Dr. Bacchus did not document the reason why he prescribed an opioid.

In his evidence, Dr. Gizzarelli opined that opioids are not indicated for the type and duration of pain experienced by DE; that even in the event that they were appropriate in the circumstances, that they should only be prescribed in a limited amount, and only until the pain was eased through a dental procedure, as required by the Opioid Guidelines.

Upon a consideration of the patient chart for Patient DE, the College's Guidelines, and the oral evidence of Dr. Gizzarelli and of Dr. Bacchus, the Panel is satisfied, on a balance of probabilities, that Dr. Bacchus committed professional misconduct when he failed to comply with the College's Guidelines in that: (a) he failed to keep proper records and to document why, in his professional judgment, an opioid was necessary for Patient DE, and (b) that he thereby prescribed a drug for an improper purpose. More specifically, Dr. Bacchus' records do not provide a justification for the prescription or a rationale for why twenty (20) Tylenol #3 tablets were required when Dr. Bacchus provided treatment to alleviate the source of pain just two days later.

Patient JO: The evidence before the Panel was that JO had in the past demonstrated drug-seeking behaviour. On March 2, 2016, Dr. Bacchus performed root canal therapy on JO's Tooth 22, and he prescribed Percocet.

In Dr. Gizzarelli's opinion, this prescription was not warranted. He noted that a patient's pain lessens following a root canal because the source of the pain has been removed, and the patient's

pain had been managed by non-opioid painkillers prior to the root canal treatment. Dr. Bacchus did not document any reason for prescribing an opioid in these circumstances.

The evidence was uncontroverted that on March 7, 2016, Dr. Bacchus prescribed Percocet again following a root canal on Patient JO's lower right molar. Dr. Bacchus's progress notes in JO's patient chart do not document why that prescription was appropriate in the circumstances.

On September 28, 2016, Dr. Bacchus prescribed Patient JO a further fifteen (15) tablets of Percocet for a sore tongue.

On September 30, 2016, being just two days later, Dr. Bacchus prescribed another fifteen (15) tablets of Percocet without documenting the reason for the prescription.

Dr. Gizzarelli testified that his review of the patient records for Patient JO revealed that Dr. Bacchus's progress notes do not document why an opioid was prescribed in these circumstances. Dr. Gizzarelli was particularly concerned with the fact that this patient had exhibited drug-seeking behaviour in the past. Given those circumstances, Dr. Bacchus ought to have been careful to assess the patient's pain and explore alternatives before prescribing an opioid, and to document his care.

Upon a consideration of the patient chart for Patient JO, the College's Guidelines, the oral evidence of Dr. Gizzarelli and of Dr. Bacchus, the Panel is satisfied, on a balance of probabilities, that Dr. Bacchus committed professional misconduct when he failed to comply with the College's Guidelines. Specifically, he failed to (a) keep proper records and (b) to document why, in his professional judgment, an opioid was necessary for Patient JO. He thereby prescribed a drug for an improper purpose. More specifically, the records regarding Dr. Bacchus' prescriptions for Percocet for Patient JO establish that he wrote four prescriptions for this patient: an initial prescription on March 2, 2016, followed by a refill of that prescription on March 7, 2016. He also prescribed 20 tablets of Percocet on September 28, 2016 followed by a refill of another refill of fifteen (15) Percocet tablets just two days later, on September 30, 2016; and Dr. Bacchus' records for Patient JO do not provide a justification for the prescriptions or a rationale for why he prescribed Percocet for Patient JO on any of these occasions.

Patient JU: On June 3, 2016, Dr. Bacchus performed root canal therapy on Patient JU's tooth. At the time, the tooth was infected, and it was draining on the palate. Since the nerve ending was dead, in Dr. Gizzarelli's opinion, there was no indication for prescription of an opioid in these

circumstances. The infection was removed by the root canal therapy and over-the-counter painkillers ought to have been sufficient. If, in Dr. Bacchus's opinion, opioids were warranted, Dr. Gizzarelli explained that he was required by the Guidelines to document the reason why. On cross-examination, Dr. Bacchus said that in his professional judgment, the prescription of opioids for JU was justified.

In the absence of a documented justification for the prescription for JU, and in light of the fact that the treatment provided to JU likely alleviated their pain, the Panel finds that the evidence establishes, on a balance of probabilities, that Dr. Bacchus contravened the Guidelines and failed to keep proper records, as required; that he failed to document any rationale or justification in the patient records for the prescription of opioids for Patient JU and thus committed professional misconduct.

Prescribing Opioids in Excess of the Guideline Amounts

With respect to Dr. Bacchus' prescription of opioids, the Panel also heard evidence to support the College's allegations that Dr. Bacchus prescribed opioids to patients in excess of the amounts permitted by the Opioid Guidelines, and without documenting why.

Dr. Gizzarelli testified that in his opinion, and based on the information contained in the NMS, Dr. Bacchus prescribed opioids in excess of the Opioid Guidelines, without documenting his reasons or rationale for doing so. In some instances, Dr. Bacchus over-prescribed by one tablet, but for others he over-prescribed by as many as six tablets.

Dr. Gizzarelli testified that in his opinion, when a dentist prescribes opioids, only the lowest possible dosage for the shortest duration should be prescribed. In his view, the prescription limits in the Guidelines are the "upper limit" and are not to be exceeded. If a prescription is necessary, Dr. Gizzarelli testified that it should be made for the fewest number of tablets possible.

While the Panel was not provided with the patient charts relevant to the information contained on the NMS, Dr. Bacchus did not dispute the accuracy of the information or that he gave his patients the prescriptions, as alleged. Dr. Bacchus also acknowledged in his evidence that he had the patient charts at issue in his possession and that he had chosen not to provide them to the College or the Panel.

Dr. Bacchus argued that in every instance the nature of the treatment itself justified the opioid prescription, including the amount prescribed. He did not provide a rationale for exceeding the

Guidelines with respect to the patients listed on the NMS records. Essentially, it was Dr. Bacchus' position that "the procedures are the justification".

To summarize, the evidence obtained from the NMS establishes that:

1. With respect to prescriptions for Percocet, Dr. Bacchus exceeded the Guideline amounts as follows:
    a. He exceeded the Guideline amount by one (1) tablet on forty-three (43) occasions for thirty-nine (39) patients.
    b. He exceeded the Guideline amount by two (2) tablets on five (5) occasions for five (5) patients.
    c. He exceeded the Guideline amount by four (4) tablets on twenty-seven (27) occasions for twenty-two (22) patients.
    d. He exceeded the Guideline amount by six (6) tablets on three (3) occasions for three (3) patients.
2. With respect to prescriptions for Oxycodone, Dr. Bacchus exceeded the Guideline amount as follows:
    a. He exceeded the Guideline amount by one (1) tablet on eleven (11) occasions for seven (7) patients.
    b. He exceeded the Guideline amount by two (2) tablets on three (3) occasions for three (3) patients.
    c. He exceeded the Guideline amount by four (4) tablets on six (6) occasions for six (6) patients.
    d. He exceeded the Guideline amount by six (6) tablets on three (3) occasions for three (3) patients.

The Panel finds, on a balance of probabilities, that the evidence clearly establishes that Dr. Bacchus prescribed opioids above the maximum number provided for in the Opioid Guidelines on many occasions, for many patients. He did so without documenting his justification or rationale. In the Panel's view, Dr. Bacchus prescribed opioids for many patients over a prolonged period and in troubling disregard of the Guidelines or for the health and safety of his patients.

The Panel accepts Dr. Gizzarelli's opinion that the frequency with which Dr. Bacchus prescribed opioids is "problematic" and does not demonstrate the exercise of reasonable professional judgment or a concern for minimizing the risk of drug misuse.

Prescribing Opioids too Frequently

Finally, the Panel received and reviewed documentary evidence with regard to the pattern and frequency of opioids prescribed by Dr. Bacchus to Patient AG. The records confirm that in the spring of 2018, Dr. Bacchus provided five consecutive opioid prescriptions to Patient AG between April 25, 2018, and June 2, 2018. This exceeded the Guidelines which requires that a dentist limit the number of consecutive prescriptions of opioids to no more than three. Further, it is important to note that, at that time, Patient AG was on methadone due to her history of chronic opioid dependence. Dr. Gizzarelli testified that in his view, the prescription of opioids to patients on methadone should be limited to very small amounts to prevent exacerbating their dependency or increasing the chance of a relapse.

Dr. Bacchus testified that the prescriptions were necessary because Patient AG had been in a severe car accident and had suffered extensive damage to her teeth. The patient records available to the Panel (which were not complete) indicate that Patient AG had been in a car accident about two years before the 2018 prescriptions. Dr. Bacchus testified that Patient AG must have been in two severe car accidents in that period.

The Panel finds that the patient records available to it did not establish the possibility of AG having been in two separate catastrophic car accidents in the span of two years. It is noted in this regard that only Dr. Bacchus had access to the complete records at the time he prepared his response to the College with respect to this allegation.

In the circumstances, the Panel is satisfied, on a balance of probabilities, that Dr. Bacchus provided AG with five consecutive opioid prescriptions between April 24 and June 2, 2018. The frequency of the prescriptions was in breach of the Opioid Guidelines and there was nothing before the Panel to suggest that exceeding the Guideline maximums was justified or necessary in this case. In fact, the records that were available to the Panel strongly suggest that given AG's history of chronic opioid dependence, the five consecutive prescriptions were unjustified and inappropriate and further, posed a potential risk to their on-going health and safety.

Overall, the Panel finds on a balance of probabilities and having regard to all the circumstances and evidence as described above, that Dr. Bacchus engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional and unethical, contrary to Para, 59 of Section 2 of Ontario *Regulation 853/93*, as amended.

Record Keeping & Informed Consent

Dr. Gizzarelli further testified that in his opinion, Dr. Bacchus failed to obtain informed consent for certain of his patients, as required, in that his records did not contain any documentation of Dr. Bacchus having discussed with each patient, their diagnosis, overall treatment plan, risks and limitations of treatment, estimated costs of treatment and the likely consequences of not having treatment.

Dr. Gizzarelli noted that while informed consent can be in writing or provided orally, the Recordkeeping Guideline requires a dentist to make a notation that they discussed the relevant issues with the patient and that consent was obtained. Dr. Gizzarelli testified that the information necessary to confirm informed consent was missing from the patient records for Patients TH, JK, JD, JO, and JU.

Dr. Bacchus testified that he had obtained informed consent from all his patients, even where that was not explicitly documented in their charts. He said that he was under the impression that until 2019, he was not required to document informed consent.

The Panel heard evidence that Dr. Bacchus was practicing under the supervision of Dr. Roger Howard, following a decision by the ICRC in 2013. With respect to record-keeping, Dr. Howard specifically warned Dr. Bacchus that if he did not write something down, it was assumed not to have happened. Further, Dr. Howard counselled Dr. Bacchus about all the steps that were required to be noted for the informed consent process, including exam findings, a clear diagnosis, a treatment plan with options and the patient's decision. In this regard, it is also noted that in his report to the College dated May 14, 2013[6], Dr. Howard reported that Dr. Bacchus informed him that he had checked with someone who also worked as a practice monitor, and that this person had advised him to "write it so the next reader will understand it."[7]

In addition to the specific issues regarding informed consent, the Panel was provided with patient records which established that the insurer was charged for services not documented in the records and that on some occasions, the records failed to identify and record a diagnosis and/or treatment plan.

[6] Exhibit 68
[7] Exhibit 68, p. 2

Further, with regard to root canals on at least three patients (JD, AG, and JO), the records establish that Dr. Bacchus did not document the use of an apex locator, working lengths or a rubber dam. In this regard, Dr. Gizzarelli testified that as part of their basic recordkeeping obligations, dentists must document the size and length of the gutta percha and working length, so that when the dentist is cleaning the root canal, they will know how far the files can be inserted.

Dr. Bacchus testified that as he understood it, documenting informed consent was not required until 2019. In this regard, Dr. Bacchus was simply not credible. Dr. Bacchus received counsel from Dr. Howard as early as May 2013 about the need to document, and the required contents of the documentation.

Moreover, the Recordkeeping Guideline has been in effect since 2016. It requires, among other things, a "notation that informed consent was obtained from the patient…and, where appropriate, such informed consent appears in writing".

The Guideline further provides specific guidance to dentists in obtaining and documenting informed consent, as follows:

1. All patients should be provided an explanation of their overall treatment plan, treatment alternatives, any risks or limitations of treatment and the estimated costs of the treatment, and that the fact this has been provided to a patient should be noted in the patient record.
2. Consent may be either express or implied. Implied consent is sufficient for "simple examinations or non-invasive procedures that pose no risk of harm to the patient".
3. Express consent must be obtained where the procedure is "beyond a simple examination or procedure".
4. In order for the consent to be informed, the dentist must provide the patient with; a diagnosis, the nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, treatment alternatives, the likely consequences of not having treatment, and the cost of each option.
5. Regardless of whether the patient consents in writing or orally, the dentist should keep a record of the nature of the conversation, the information provided, and the patient's decision.
6. Except for Patient AG, the records establish that Dr. Bacchus failed to document having discussed any of the above elements with the other patients identified.

The Recordkeeping Guideline in effect in 2016 clearly required dentists to document informed consent obtained for all procedures other than a simple examination. Dr. Bacchus' assertion that no such documentation was required until 2019 is simply incorrect. The Guideline is clear.

In addition, and as noted, Dr. Bacchus was specifically warned as early as 2013 by his practice monitor, Dr. Howard, that if he did not write down his discussions with patients about their informed consent, it was assumed that the discussion did not happen.

Upon a consideration of the oral and documentary evidence before it, including the testimony of Dr. Bacchus and Dr. Gizzarelli, the relevant patient records, the Recordkeeping Guideline and the report of Dr. Howard, the Panel finds that Dr. Bacchus was aware of his obligations to fully document his discussions with patients regarding their informed consent. Having failed to do so, the Panel finds that Dr. Bacchus' conduct fell below the standards of practice and that he thus engaged in professional misconduct as alleged.

Charging Fees for Services Not Provided, Failing to Document a Diagnosis & Failing to Keep Accurate and/or Complete Records

The Panel received evidence that with respect to four (4) patients, the records review established that Family Dental submitted claims for treatments that were not documented as having actually been provided. In each instance, claims were made for services, including complete and recall examinations, x-rays, and restorative work, where the patient records do not include any notes or descriptions confirming the treatment.

The Panel also received evidence that in a number of instances, Dr. Bacchus simply failed to keep adequate or complete records of the treatment and services provided to his patients. Dr. Gizzarelli identified several examples where Dr. Bacchus failed to document a comprehensive description of his treatment plan, that he noted that work was done on one tooth when in fact it was done on a different tooth and claimed for restorations on three teeth without there being any treatment plans describing the work.

Finally, the Panel received evidence that with respect to nine (9) patients over a 12-month period, Dr. Bacchus performed root canals and restorations on these patients without documenting a diagnosis or treatment plan in the patients' charts. Dr. Bacchus did not dispute that the information was missing from his charts but argued that his diagnosis could be inferred from the procedures that were ultimately performed.

Having considered the patient records presented, the testimony of both Dr. Bacchus and Dr. Gizzarelli, and the Recordkeeping Guideline, the Panel finds, on a balance of probabilities, that Dr. Bacchus' patient records fell well below the standards established by the Guideline. In several instances, the documentary evidence established that Dr. Bacchus billed for services that were not provided or that were at least not documented as having been provided. Further, he failed to properly document treatment plans and diagnoses.

The Recordkeeping Guideline sets out the minimum expectations of the College for its members. Accurate, up-to-date patient records are vital for continuity of care and to ensure that treatment is appropriate and in keeping with the patient's history. While there was no evidence of patient harm in these cases, incomplete or inaccurate records can lead to misdiagnosis and inadequate care. Accurate patient records are one tool for preventing harm to patients. In the view of the Panel, Dr. Bacchus conducted himself in blatant disregard of the College's Recordkeeping Guidelines.

Failing to Document the Use of an Apex Locator, Working Lengths, or a Rubber Dam

The College alleged that Dr. Bacchus performed root canal therapies with respect to at least three (3) patients without documenting either the working length of the root or the use of an apex locator.

Dr. Gizzarelli testified at length about the need to use an apex locator and a rubber dam during a root canal procedure. He explained to the Panel that the purpose of a root canal therapy is to remove infection from the entire root system; that it is therefore important that the dentist know how long the root is so that they can stop when they reach the end of the root,

Dr. Gizzarelli further testified in some detail that when performing a root canal procedure, a dentist must determine the length of the root; that this can be determined either by taking trial file x-rays or by using an apex locator. Dr. Gizzarelli gave evidence that it is thus crucial to establish the working length of the root in order to know how far to insert the files and for measuring the sealing material (gutta percha) that will be placed in the root canal.

Dr. Gizzarelli testified that dentists are required, as part of their recordkeeping responsibilities, to document the size and length of the gutta percha and the working length. Dr. Gizzarelli explained that documenting the working length, in particular, is crucial because if the tooth fails or needs a post, the dentist can refer back to their chart notes to look at the length of the root.

In their respective testimonies, both Dr. Gizzarelli and Dr. Goldberg identified that, with respect to Patients JDA, AG and JO, all of whom received root canal therapy from Dr. Bacchus, that he had failed to document either the working lengths or the use of an apex locator in the patients' charts.

Dr. Bacchus testified that he uses an apex locator for all of his root canals and that while this was not specifically documented in the chart notes reviewed by Drs. Gizzarelli and Goldberg, he asserted in his testimony that the use of an apex locator did not need to be documented in the "methods and materials" section of the notes or at all.

The Panel was persuaded by Dr. Gizzarelli's evidence regarding the need to use an apex locator. It defies logic to suggest that the use of an apex locator does not need to be documented when it is clear that knowing the length and the end of the root point is crucial both during and after the root canal procedure. If Dr. Bacchus indeed used an apex locator, he ought to have properly documented that fact in the patients' chart notes.

In addition to the concerns articulated by Dr. Gizzarelli regarding the apex locator, he also gave evidence that, based upon his review of the patients' records, that Dr. Bacchus failed to document either that he used a rubber dam when providing root canal treatments for five patients.

Dr. Gizzarelli gave evidence that a rubber dam should have been used during the subject root canal therapies to prevent the patients from choking and to minimize the risk of infection. It was Dr. Gizzarelli's opinion that Dr. Bacchus did not document the use of a rubber dam because he in fact did not use it at all. There was no rubber dam clamp visible in the x-rays he reviewed with the Panel.

Dr. Bacchus testified that he does use a rubber dam for all root canal therapies, but that he does not document doing so. Further, he testified that the rubber dam clamp was not visible in the x-rays because he took off the clamp at the end of the procedure when he took the x-rays.

When pressed on these points in cross-examination, Dr. Bacchus acknowledged that the x-rays were taken during the root canal and not at the end, so that the clamp part of the rubber dam structure, if used, would have been visible. Further, he admitted that in other patient records not produced at this hearing, he has documented "RD/C", which means "rubber dam/clamp".

The Panel finds, on a balance of probabilities, that in the patient charts identified by Dr. Goldberg and reviewed by Dr. Gizzarelli, Dr. Bacchus failed to document either his use of an apex locator in some instances or his use of a rubber dam and clamp in other instances during root canal

procedures. He either failed to document this important information, which is itself a breach of the standards of practice, or he simply did not use the materials as alleged. In either case, the Panel is satisfied that the College has established, on a balance of probabilities, that Dr. Bacchus engaged in professional misconduct as relates to the care provided during root canal treatments to Patients JDA, AG, and JO.

Evidence re the Allegations set out in Notice of Hearing H200006 (Exhibit 2)

The College alleged that Dr. Bacchus sexually abused a patient, namely Person A. In particular, the College alleged that Dr. Bacchus engaged in sexual intercourse, physical sexual relations, touching of a sexual nature and/or behaviour or remarks of a sexual nature while Person A was both his patient and his employee.

It is further alleged by the College that in so doing, Dr. Bacchus committed acts of professional misconduct, contrary to Section 51(1)(c) of Schedule 2 of the Ontario *Regulated Health Professions Act 1991*, SO 1991 C.18.

The Panel heard testimony that in June 1997, Person A was hired to assist Dr. Roussy in Dr. Bacchus' practice on McNaughton Avenue in Wallaceburg. She also occasionally worked in Dr. Bacchus' father's practices in Wallaceburg, Forest and Sarnia. In 1998 or 1999, Person A became a full-time chair-side assistant for Dr. Bacchus in the Wallaceburg office. Person C and SD were also dental hygienists at Dr. Bacchus' Wallaceburg practice, at the relevant time.

Person A testified that from the time she began working at the Wallaceburg practice, Dr. Bacchus was her dentist. She said that from 1997 up until her first maternity leave in October 2003, she was not treated by any other dentist, except for possibly one recall exam performed by Dr. Roussy.

Person A testified that it was Dr. Bacchus' standard practice to provide his employees with free dental care. Dr. Bacchus and other witnesses confirmed this standard practice.

Person A said that she did not have dental insurance and so she made sure to have all her cleaning and dental work performed at the Wallaceburg office. She testified that she had no history of cavities until 1999, when she began dating her first husband. She recalled that Dr. Bacchus provided her with four or five fillings in and around 2000.

In January 2003, Person A and Dr. Bacchus began a sexual relationship. At the time, she was married to her first husband and Dr. Bacchus was in a long-term relationship with Dr. Roussy. Person A testified that the sexual relationship lasted from January until shortly before she gave birth to her first child in October 2003.

Person A told the Panel that in January 2003, she and some of her other hygienist colleagues, together with Dr. Bacchus travelled to Toronto following Person C's completion of the restorative hygiene program. The trip was intended as a celebration of Person C's achievement. Dr. Roussy did not attend.

Person A testified that she and her colleagues went out for dinner and then to a dance bar. She recalled that she danced closely with Dr. Bacchus and that he tried to kiss her. She said that the relationship became sexual about a week later when Dr. Bacchus asked her to spend some time alone with him to talk. He invited her to a friend's apartment, where they had sex for the first time.

Person C told the Panel that she became aware of Dr. Bacchus' and Person A's sexual relationship during their visit to Toronto in early 2003. She said that she witnessed the two on the dance floor at the bar, kissing and dancing and generally looking like a couple.

Dr. Bacchus testified that he and Person A had a brief sexual relationship that took place from about March to approximately July of 2003. He denied that Person A was his patient at the time of their sexual relationship, although she was his employee.

Dr. Bacchus testified that Person A became a patient in 2005. He said that Person A was initially treated by Dr. Roussy, something Person A, Person C and SD deny. Dr. Bacchus acknowledged, however, that Dr. Roussy left the Wallaceburg practice by June 2002, about six months before Person A's and his sexual relationship began.

In his testimony, Dr. Bacchus also suggested that it was possible that Person A was receiving dental care from another dentist (possibly his father or Dr. Roussy) at one of the other practice locations. Dr. Bacchus made this claim, even though Person A was a full-time employee at the Wallaceburg practice, that others had seen him treat Person A there, and that they all confirmed that Dr. Bacchus provided free dental services to his staff.

Person A was confident in her testimony that Dr. Roussy was never her dentist. She said that at most, Dr. Roussy may have provided her with a recall exam, but she did not recall Dr. Roussy ever performing any dental work on her. Further, Person A told the Panel that as of June 2002,

Dr. Roussy went on maternity leave and never returned to the practice, and so she could not have been involved in Person A's dental care after that time.

SD worked as a dental assistant for Dr. Bacchus at his Wallaceburg practice in the late 1990s and early 2000s. She testified that she and Person A became close friends while working together. SD was aware of the sexual relationship between Person A and Dr. Bacchus. She testified that the relationship occurred when Person A was pregnant with her first child in 2003.

SD also testified that Dr. Bacchus performed dental work for all his employees, including Person A. SD told the Panel that she specifically recalled assisting Dr. Bacchus when he performed dental work on Person A.

The Panel received Person A's patient records from the Wallaceburg office. The records were incomplete. The earliest chart entries are dated April 2011, two years after Dr. Bacchus sold the practice to Dr. Sarhan.

In addition, the Panel received two financial records from the Wallaceburg office that were relevant to Person A. The Panel received a "fee summary", in which the earliest entry is dated April 2010, as well as an excerpt from ABELDent, which is a dental practice management and billing software. The excerpt reveals that on June 17, 2005, Dr. Bacchus provided Person A with a recall examination, took two bitewing radiographs, and that Person A also received scaling and polishing. Person A testified that she was certain she was Dr. Bacchus' patient before June 2005.

The undisputed evidence before the Panel was that in June 2010, shortly after Dr. Bacchus sold the Wallaceburg practice to Dr. Sarhan, there was a break-in at the office where 95% of the paper charts were stolen. Because the chart notes were at the time kept exclusively in paper format, the patient charts prior to 2010 were no longer available, including those for Person A.

The Panel's Findings

Person A's evidence was presented in a clear and forthright manner. She testified openly about her affair with Dr. Bacchus. It did not appear to the Panel that Person A tried to minimize or exaggerate her evidence in any way. She conceded when she could not recall specific details. Person A testified that she came forward with her complaint about Dr. Bacchus because she felt that his behaviour was "escalating."

In reporting the relationship, Person A undertook some personal reputational risk; she had to reveal that she had an extramarital affair, while pregnant with her first child.

Regarding her status as Dr. Bacchus' patient, Person A was unequivocal. Her evidence that Dr. Bacchus began providing her with dental services once she began working in the Wallaceburg office was consistent with the evidence of the other staff members and with the evidence of Dr. Bacchus himself. Person A, Person C, SD and Dr. Bacchus himself testified that it was his practice to provide free dental treatment to his staff.

Dr. Bacchus' evidence regarding Person A was not credible. While he conceded that he and Person A had engaged in a sexual relationship, he would not acknowledge that she was at that time, his patient. Initially, Dr. Bacchus maintained that Person A was Dr. Roussy's patient and not his. When pressed, he acknowledged that Dr. Roussy did not return to the practice after the birth of her first child in June 2002, so that at the very least she could not have been Person A's treating dentist in the year prior to their sexual relationship. Further, Dr. Bacchus' alternative explanation, that Person A only became his patient in 2005, defies logic, when considered together with all the other evidence available. In the face of Dr. Roussy's departure in June 2002 and given the uncontested evidence that Dr. Bacchus provided his employees free dental care, it makes no sense to conclude that Person A was Dr. Roussy's patient until June 2002 and that she then simply did not receive any dental care until 2005.

Upon a consideration of the documentary evidence, and the oral evidence of Person A, Person C, SD and Dr. Bacchus, the Panel is satisfied, on a balance of probabilities, that Person A and Dr. Bacchus engaged in a sexual relationship in or about March to June 2003, while Person A was both Dr. Bacchus' employee and his patient.

For the reasons set forth above, where the evidence of Dr. Bacchus conflicts with that of Person A, SD and Person C, the Panel prefers the evidence of the latter three (3) witnesses.

In the circumstances, the Panel finds that the registrant engaged in professional misconduct as alleged – namely, that he abused his patient, Person A, contrary to paragraph 8 of Section 2 of *Ontario Regulation 853/93*.

The Panel further finds, on a balance of probabilities, that Dr. Bacchus engaged in conduct that, having regard to all the circumstances, would reasonably be regarded by dentists as disgraceful,

dishonourable, unethical, and unprofessional, contrary to paragraph 59 of Section 2 of *Ontario Regulation 853/93*.

Evidence re the Allegations set out in Notice of Hearing 21-0187 (Exhibit 3)

The College alleged that Dr. Bacchus engaged in a sexual relationship with a patient and employee, namely Person B, in 2017. The College received two reports in December 2017 regarding this allegation. Dr. Bacchus denied that there was ever a sexual relationship between he and Person B. Person B did not testify. The Panel was provided with information that she did not wish to be involved in this process.

There is no dispute that beginning in 2015, Person B began working at the Family Dental Centre as a receptionist. She and her then-husband, Person D, have known Dr. Bacchus since they were in high school, and her then-sister-in-law, Person C, was a long-time employee of Dr. Bacchus'. Sometime in 2017, Person B began working with Dr. Bacchus at his new practice locations at Cathcart Dental and Wallaceburg Family Dental. There was no dispute that on occasion, Person B drove with Dr. Bacchus to and from the Wallaceburg office.

The Panel heard from Person D regarding the alleged relationship between Person B and Dr. Bacchus. He testified that before the night of November 24/25, 2017, he had no issues with Dr. Bacchus. That night, however, Dr. Bacchus hosted a staff holiday party. The party started at Dr. Bacchus' home and then moved to a local bar, namely the Two Amigos. Person D did not attend the party as he and Person B were having marital issues at the time. Leanne Dagg, Dr. Bacchus' spouse, did not attend the party either. Person C, her husband, and several other staff were in attendance.

Person D testified that he and Person B had been arguing on the night of November 24, 2017. He stayed at his parents' house that evening, but at some point, in the very early hours of November 25th, he returned to the home he shared with Person B. Person D testified that when he returned home, the lights were on, and he noticed his wife's shoes at the front door. The basement door was ajar, and he could hear noises coming from the basement, so he went down to see what was going on.

Person D told the Panel that he startled his wife as he was midway down the stairs to the basement. He said that his wife was standing at the side of the stairs, naked from the waist-up.

Person B ran into the basement bedroom and closed the door. Person D testified that Dr. Bacchus was sitting on the couch in the basement. He was fully clothed, but his pants were not done up and he had no shoes on.

Dr. Bacchus testified that he, Person B, MH, and MH's husband stayed at the holiday party at the Two Amigos until just before 2:00am. He said that around that time, Person B invited everyone back to her home, including Panos Ikonomou[8], a friend of Dr. Bacchus' who was also present that night. Mr. Ikonomou owned the Two Amigos. Dr. Bacchus said that he and Person B shared a cab to her house together with MH and her husband. When they arrived at Person B's home, MH and her husband did not go in and instead stayed in the cab and continued home. Dr. Bacchus said that he and Person B arrived at her home around 2:00am; that Person B was upstairs making a drink when Person D arrived a few minutes later.

Dr. Bacchus' previous statements to the College about the night at issue were put to him on cross-examination. In his response to the College dated August 19, 2020, Dr. Bacchus made no mention of Mr. Ikonomou being present at the party or that Person B had invited a group of people to her home while they were still out at the Two Amigos.

Person D testified that an altercation with Dr. Bacchus ensued upon his return to his home that night. According to Person D, when he looked at Dr. Bacchus he smiled and as Person D approached him, Dr. Bacchus punched him in the face. Person D testified that he also punched Dr. Bacchus back and eventually Dr. Bacchus ran up the basement stairs and out of the house. Person D testified that he did not follow Dr. Bacchus out of the house.

Dr. Bacchus denied that he and Person B were engaging in or about to engage in any sexual activity in the early morning hours of November 25th. He acknowledged that he was in her home alone with her and that at some point shortly after their arrival, her husband showed up and attacked him physically. Dr. Bacchus described the attack as involving a baseball bat. He said that he could not escape Person D's attack until Person B jumped on her husband's back. Dr. Bacchus denied that Person D accused him of having an affair with his wife.

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[8] Contrary to Dr. Bacchus' testimony, Mr. Ikonomou testified that he left the bar around 2:45am and 3:00am, after Dr. Bacchus and Person B left earlier. Mr. Ikonomou also testified that he travelled in a cab with a woman whom he had just met. He said that as he approached Person B's home, he saw an altercation unfolding between two men and so he instructed the driver not to stop there.

Person D testified that once Dr. Bacchus left their property, he and Person B argued. He was injured and so he decided to return to his parents' home. He also spoke to his sister, Person C, about the altercation. Person C told the Panel that upon hearing from her brother, she became concerned for Person B and for Dr. Bacchus. She left her home with her husband, Person E, to drive to Person B's house. On the way there, Person C found Dr. Bacchus on or near the driveway at his own home. He was injured and bloody. He told her that he could not get into his house because he did not have his keys. In this regard, Person C testified that to the best of her recollection, Dr. Bacchus was not wearing a jacket or shirt at the time.

Person C also testified that she and her husband took Dr. Bacchus back to Person B's house to retrieve his keys and his jacket. They then took him to the Family Dental Centre so that he could get cleaned up before returning home to his spouse, Leanne Dagg. Person E testified that during this time, it was his opinion that Dr. Bacchus was "quite intoxicated" and that he was "delirious."

Dr. Kunwar Singh testified that he received a telephone call from Person E at approximately 4:00 AM on the morning of November 25, 2017, in which Person E asked him to attend at Dr. Bacchus' house because he was injured, having been hit by a baseball bat or hockey stick. Person E testified that he made the call at Ms. Dagg's request.

Dr. Singh testified further that he met Person E in the driveway of Dr. Bacchus' home; that Person E did not go in, saying he was tired and wanted to go home; that Dr. Singh did enter the home and he went upstairs to attend to Dr. Bacchus; that Dr. Singh saw swelling on Dr. Bacchus' right hand, that there was swelling on the side of his head, that one eye was swollen as was his right foot; and that Dr. Bacchus was in a lot of pain.

Dr. Singh testified that he then drove Dr. Bacchus to the emergency department at the hospital and that he remained with him until he was discharged. He thereupon drove Dr. Bacchus home and dropped him at his side door.

The Panel found Dr. Singh to be a very credible witness who testified in an open and forthright manner.

The Panel heard conflicting evidence about what occurred next. According to Person D, he received a call from Ms. Dagg on November 26th about the altercation he had with Dr. Bacchus. He testified that Ms. Dagg wanted him to go over to her home to discuss the incident.

Dr. Bacchus denies that Ms. Dagg called Person D. He testified that instead, Ms. Dagg intended to call Person B to ask about what had happened. Ms. Dagg was not called to testify.

It is not disputed that Person D did attend Dr. Bacchus' and Ms. Dagg's home on November 26th. Person D testified that during this meeting, Ms. Dagg asked Dr. Bacchus about whether he had had sex with Person B. According to Person D, Dr. Bacchus admitted that he and Person B had engaged in sexual intercourse in his office and that their relationship had been going on since Person B's birthday in May 2017. Dr. Bacchus' evidence was that this conversation did not take place and that he denied having had a sexual relationship with Person B.

Dr. Bacchus told the Panel that when Person D arrived at his home (he and Ms. Dagg were expecting Person B), Person D was "screaming" and threatening to "finish what he started." Dr. Bacchus testified that he did not know why Person D showed up screaming or why he was so angry with him. Dr. Bacchus also testified that his cousin, Caedmon Nanco was also present during this incident. Mr. Nanco was not called to testify.

Ms. Dagg was not called to testify before the Panel although she did testify under oath at his recent criminal trial. On cross-examination by the College, Dr. Bacchus admitted that during his recent criminal trial, Ms. Dagg did not corroborate his version of the events of that day. More specifically, Ms. Dagg's evidence at the criminal trial was that Person D was not screaming or threatening. She said that Person D "just came in quickly", he looked at Dr. Bacchus and he said "hmm". She said it "wasn't like a, a talk or anything like that". She also testified at the criminal trial that Person D wasn't there very long.

Person C testified that on November 27, 2017, she and her work colleagues, MD, and MH, attended a meeting at Dr. Bacchus' house. During this meeting, Person C said that both she and Ms. Dagg asked Dr. Bacchus' questions about his relationship with Person B. According to Person C, Dr. Bacchus admitted that he had a sexual relationship with Person B. He told her that his and Person B's relationship started during the time that they were driving back and forth together from the Wallaceburg office. Person C testified further that Dr. Bacchus admitted that the relationship had been going on between six months to a year and that he and Person B would have sex at the Cathcart office and occasionally at Person B's home when Person D was working out of town.

Dr. Bacchus did not dispute that there was another meeting at his home on November 27, 2017. Dr. Bacchus testified that Person C yelled at him and told him that she could no longer work for

him, but he did not know why she would say those things, or what she was yelling about. Dr. Bacchus denied that Person C accused him of having sex with Person B.

Person B did not testify before the Panel. The Panel was advised that she had declined to cooperate with the College's investigation. The Panel did receive a two-page statutory declaration from Person B in which she denied ever having had a sexual relationship with Dr. Bacchus. The declaration does not address the events that took place over November 24-25, 2017.

The College informed the Panel that it had exercised its prosecutorial discretion not to call Person B to testify because it did not find Person B's evidence credible. Further, the College followed its general policy not to summons witnesses who have been allegedly sexually abused by registrants, particularly where that witness may then be subject to cross-examination by the College as a hostile witness in a discipline hearing.

Dr. Bacchus' counsel argued that the Panel should accept Person B's statutory declaration as evidence. His counsel conceded that while the statement itself is hearsay, it could be admitted for the truth of its contents under the principled exception to the hearsay rule. She argued that the statement was "reliable" because it was sworn before a lawyer and that it was "necessary" because Person B refused to attend the hearing to be examined.

The Panel's Findings

The Panel carefully considered Dr. Bacchus' evidence as against the evidence of Person C and Person D. Person C was both an employee and patient of Dr, Bacchus, as well as the sister-in-law of Person B. Person D is the spouse of Person B and Person C's brother. While the Panel did not have the benefit of hearing oral evidence from Person B, it is satisfied that the available evidence shows that it was more likely than not that Dr. Bacchus engaged in a sexual relationship with Person B, as alleged.

With respect to Person B's statutory declaration, the Panel was not persuaded that it should be entered as evidence for the truth of its contents. While the declaration was sworn before a lawyer, the Panel had no information about the circumstances surrounding Person B's making of the statement, whether Dr. Bacchus was in any way involved, or whether Person B's declaration was made with concern about Person D's reaction to the proposed evidence. Further, Person B's statutory declaration is silent with respect to what happened on November 24-25, 2017, between

Person B and Dr. Bacchus and between Person D and Dr. Bacchus, other than to deny any sexual relationship between herself and Dr. Bacchus.

Finally, the Panel was not persuaded that the statutory declaration is necessary. Person B could have been summoned to appear before the Panel. While steps were taken by Dr. Bacchus' counsel to convince Person B to participate, it is not clear to the Panel why more and better efforts were not made to require her attendance, for instance by means of a summons. In the circumstances, the Panel could place no evidentiary weight on the statutory declaration.

Dr. Bacchus' explanation for the fight between himself and Person D in the early morning hours of November 25, 2017, and the subsequent ill will between him and Person D, was simply not reasonable in the circumstances and was therefore not credible. The Panel concludes that, it is more likely that not that the most plausible reason for the sudden violence between the two men was that Person D walked in on Dr. Bacchus and Person B while they were engaged in or about to engage in sexual activities. There was no basis upon which to believe that – after knowing and being friends with Dr. Bacchus for decades – Person D simply became suddenly irrational and violently attacked him in the early morning hours of November 25, 2017, and that Person D subsequently went after Dr. Bacchus the following day, all of which culminated in criminal charges being laid against Dr. Bacchus.

In contrast to Dr. Bacchus' evidence, which the Panel found to be implausible, and which was internally inconsistent over time, Person D provided the Panel with clear and consistent evidence. He was composed and responsive in providing his evidence on direct examination by the College. He freely admitted to his own improper conduct in the early morning hours of November 25th. He acknowledged that he was mad about finding his wife, Person B, and Dr. Bacchus in his basement that night and he acknowledged that he and Dr. Bacchus engaged in a physical altercation as a result.

On cross-examination, Person D's evidence remained consistent on the salient points. When challenged that other witnesses, including Dr. Bacchus, would say that Person D hit Dr. Bacchus with a baseball bat that night, he stood firm in saying that those other witnesses should have been there that night. He asserted that if Dr. Bacchus were to say that he did not have a sexual relationship with Person B, that Dr. Bacchus would be lying.

Further, the Panel notes that Dr. Bacchus admitted to having engaged in sexual activities with Person B prior to November 24-25, 2017, when he was confronted by Person D and Person C.

Both Person D and Person C testified to this in a credible way. Person C's evidence was consistent with the statement she made via email to the College on December 8, 2017, in which she said that "the affair (between Dr. Bacchus and Person B) has been going on for at least six months…" and that she has "been a witness to inappropriate comments and behaviour by Dr. Bacchus in the past years." [9]

The Panel was not persuaded by Dr. Bacchus' denial of these conversations during his evidence. Moreover, Dr. Bacchus' testimony about Person D's behaviour at his home the following day was in sharp contrast with the testimony given under oath by his spouse, Leanne Dagg, at Dr. Bacchus' criminal trial. Ms. Dagg did not describe Person D as screaming and raging, as Dr. Bacchus testified before this panel. In addition, and as described above, Dr. Bacchus gave evidence regarding the details of the evening of November 24, 2017, that were new and different than the information he provided to the College in his initial responses to these allegations.

In the circumstances, the Panel did not find Dr. Bacchus to be credible regarding his relationship with Person B. The Panel is satisfied that it is more likely than not that Dr. Bacchus and Person B engaged in sexual activities both on the night of November 24, 2017, and prior to that night, as Dr. Bacchus admitted to Person D, Person C and others, beginning in or around the time of Person B's birthday in May 2017 The Panel made this finding in consideration of the oral evidence of Dr. Bacchus, Person D and Person C, as well as the evidence of Dr. Singh and Person E.

As noted above, the Panel did not put any weight on Person B's statutory declaration in assessing the whole of the evidence on this point. Dr. Bacchus' counsel argued that Person B's declaration corroborated his version of events. However, without the benefit of seeing Person B testify and hearing her account of the relevant events and submitting to cross-examination on the substance of her declaration, the Panel could not give the statutory declaration the weight it gave to the evidence of the witnesses who testified in person before it. Further, as described above, the Panel did not find that the use of the statutory declaration was necessary in all the circumstances of this case.

The Panel finds on a balance of probabilities that there is sufficient credible and reliable evidence that Dr. Bacchus engaged in sexual abuse of a patient, as defined in the *RHPA* and as alleged in Notice of Hearing 21-0187.

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[9] Exhibit 7

In particular, the Panel relied on the evidence of Person C, and Person E, who provided a consistent account of their respective first-hand knowledge. Accordingly, the Panel finds as follows:

1. That Dr. Bacchus committed acts of misconduct in that during the year 2017, he sexually abused Person B who was his employee and his patient, contrary to Section 51(1)(b.1) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* as alleged.
2. That Dr. Bacchus committed acts of misconduct in that during the year 2017, he sexually abused Person B, contrary to Section 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* as alleged.
3. That Dr. Bacchus committed acts of professional misconduct in that, during 2017, he engaged in conduct and performed acts that would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional and unethical, contrary to paragraph 59 of Section 2 of *Ontario Regulation 853*, Regulations of Ontario, as amended, as alleged.

Evidence re the Allegations set out in Notice of Hearing 21-0432 (Exhibit 5)

Person C was employed with Dr. Bacchus from about 1996 to 2017. She began as a dental hygienist. In 2003, she obtained her restorative hygienist designation. Person C was Dr. Bacchus' patient throughout this time.

Person C testified that Dr. Bacchus touched her in an inappropriate manner on two occasions in 2013 at the Family Dental Centre.

More specifically, Person C testified that on one occasion in or around 2013, she was seated in the lunchroom at the Family Dental Centre. She said that she had her back to the wall and that she was stretching her neck. Person C's evidence was that Dr. Bacchus entered the lunchroom and put his hands on her neck and shoulders. She said that he massaged her neck, shoulders, and down her arms. Person C said that she froze initially, that she was embarrassed and that she told Dr. Bacchus that she "was good" so that he would stop. Person C said she felt embarrassed and humiliated. In her written complaint to the College dated June 6, 2020, she stated that "it was wrong for him to touch me without my permission, and it was totally unprofessional."[10] Finally,

[10] Exhibit 6

according to Person C there were two other people in the lunchroom at the time of the incident – JR and SB. During cross-examination, Person C was challenged on this aspect of her testimony. Dr. Bacchus' counsel told Person C that it was the defence's understanding that JR was not working for Dr. Bacchus in 2013, when she said this massage took place. She suggested to Person C that a conversation about this allegation had taken place between JR and Wendy Waterhouse, the College's investigator; that the call took place on June 29, 2020. Nevertheless, Person C was unwavering in her response: she reaffirmed that JR was there, that she and JR had had a conversation about the massage, but that "she just doesn't want to get involved, like a lot of people."

The Panel also heard from JR, whom Person C identified as having observed the first incident of inappropriate touching by Dr. Bacchus, and who Person C further identified in her letter of complaint[11] as having also been a victim of inappropriate touching by Dr. Bacchus.

In her own evidence, however, JR testified that she worked for Dr. Bacchus on a part-time basis from 2007 to June 2008, when she went on maternity leave; that she has not worked for Dr. Bacchus since that time. She was candid in saying that when she was first contacted by Ms. Waterhouse, she was "very angry" because she had no prior knowledge that she was being brought into this. She was clear in stating that she had never observed inappropriate touching by Dr. Bacchus, nor had she been inappropriately touched by Dr. Bacchus.

Person C testified that Dr. Bacchus touched her on a second occasion in 2013. She said that she believed the second incident occurred within three months of the first. In the second incident, Person C was again sitting in the lunchroom at the Family Dental Centre. She complained that her neck hurt, and Dr. Bacchus began rubbing her neck. She said that the interaction lasted less than 30-seconds. Person C testified that there was no one else in the room to witness the second incident. Dr. Bacchus denied ever touching Person C as she alleged.

The Panel's Findings

The Panel was not persuaded by the evidence presented by the College that Dr. Bacchus engaged in inappropriate conduct as alleged in Notice of Hearing 21-0432.

Person C's recollection of the alleged events was in direct contrast with the clear evidence provided by JR, who testified that she could not have witnessed the interaction as Person C

[11] Ibid

alleged. The Panel found JR's evidence to be clear and reasonable. She had no motive to lie and was clearly trying to assist the Panel.

While Person C was also trying to assist the Panel with her recollection of the alleged incidents, the Panel could not find, on a balance of probabilities, that the events she described occurred as alleged.

In the result, the Panel finds, on a balance of probabilities, that it did not have sufficient reliable and credible evidence before it on this allegation and therefore, the College has not established that Dr. Bacchus committed the acts of professional misconduct as alleged. As such, with respect to the allegations regarding his alleged conduct towards Person C, the Panel finds that Dr. Bacchus' conduct cannot be said to be that which would reasonably be regarded by members of the dental profession as disgraceful, dishonourable, unprofessional, or unethical.

CONCLUSION

The hearing of this matter was complex and lengthy. The hearing took seventeen (17) days to conclude, and the Panel engaged in two (2) full days of deliberations in July 2023. The Panel carefully considered the evidence and the arguments from both the College and Dr. Bacchus' counsel. The Panel did not reach its decisions lightly. All the allegations made against Dr. Bacchus were serious and the Panel recognizes that its findings are significant.

With respect to the allegations relating to record keeping, overprescription of opioids and improper billing practices, the documentary evidence provided was overwhelming. Dr. Bacchus engaged in billing practices intended to mislead GSC, the insurer, and he kept inadequate records generally. In particular, his record keeping in relation to his prescription of opioids, was seriously deficient such that, in the opinion of the Panel, it could have put the health and safety of his patients at risk. Similarly, the Panel found, with respect to many patients, that the number of opioid tablets prescribed by Dr. Bacchus exceeded the maximum number of such tablets set out in the College's Opioid Guidelines, and that he refilled prescriptions for opioid medications more than the Guideline amount of a maximum of three. Each of these acts of misconduct put the health and safety of Dr. Bacchus' patients at risk.

As set out above, the Panel concluded that Dr. Bacchus engaged in sexual relationships with both Person A and Person B, while they were both his employees and his patients. The *RHPA* contains an absolute prohibition on sexual abuse of a patient, which is defined to include sexual intercourse

or other forms of physical sexual relations between a registrant and his/her patient. While the term “patient” is not defined in the *Health Professions Procedural Code*, the Panel considered the evidence presented was sufficient to conclude, on a balance of probabilities, that both Person A and Person B were patients at the time that they respectively engaged in sexual relations with Dr. Bacchus. In particular, with respect to the issue of who was a “patient,” the Panel considered the evidence of Person A and other staff members, all of whom confirmed that Dr. Bacchus provided his staff with free dental services while they were employed at his clinics; and Person A’s evidence that she received dental treatments from Dr. Bacchus both before, during and after their sexual relationship.

Having concluded that Person A and Person B were patients at the time the Panel found that Dr. Bacchus engaged in a sexual relationship with each of them, the Panel finds that Dr. Bacchus engaged in sexual abuse as alleged and that his conduct in relation to Person A and Person B would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional, and unethical.

I, Judy Welikovitch, sign these Reasons for Decision as Chairperson of this Discipline Panel.

Dated this 6th day of June, 2024 

Discipline Panel members:
Dr. Nancy DiSanto
Dr. Ian Brockhouse
Dr. Carol Janik
Mr. Brian Smith

ATTACHMENTS

H190012

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. KEVIN F. M. BACCHUS,** of the City of Sarnia, 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.

TO: DR. KEVIN F. M. BACCHUS
1208 Michigan Ave
Sarnia ON N7S 6M7

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

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(s) 2016 and 2017, you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to the patient GD, contrary to paragraph 28 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- You submitted and/or arranged for the submission on your behalf of a claim for services rendered to this patient that were provided on a date or dates different from the date indicated on the claim. In particular:
    - You submitted and/or arranged for the submission on your behalf of a claim for services which indicated that the following services were rendered on January 13, 2017:
        - 01205 – Emergency exam and diagnosis;
        - 33131 – Root canal therapy, 3 canals; and
        - 22322 – Tooth coloured restoration, 2 surfaces.
    - These services were not provided on January 13, 2017. Rather, root canal therapy on the patient' s tooth 16 was performed by you on September 7, 2016 as per the radiographs and treatment plan. Root canal therapy and a two-surface restoration on the patient' s tooth 16 were noted in the patient' s chart as having occurred on January 17, 2017.
- You submitted and/or arranged for the submission on your behalf of claims for services rendered to this patient which were listed with the service provider being Dr. Ali Ahmed, when in fact it was you who was the service provider, in order to mislead the insurance company. In particular:
    - With respect to the above-noted claim for services for this patient indicating a treatment date of January 13, 2017, you submitted and/or arranged for the submission on your behalf of this claim with Dr. Ali Ahmed listed as the service provider rather than yourself, when in fact it was you who provided the services to the patient.
    - With respect to a claim for services rendered September 15, 2016 in relation to treatment for a three-unit bridge for teeth 11-13, you submitted and/or arranged for the submission on your behalf of this claim with Dr. Ali Ahmed listed as the service provider rather than yourself, when in fact it was you who provided the services to the patient.

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 2016 and 2017, you submitted an account or charge for dental services that you knew or

ought to have known was false or misleading relative to the patient GD, contrary to paragraph 33 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- You submitted and/or arranged for the submission on your behalf of a claim for services rendered to this patient that were provided on a date or dates different from the date indicated on the claim. In particular:
    - You submitted and/or arranged for the submission on your behalf of a claim for services which indicated that the following services were rendered on January 13, 2017:
        - 01205 – Emergency exam and diagnosis;
        - 33131 – Root canal therapy, 3 canals; and
        - 22322 – Tooth coloured restoration, 2 surfaces.
    - These services were not provided on January 13, 2017. Rather, root canal therapy on the patient' s tooth 16 was performed by you on September 7, 2016 as per the radiographs and treatment plan. Root canal therapy and a two-surface restoration on the patient' s tooth 16 were noted in the patient' s chart as having occurred on January 17, 2017.
- You submitted and/or arranged for the submission on your behalf of claims for services rendered to this patient which were listed with the service provider being Dr. Ali Ahmed, when in fact it was you who was the service provider, in order to mislead the insurance company. In particular:
    - With respect to the above-noted claim for services for this patient indicating a treatment date of January 13, 2017, you submitted and/or arranged for the submission on your behalf of this claim with Dr. Ali Ahmed listed as the service provider rather than yourself, when in fact it was you who provided the services to the patient.
    - With respect to a claim for services rendered September 15, 2016 in relation to treatment for a three-unit bridge for teeth 11-13, you submitted and/or arranged for the submission on your behalf of this claim with Dr. Ali Ahmed listed as the service provider rather than yourself, when in fact it was you who provided the services to the patient.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

(1) directing the Registrar to revoke your certificate of registration;
(2) directing the Registrar to suspend your certificate of registration for a specified period of time;
(3) directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;
(4) requiring you to appear before the panel to be reprimanded;
(5) requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

1. the College's legal costs and expenses;

2. the College's costs and expenses incurred in investigating the matter; and
3. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code.* You or your representative may contact the prosecutor for the College, [redacted], in this matter at:

[redacted]

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 11th day of December, 2019.

[Seal]

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. KEVIN F. M. BACCHUS,** of the City of Sarnia, 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..

NOTICE OF HEARING

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO
6 Crescent Road
Toronto ON M4W 1T1
Telephone: 416-961-6555
Fax: 416-961-5814

H200006

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. KEVIN F. M. BACCHUS,** of the City of Sarnia, 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.

TO: DR. KEVIN F. M. BACCHUS
1208 Michigan Ave
Sarnia ON N7S 6M7

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(b.1) 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 or around the years 2002 and/or 2003, you sexually abused a patient, Person A.

   Particulars:

   - in or around the years 2002 and/or 2003, you engaged in sexual intercourse, physical sexual relations, touching of a sexual nature, and/or behaviour or remarks of a sexual nature, with Person A while she was your patient and your employee.

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 or around the years 2002 and/or 2003, you abused a patient, Person A, contrary to paragraph 8 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - in or around the years 2002 and/or 2003, you engaged in sexual intercourse, physical sexual relations, touching of a sexual nature, and/or behaviour or remarks of a sexual nature, with Person A while she was your patient and your employee.

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, in or around the years 2002 and/or 2003, 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, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   o in or around the years 2002 and/or 2003, you engaged in sexual intercourse, physical sexual relations, touching of a sexual nature, and/or behaviour or remarks of a sexual nature, with Person A while she was your patient and your employee.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

(6) directing the Registrar to revoke your certificate of registration;
(7) directing the Registrar to suspend your certificate of registration for a specified period of time;
(8) directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;
(9) requiring you to appear before the panel to be reprimanded;
(10) requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

4. the College's legal costs and expenses;
5. the College's costs and expenses incurred in investigating the matter; and
6. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code.* You or your representative may contact the prosecutor for the College, [redacted], in this matter at:

[redacted]

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 25th day of May, 2020.

[Seal]

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. KEVIN F. M. BACCHUS,** of the City of Sarnia, 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..

NOTICE OF HEARING

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO
6 Crescent Road
Toronto ON M4W 1T1
Telephone: 416-961-6555
Fax: 416-961-5814

21-0187

~~**G170106**~~

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. KEVIN F.M. BACCHUS,** of the City of Wallaceburg, 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.

TO: DR. KEVIN F.M. BACCHUS
1231 Dufferin Ave
Wallaceburg, ON N8A 2W3

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(b.1) 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 2017, you sexually abused a patient, Person B.

   Particulars:

   - In or about May until November 2017, you engaged in sexual intercourse, physical sexual relations, touching of a sexual nature, and/or behaviour or remarks of a sexual nature, with Person B while she was your patient and your employee.

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 year 2017, you abused a patient, Person B, contrary to paragraph 8 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

- Particulars:
  In or about May until November 2017, you engaged in sexual intercourse, physical sexual relations, touching of a sexual nature, and/or behaviour or remarks of a sexual nature, with Person B while she was your patient and your employee.

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 2017, 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, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about May until November 2017, you engaged in sexual intercourse, physical sexual relations, touching of a sexual nature, and/or behaviour or remarks of a sexual nature, with Person B while she was your patient and your employee.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1, or by electronic hearing as required. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

(1) directing the Registrar to revoke your certificate of registration;

(2) directing the Registrar to suspend your certificate of registration for a specified period of time;

(3) directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;

(4) requiring you to appear before the panel to be reprimanded;

(5) requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

1. the College's legal costs and expenses;

2. the College's costs and expenses incurred in investigating the matter; and

3. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code.* You or your representative may contact the solicitor for the College, [redacted], in this matter at:

[redacted]

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 21st day of January, 2021.

[Seal]

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. KEVIN F.M. BACCHUS,** of the City of Wallaceburg, 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.

NOTICE OF HEARING

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO
6 Crescent Road
Toronto ON M4W 1T1
Telephone: 416-961-6555
Fax:416-961-5814

: **21-0188**

~~**G180069**~~

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. KEVIN F.M. BACCHUS,** of the City of Wallaceburg, 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.

TO: DR. KEVIN F.M. BACCHUS
1231 Dufferin Ave
Wallaceburg, ON N8A 2W3

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

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(s) 2015 and 2016, you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to the following patients, contrary to paragraph 28 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You submitted and/or arranged for the submission on your behalf of claims for services rendered by you to the following patients, using another provider's constituent identification number on the explanation of benefits and/or another provider's name on the standard claim form.

Patients	Date(s) [on or about]
A, F	Nov. 13/15
B, B	Sept. 30/16; Oct. 04/16; Nov. 01/16
C, J	Jan. 28/16; Aug. 04/16
C, C	Jan. 27/15
D, J 1	Feb. 17/16; Feb. 18/16
D, J 2	May 20/16; May 24/16
E, D	Jun. 24/16; Oct. 25/16; Oct 27/16
G, A	Jul. 25/16; Jul. 28/16; Aug. 04/16
H, T	Feb. 16/16; Mar. 10/16; Sept. 16/16; Sept. 30/16
K, J	May 26/16; May 31/16; Jun. 09/16; Aug. 31/16
M, R	Aug. 11/16; Aug. 22/16; Aug. 22/16; Aug. 29/16
O, J	Aug. 04/16; Aug. 05/16
P, M	May 30/16; Jun. 06/16; Jun. 24/16
T, B	May 06/16; May 12/16; May 16/16
U, J	Jun. 02/16; Jun. 03/16; Jun. 28/16
V, L	Nov. 26/15; Sept. 28/16; Oct. 19/16
Z, T	Jan. 05/16; Jun. 21/16; Sept. 22/16

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 2015 and 2016, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to the following patients, contrary to paragraph 33 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You submitted and/or arranged for the submission on your behalf of claims for services rendered by you to the following patients, using another provider's constituent identification number on the explanation of benefits and/or another provider's name on the standard claim form.

Patients	Date(s) [on or about]
A, F	Nov. 13/15
B, B	Sept. 30/16; Oct. 04/16; Nov. 01/16
C, J	Jan. 28/16; Aug. 04/16
C, C	Jan. 27/15
D, J 1	Feb. 17/16; Feb. 18/16

D, J 2	May 20/16; May 24/16
E, D	Jun. 24/16; Oct. 25/16; Oct 27/16
G, A	Jul. 25/16; Jul. 28/16; Aug. 04/16
H, T	Feb. 16/16; Mar. 10/16; Sept. 16/16; Sept. 30/16
K, J	May 26/16; May 31/16; Jun. 09/16; Aug. 31/16
M, R	Aug. 11/16; Aug. 22/16; Aug. 22/16; Aug. 29/16
O, J	Aug. 04/16; Aug. 05/16
P, M	May 30/16; Jun. 06/16; Jun. 24/16
T, B	May 06/16; May 12/16; May 16/16
U, J	Jun. 02/16; Jun. 03/16; Jun. 28/16
V, L	Nov. 26/15; Sept. 28/16; Oct. 19/16
Z, T	Jan. 05/16; Jun. 21/16; Sept. 22/16

- You submitted and/or arranged for the submission on your behalf of a claim for services rendered to patient J.O. that were provided on a date or dates different from the date indicated on the claim. In particular:
    - You submitted and/or arranged for the submission on your behalf of a claim for services which indicated that the following services were rendered on or about August 4, 2016, when they were actually performed by you on or about March 11, 2016:
        - 23325 – Five surface restoration; and
        - 25731 – One post (Tooth 46).

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 2015, 2016, 2017 and 2018, you contravened a standard of practice relative to the following patients, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended:

   Particulars:

   - You prescribed opioid medication to six patients without a documented justification or reason for the opioid prescription and you did not document that a non-opioid medication was considered first.

Patients	Date(s) [on or about]
A, F	Nov. 26/15
B, B	Dec. 30/15
D, J 2	May 20/16
E, D	Oct. 25/16
O, J	Mar. 02/16; Mar. 07/16; Sept. 28/16; Sept. 30/16
U, J	Jun. 03/16

- You prescribed 25 tablets of Tylenol #3, which exceeds the recommended maximum number of tablets of opioids by one tablet 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, with respect to 43 prescriptions for 39 patients:

Patients	Date(s) Prescription Filled [on or about]
A, L	Sept. 07/17
B, C	Dec. 28/16
B, J 1	Mar. 05/18
B, H	Sept. 12/17
B, T	Apr. 10/17
B, M	Jan. 13/17
B, J 2	Sept. 17/16
C, A	Sept. 05/17
C, K	Mar. 14/15
D, M	Jan. 03/17; Jan. 07/17
D, J	Dec. 16/16
D, D 1	May 04/17
D, R	Aug. 05/17
E, F	Jan. 25/16
G, B 1	Dec. 03/16; Jul. 24/17; Aug. 28/17
G, R	Jan. 12/16
G, B 2	Feb. 17/17
H, J 1	Jul. 27/17; Feb. 01/18
H, M	Sept. 06/16
H, J 2	Mar. 24/16
H, D	Sept. 29/17
L, D	Oct. 13/17
M, G	Aug. 28/17
M, L	Jun. 12/17
M, J	Feb. 17/17
O, M 1	Jan. 30/17
P, V	Oct. 02/17
P, D	Jan. 18/17
P, P	Jun. 13/17
P, R	Feb. 27/18
R, M 1	Jan. 12/16
R, M 2	Mar. 02/17
S, S 1	Jul. 29/17
S, S 2	Nov. 21/17
S, T	Feb. 15/18
T, E	Dec. 28/16
V, J	Dec. 12/16
W, M	Aug. 29/17
W, A	Jan. 21/16

- You prescribed 26 tablets of Tylenol #3, which exceeds the recommended maximum by two tablets 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, with respect to five prescriptions for five patients:

Patients	Date(s) Prescription Filled [on or about]
A, T	Dec. 09/17
D, D 2	Jan. 21/18
D, D 3	May 18/18
K, E	Jul. 01/16
S, N	Jul. 26/16

- You prescribed 28 tablets of Tylenol #3, which exceeds the recommended maximum by four tablets 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, with respect to 27 prescriptions for 22 patients:

Patients	Date(s) Prescription Filled [on or about]
D, D 4	Apr. 11/17; Oct. 12/17
F, S	Jan. 29/18; Feb. 28/18
G, B	May 12/18
H, J	Nov. 17/17
H, K	Nov. 24/17
I, A	May 29/18
K, D	May 25/18
L, R	Apr. 04/17
L, K	Feb. 01/18
M, A	Dec. 02/16
O, M 1	Jan. 09/18; May 29/18
O, M 2	Apr. 21/18
R, R	Feb. 03/17
R, M 3	Nov. 06/17
R, D	Jan. 30/18
S, S 1	Jan. 11/18
S, S 2	Nov. 17/17; Apr. 20/18
S, M	Jan. 27/18
S, E	Mar. 29/17
T, R	Mar. 31/17
V, J	Apr. 18/18
W, D	Feb. 08/18; Apr. 04/18

- You prescribed 30 tablets of Tylenol #3 to three of your patients, which exceeds the recommended maximum by six tablets 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, with respect to three prescriptions to three patients:

Patients	Date(s) Prescription Filled [on or about]
W, L	May 03/18
D, J 2	May 20/16
P, M	Aug. 29/17

- You prescribed 25 tablets of Oxycodone, which exceeds the recommended maximum by one tablet 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, with respect to 11 prescriptions for seven patients:

Patients	Date(s) Prescription Filled [on or about]
G, T	Aug. 11/17
G, S	Mar. 22/18
H, D	Aug. 16/16
R, D	Jul. 27/17
T, J	Apr. 20/15
T, F	Feb. 25/16; Mar. 22/17; March 24/17
T, B	Apr. 05/17; Apr. 10/17; Apr. 12/17

- You prescribed 26 tablets of Oxycodone, which exceeds the recommended maximum by two tablets 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, with respect to three prescriptions for three patients:

Patients	Date(s) Prescription Filled [on or about]
C, T	Jun. 11/18
C, R	Jun. 22/18
T, J	Apr. 23/18

- You prescribed 28 tablets of Oxycodone, which exceeds the recommended maximum by four tablets 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, with respect to six prescriptions for six patients:

Patients	Date(s) Prescription Filled [on or about]
C, R	Jun. 15/18
L, J	Feb. 22/17
M, M	Feb. 03/18
O, M 1	Mar. 21/18
S, T	Apr. 13/18
W, J	Jun. 12/18

- You prescribed 30 tablets of Oxycodone, which exceeds the recommended maximum by six tablets 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, with respect to three prescriptions for three patients:

Patients	Date(s) Prescription Filled [on or about]
A, C	Apr. 13/18
C, A	Dec. 11/17
W, S	Oct. 26/17

- 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:
    - For patient A.G., you provided four prescriptions for Oxycocet between April 25, 2018 and June 2, 2018.
    - For patient J.O., you provided four prescriptions for Oxycocet between March 2, 2016 and September 30, 2016.
    - For patient B.T, you provided nine prescriptions for Oxycocet between April 5, 2017 and August 18, 2017.
- For patient R.M., on or about November 9, 2016, you failed to record a corresponding chart entry in the patient chart notes for a prescription for Oxycocet that you provided.

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 2015 and 2016, 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 the following patients, 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 patient R.M, on or about November 9, 2016, you prescribed Oxycocet

without documenting any corresponding treatment.

- You prescribed opioid medication to the following patients without justification or reason for the opioid prescription documented and you did not document that a non-opioid medication was considered first.

Patients	Date(s) [on or about]
A, F	Nov. 26/15
B, B	Dec. 30/15
D, J 2	May 20/16
E, D	Oct. 25/16
O, J	Mar. 02/16; Mar. 07/16; Sept. 28/16; Sept. 30/16
U, J	Jun. 03/16

5. 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 2016, you recommended and/or provided an unnecessary dental service relative to one of your patents, namely L.V., contrary to paragraph 6 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about October 19, 2016, you claimed for restorations on 36OBDL and 37MO but there is no justification for placing the restorations documented in the patient chart, and therefore the treatment was unnecessary.

6. 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 2015 and 2016, you charged a fee that was excessive or unreasonable in relation to the service performed relative to the following patients, contrary to paragraph 31 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended:

   Particulars:

   - For patient J.O, on or about August 4, 2016, you billed/claimed for services where there is no corresponding chart entry. In particular:
     - You submitted and/or arranged for the submission on your behalf of a claim for services which indicated that the following services were rendered on or about August 4, 2016:

        - 01204 – specific examination; and
        - 33131 – endodontic treatment (Tooth 46).
    - There are no chart entries on August 4, 2016.

- For patient F.A., on or about November 13, 2015, you claimed for but did not document providing a complete examination and therefore the charge for a complete examination was excessive or unreasonable.
- For patient R.M., on or about August 11, 2016, you claimed for but did not document providing a recall examination, and therefore the charge for a recall examination was excessive or unreasonable.
- For patient L.V., on or about October 19, 2016, you claimed for restorations on 36OBDL and 37MO but there is no justification for placing the restorations documented in the patient chart, and therefore the charges for the restorations were excessive or unreasonable.

7. 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 2016 and 2017, you treated the following 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 such a consent, contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended:

    Particulars:

    - You provided restorative or endodontic treatment to six patients and failed to obtain their informed consent. Your records do not reflect that you discussed with the following patients the diagnosis, nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, the treatment alternatives available, the consequences of not having the treatment provided and/or the cost of each option.

Patients	Date(s) [on or about]
H, T	Mar. 22/16; Mar. 29/16
K, J	May 31/16
D, J 2	May 20/16
G, A	Jul. 28/16
O, J	Mar. 02/16; Jan. 19/17
U, J	Jun. 03/16

8. 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 2015, 2016 and 2017, 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:

   Particulars:

   - You provided restorative or endodontic treatment to six patients and failed to document their informed consent. Your records do not reflect that you discussed with the following patients the diagnosis, nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, the treatment alternatives available, the consequences of not having the treatment provided and/or the cost of each option.

Patients	Date(s) [on or about]
H, T	Mar. 22/16; Mar. 29/16
K, J	May 31/16
D, J 2	May 20/16
G, A	Jul. 28/16
O, J	Mar. 02/16; Jan. 19/17
U, J	Jun. 03/16

   - You prescribed opioid medication to six patients without justification or reason for the opioid prescription documented and you did not document that a non-opioid medication was considered first.

Patients	Date(s) [on or about]
A, F	Nov. 26/15
B, B	Dec. 30/15
D, J 2	May 20/16
E, D	Oct. 25/16
O, J	Mar. 02/16; Mar. 07/16; Sept. 28/16; Sept. 30/16
U, J	Jun. 03/16

   - You failed to document a diagnosis and/or treatment plan in the patient charts for the following patients involving 12 appointments.

Patients	Date(s) [on or about]	Procedures Performed
B, B	Sept. 08/15	27O
D, J 1	Feb. 18/16	85OB
D, J 2	May 20/16	Tooth 25 RCT

G, A	Jul. 28/16	13 RCT
	Aug. 04/16	21dl; 23mvd
O, J	Mar. 11/16	46 RCT
T, B	May 06/16	13B
	May 12/16	26O; 27OB; 23B
U, J	Jun. 28/16	22DILB; 21DILB; 12DIBL
V, L	Oct. 19/16	36DOBL; 37MO
Z, T	Jan. 05/16	32MIBL; 42MBL; 1MDBL;41MDBL
	Dec. 22/16	33IB; 43IB

- You failed to document the working lengths in the progress notes and/or document that an apex locator was used for three endodontic treatments that were provided to the following patients.

Patients	Date(s) [on or about]
D, J 2	May 20/16
G, A	Jul. 28/16
O, J	Mar. 02/16

- You failed to document that a rubber dam was used for root canal treatment at the appointments for the following patients:
    - The intra-operative periapical radiographs do not appear to demonstrate the presence of a rubber dam clamp; and/or there does not appear to be documentation in the chart entries that a rubber dam was used.

Patients	Date(s) [on or about]
D, J 2	May 20/16
G, A	Jul. 28/16
H, T	Mar. 29/16
O, J	Mar. 02/16
U, J	Jun. 03/16

- For patient T.H., on or about March 10, 2016, you failed to document a comprehensive description of the treatment that was provided on tooth 33 or tooth 34.
- For patient J.O., on or about August 4, 2016, you billed/claimed for services where there is no corresponding chart entry.
- For patient F.A., on or about November 13, 2015, you claimed for a complete examination but the documentation associated with a complete examination is incomplete.
- For patient B.B., on or about December 14, 2015, you claimed for a restoration on tooth 18 MODB but documented that a restoration was placed on tooth 25 MODB.

- For patient J.D. 2, on or about May 20, 2016, you claimed for a restoration on the mesial surface of tooth 25 but the radiographs show that a restoration was placed on tooth 25 DOB.
- For patient T.H., on or about February 16, 2016, you failed to complete the dental history form.
- For patient B.T., on or about May 12, 2016, you provided restorations but your progress notes do not contain sufficient detail, including the materials and methods used in the treatment that was provided.
- For patient M.P., on or about February 22, 2017, you failed to document instructions with respect to the drug prescribed.

9. 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 2016, 2017 and 2018, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to the following patients, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended:
   Particulars:

   - 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:
     - For patient A.G., you provided four prescriptions for Oxycocet between April 25, 2018 and June 2, 2018.
     - For patient J.O., you provided four prescriptions for Oxycocet between March 2, 2016 and September 30, 2016.
     - For patient B.T., you provided nine prescriptions for Oxycocet between April 5, 2017 and August 18, 2017.
   - Based on the number and frequency of narcotic medication you prescribed to your patients, 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 patients.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1, or by electronic hearing as required. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

(1) directing the Registrar to revoke your certificate of registration;

(2) directing the Registrar to suspend your certificate of registration for a specified period of time;

(3) directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;

(4) requiring you to appear before the panel to be reprimanded;

(5) requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

1. the College's legal costs and expenses;

2. the College's costs and expenses incurred in investigating the matter; and

3. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code.* You or your representative may contact the solicitor for the College, [redacted], in this matter at:

[redacted]

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 21st day of January, 2021.

[Seal]

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. KEVIN F. M. BACCHUS,** of the City of Wallaceburg, 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.

NOTICE OF HEARING

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO
6 Crescent Road
Toronto ON M4W 1T1
Telephone: 416-961-6555
Fax: 416-961-5814

21-0432

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. KEVIN F. M. BACCHUS,** of the City of Wallaceburg, 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.

TO: DR. KEVIN F.M. BACCHUS
1231 Dufferin Ave
Wallaceburg, ON N8A 2W3

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

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, in or around the year 2013, 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, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or around the year 2013, you failed to maintain appropriate professional boundaries with Person C, while she was your employee.

   - In or around the year 2013, you engaged in touching of an inappropriate nature with

Person C by providing her a massage on one or more occasions.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1, or by electronic hearing as required. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

(1) directing the Registrar to revoke your certificate of registration;

(2) directing the Registrar to suspend your certificate of registration for a specified period of time;

(3) directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;

(4) requiring you to appear before the panel to be reprimanded;

(5) requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

1. the College's legal costs and expenses;

2. the College's costs and expenses incurred in investigating the matter; and

3. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code.* You or your representative may contact the solicitor for the College [redacted], in this matter at:

[redacted]

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 18th day of May, 2021.

[Seal]

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. KEVIN F. M. BACCHUS,** of the City of Wallaceburg, 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.

NOTICE OF HEARING

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