H200008

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. GREGORY HOOPER**, of the City of Niagara Falls, 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 PUBLICATION BAN

This is formal notice that on June 2, 2021, the panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario made an Order directing that no person shall publish or broadcast the identity of any patients of the Member, or any information that could disclose the identity of any patients who are named in the Notice of Hearing and/or the Agreed Statement of Facts in this matter.

This Order is made pursuant to subsection 45(3) of the *Code*.

Subsection 93(1) of the *Code* reads:

93(1) Every person who contravenes an order made under subsection 7(3) or Section 45 or 47, or who contravenes subsection 76(3), 82(2) or (3), 85.2(1), 85.5(1) or (2) or 85.14(2) or Section 92.1 is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than $50,000 for a first office and not more than $200,000 for a second or subsequent offence.

June 2, 2021

Dr. Richard Hunter, Chair
Discipline Panel

Date

H200008

THE DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 ("*Code"*) respecting one **DR. GREGORY HOOPER,** of the City of Niagara Falls, in the Province of Ontario;

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

AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Rajiv Butany, Professional Member
Mr. Brian Smith, Public Member

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Paul Le Vay
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	

	)	Hollie Duncan, with Dr. Helene Goldberg
	)	for the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. GREGORY HOOPER	)	Josh Koziebrocki and Jakub Schnitzler for the Member
	)	

Hearing held by way of videoconference

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on June 2, 2021. This matter was heard electronically.

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

The College also sought to amend the Notice of Hearing to correct a typographical error in allegation number 1: that the allegations in respect of patient R.C. were only in respect of 2016, not 2019. The Member consented and the Panel granted the order.

THE ALLEGATIONS

The allegations against the Member were contained in the Notice of Hearing, dated June 15, 2020 (Exhibit 1).

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that, during the years 2015, 2016, and 2017, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to the following patients, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patients	Year(s)
T. A	2016
L.A.	2016
J. B	2016
M. B	2016
A. B	2016
J. B	2016
D. C	2016, 2017
T. C	2016
N. C	2016
P. C	2016
C. C	2017
S. C	2017
R. C	2016, ~~2019~~
P. D	2017
J. D	2016
T. D	2015, 2016, 2017
R. D	2017
J. D	2015
B. E	2017
K. E	2016
N. F	2016
S. G	2015
J. H	2017
A. H	2016
S. H	2017
R. H	2017
L. H	2017
B. H	2016
J. H	2017
H. L	2016
M. H	2017
A. H	2017
W. H	2017
A. J	2016
B. J	2016
H. K	2016
M. K	2016
J. K	2015
J. K	2016
M. K	2017

D. K	2015
K, K	2016
P. L	2017
C. L	2017
R. L	2017
M. L	2016
S. L	2017
J. L	2017
J. M	2016
J. M	2016
J. M	2015, 2016
S. M	2017
S. M	2017
J. M	2017
T. M	2017
J. N	2015, 2016
A. N	2016
C. N	2017
A. O	2017
P. O	2016
S. O	2017
W. P	2016
J. P	2017
W. R	2016
A. R	2015, 2016
S. R	2015
M. R	2016, 2017
D. S	2017
A. S	2017
S. S	2015, 2016
B. S	2016
M. S	2016
B. S	2017
D. S	2016
K. S	2017
M. S	2017
G. S	2017
M. T	2017
V. V	2017
D. V	2017
P. W	2017
A. W	2015

D. W	2017
A. W	2016
E.B. Y	2016
M. Z	2017

Particulars

- You prescribed opioid medication without justification in that you did not document an appropriate diagnosis or assessment of the patient's pain, rationale for the narcotic prescription, or that you had tried a non-opioid medication first. Specifically:

    - For three patients, in 24 cases, no rationale (i.e., diagnoses, symptoms or chart entries), for the narcotic prescribed was documented/found (R. C, T. D, and J.N).
    - For three patients, in eight cases, the conditions, treatment or symptoms as documented in the chart entries (i.e. insertion of loose bridge, denture sore spot adjustment, bite adjustment, dental reline), do not usually warrant a prescription for narcotics (T.D, S.H, D.V).
    - For 18 patients, involving 45 cases, where opioids were historically prescribed for treatment and/or symptoms documented in the chart entry, it appears that a non-opioid (acetaminophen or NSAID) was not provided/considered prior to adding an opioid (T.A, A. B, D.C, R.C, T. D, B. E, S. H, B. H, C. L, J. M, J. N, A. N, M. R, B. S, D. S, M. S D. V, and P. W).
    - For two patients, in eight cases, the symptom was documented (i.e. "ache" or "pain") without documentation of further investigation (i.e., vitality testing) to justify the narcotics prescribed (T. D - Dec 11/15, Jan 29/16, Mar 11/16, Apr 25/16, May 09/16, Feb 07/17, Oct 19/17 and J. P - Jul 03/17).

- You did not limit the number of tablets of opioids dispensed to your patients in accordance with the College's Guidelines *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice* (November 2015). Specifically:

    - For 16 patients, involving 66 prescriptions, where the patient records were obtained, the number of tablets prescribed was not in accordance with the College's Guidelines, and you failed to document a rationale as to why the recommended maximum was

exceeded (T. D, J. N, R. C[redacted], B. H, D. C, J. P, M. R, B. S, D. S, M. S, P. W, T. A, S. H, J. M, C. L, A. N).

- For 69 patients, involving 75 prescriptions, where the patient records were not obtained, the number of tablets prescribed was not in accordance with the College's Guidelines, and you failed to document a rationale as to why the recommended maximum was exceeded (*Patients' Names Redacted*).

- The number of prescriptions for Oxycodone 5mg combinations (e.g., Percocet) for two patients was not limited to three, as per the Guidelines *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice* (November 2015). The prescriptions were written at an inappropriate frequency with no associated documentation of a proper assessment of the patient with respect to the patient's pain and medical history (T. D and D. V).

- You prescribed opioid medication to one patient, in nine instances, and did not document the prescription in the patient chart or retain a copy of the prescription in the patient record (T. D).

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, 2016, 2017, and 2018, you prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs relative to one or more of your patients, contrary to paragraph 10 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You prescribed opioid medication without justification in that you did not document an appropriate diagnosis or assessment of the patient's pain, rationale for the narcotic prescription, or that you had tried a non-opioid medication first. Specifically:

  - For three patients, in 24 cases, no rationale (i.e., diagnoses, symptoms or chart entries), for the narcotic prescribed was documented/found (R. C, T. D, and J. N).
  - For three patients, in eight cases, the conditions, treatment or symptoms as documented in the chart entries (i.e. insertion of loose bridge, denture sore spot adjustment, bite adjustment,

dental reline), do not usually warrant a prescription for narcotics (T. D, S. H, D. V).

- For 18 patients, involving 45 cases, where opioids were historically prescribed for treatment and/or symptoms documented in the chart entry, it appears that a non-opioid (acetaminophen or NSAID) was not provided/considered prior to adding an opioid (T. A, A. B, D. C, R. C, T. D, B. E, S. H, B. H, C. L, J. M, J. N, A. N, M. R, B. S, D. S, M. S, D. V, and P. W).
- For two patients, in eight cases, the symptom was documented (i.e. "ache" or "pain") without documentation of further investigation (i.e., vitality testing) to justify the narcotics prescribed (T. D - Dec 11/15, Jan 29/16, Mar 11/16, Apr 25/16, May 09/16, Feb 07/17, Oct 19/17 and J. P - Jul 03/17).

- You did not limit the number tablets of opioids dispensed to your patients in accordance with the College's Guidelines *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice* (November 2015). Specifically:

  - For 16 patients, involving 66 prescriptions, where the patient records were obtained, the number of tablets prescribed was not in accordance with the College's Guidelines, and you failed to document a rationale as to why the recommended maximum was exceeded (T. D, J. N, R. C, B. H, D. C, J. P, M. R, B. S, D. S, M. S, P. W, T. A, S. H, J. M, C. L, A. N).
  - For 69 patients, involving 75 prescriptions, where the patient records were not obtained, the number of tablets prescribed was not in accordance with the College's Guidelines, and you failed to document a rationale as to why the recommended maximum was exceeded (*Patients' Names Redacted*).

- The number of prescriptions for Oxycodone 5mg combinations (e.g., Percocet) for two patients was not limited to three, as per the Guidelines *The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice* (November 2015). The prescriptions were written at an inappropriate frequency with no associated documentation of a proper assessment of the patient with respect to the patient's pain and medical history (T. D and D. V).

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 failed to keep records as required by the Regulations relative to one or more of your patients, namely, T. D, B. H, M. R, P. W, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- For six prescriptions, involving two patients, where there is documentation in the patient chart of a narcotic and/or antibiotic prescription provided, although the name of the drug prescribed and quantity is noted, there does not appear to be documentation of the full instructions of use (T. D, B. H).

- For one patient, in nine instances, the narcotic prescriptions were not documented/found in chart entries (T. D).

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, 2016, 2017 and 2019, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - Based on the number and frequency of narcotic medication you prescribed to your patients, 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.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in the Notice of Hearing, marked as Exhibit 1 and set as set out above.

The Panel confirmed with the Member that he understood the effect of his admissions and as such was satisfied that Member's admissions were voluntary, informed and unequivocal. A written plea inquiry was entered as Exhibit 2.

THE EVIDENCE

On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 3) which substantiated the allegations. The Agreed Statement of Facts provides as follows:

Background

1. Dr. Gregory Hooper has been registered with the College as a general dentist since 1989.

2. At the relevant times, Dr. Hooper operated a dental practice in Niagara Falls, Ontario.

Facts and Admissions

3. Dr. Hooper admits to the allegations and particulars as set out in the Notice of Hearing dated June 15, 2020.

4. Dr. Hooper further admits that these allegations, together with the particulars and facts set out in the Notice of Hearing and this Agreed Statement of Facts, constitute professional misconduct, as set out in the Professional Misconduct Regulation.

5. The allegations of professional misconduct first came to the attention of the College as a result of a letter dated January 22, 2018 from Dr. Hooper self-reporting to the College that he had been overprescribing opioids to [redacted] T.D[redacted]. Dr. Hooper said he was prompted to send in the letter because a former colleague that he is in litigation with was extorting him and threatening to report him to the College.

6. The Registrar appointed an investigator under section 75(1)(a) of the Health Professions Procedural Code, on January 31, 2018 with respect to whether Dr. Hooper had committed an act of professional misconduct regarding his prescribing practices and recordkeeping around prescribing. The appointment was approved by the Inquiries, Complaints and Reports Committee (ICRC).

7. On February 13, 2018 information was obtained from the Narcotics and Controlled Drug Claims on the Narcotics Monitoring System (NMS) for Dr. Hooper covering the dates January 1, 2015 to February 5, 2018.

8. On March 9, 2018 the investigator attended at Dr. Hooper's office and obtained 20 patient records, selected based on the information in the NMS report.

9. A summary of the investigation is set out in the Registrar's Report, dated January 29, 2020. The Registrar's Report sets out that according to the NMS system, the total number of prescriptions of narcotics and controlled drugs from November 1, 2015 to June 25, 2018 was 207 prescriptions for 122 patients for Tylenol #2 and #3, Percocet and Benzodiazepines. The Registrar's Report analyzed the information that the College obtained from the NMS system and also analyzed the prescribing practices in the 20 patient records that were specifically obtained by the College.

10. The Registrar's Report comprehensively details, on a patient by patient basis, the prescriptions written, the associated rationale and documentation, if any, and whether or not the prescriptions for narcotics and benzodiazepines appear to be justified or not and if they were prescribed in accordance with the College's Guidelines The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice (November 2015).

11. Overall, the Registrar's Report details that of the 207 prescriptions in the 20 patient charts, it seemed that 85 of them did not appear to be justified.

12. Dr. Hooper was provided with a copy of the Registrar's Report and given an opportunity to respond. On February 25, 2020, the College received Dr. Hooper's response. Dr. Hopper stated in his response

that he was "a bit alarmed and ashamed at this micro-representation of my past prescribing habits, and am so grateful that those days with all patients, including patient X (T.D.), [redacted] are well behind me." Dr. Hooper also stated that he was taking continuing education courses to update his pharmacological knowledge base and he is aware of his "past actions".

13. A panel of the ICRC met to consider this matter on May 4, 2020. The panel reviewed the matter, including the Registrar's Report, Dr. Hooper's response and a prior decision in respect of Dr. Hooper, as is required by the legislation. The panel formed an intention to refer specified allegations of professional misconduct to the Discipline Committee. The panel offered Dr. Hooper an opportunity to make written submissions to the panel at its next meeting before it finalized its decision.

14. Dr. Hooper provided a response for the ICRC's consideration on June 2, 2020. He described the time period covered by the investigation as a time of extreme stress in his life, due to several professional and personal matters. He wrote that he was attempting to reduce stress in his life to provide better patient care. Dr. Hooper reiterated that he had continued to update his knowledge base and was aware of his past errors.

15. On June 8, 2020 a panel of the ICRC confirmed its intention and issued a decision to refer specified allegations of professional misconduct to the Discipline Committee. The allegations of professional misconduct against Dr. Hooper are set out in the Notice of Hearing dated June 15, 2020 (Appendix A).

A. Allegations 1 and 2 – Improper Prescribing Practices

16. An examination of the patient files and information from the NMS monitoring system revealed improper prescribing practices in respect of 86 patients between 2015 and 2017, as follows:

    a. Dr. Hooper did not document an appropriate diagnosis or assessment of the patient's pain, rationale for the narcotic prescription or that he tried a non-opioid medication first. Specifically:

- For three patients, in 24 cases, no rationale for the narcotic prescribed was documented/found.

- For three patients, in eight cases, the conditions, treatment or symptoms as documented in the chart entries do not usually warrant a prescription for narcotics.

- For 18 patients, involving 45 cases, where opioids were historically prescribed for treatment and/or symptoms documented in the chart entry, it appears that a non-opioid (acetaminophen or NSAID) was not provided/considered prior to adding an opioid.

- For two patients, in eight cases, the symptom was documented without documentation of further investigation to justify the narcotics prescribed.

b. Dr. Hooper did not limit the number of tablets of opioids dispensed to his patients according to the College's Guidelines on The Role of Opioids in the Management of Acute and Chronic Pain in the Dental Practice (the "Opioid Guidelines", attached at Appendix C). Specifically:

- For 16 patients, involving 66 prescriptions, where the patient records were obtained, the number of tablets prescribed was not in accordance with the Opioid Guidelines, and he failed to document a rationale as to why the recommended maximum was exceeded.

- For 69 patients, involving 75 prescriptions, where the patient records were not obtained, the number of tablets prescribed was not in accordance with the Opioid Guidelines, and he failed to document a rationale as to why the recommended maximum was exceeded.

c. Dr. Hooper did not prescribe opioids for two patients at an appropriate frequency according to the Opioid Guidelines, by not limiting the number of consecutive prescriptions to a maximum of three. The prescriptions were written at an inappropriate frequency with no associated documentation of a proper assessment of the patient with respect to the patient's medical history.

d. Dr. Hooper prescribed opioid medication to one patient, in nine instances, and did not document the prescription in the patient chart or retain a copy of the prescription in the patient record.

17. The Opioid Guidelines set out the following requirements in respect of prescribing opioids:

- Opioids should only be prescribed in appropriate cases, taking into consideration the diagnosis or clinical indication. Before prescribing an opioid, the dentist should consider whether the patient's pain is well documented, whether the patient is currently taking an opioid, and/or whether the patient's medical history suggests signs of substance misuse, abuse and/or diversion;

- Before prescribing an opioid, dentists should consider alternatives, including NSAIDs;

- Dentists who prescribe an opioid should place reasonable limits on their prescriptions and consider opportunities for collaborating with other health care professionals. If the use of an opioid is determined to be appropriate, the dentist should limit the number of tablets dispensed, generally as follows: codeine 15mg, to a maximum of 36 tablets; codeine 30mg, to a maximum of 24 tablets; oxycodone 5mg, to a maximum of 24 tablets;

- Dentists should also limit the number of consecutive prescriptions to a maximum of three; and

- Long term use of such medication should be avoided, whenever possible.

18. Dr. Hooper acknowledges that he prescribed opioids on numerous occasions without documenting the required consideration of whether it was appropriate. He also did not limit the number of tablets (or document why the maximum was exceeded) on numerous occasions, nor prescribe at the appropriate frequency (i.e., he provided more than three consecutive prescriptions). He also prescribed opioids in cases where the medication was not indicated

based on the treatment or condition, or where treatment was not rendered.

19. Therefore, Dr. Hooper admits that he contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of Section 2 of Ontario Regulation 853.

20. Further, Dr. Hooper admits that he prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs, contrary to paragraph 10 of Section 2 of Ontario Regulation 853.

B. Allegation 3 – Failure to Keep Records as Required

21. An examination of the patient files revealed that Dr. Hooper failed to keep records as required in respect of two patients between 2015 and 2018, as follows:

- Dr. Hooper prescribed opioid medication and/or antibiotics for two patients, involving six prescriptions, but did not document the full instructions of use in the patient chart.

- Dr. Hooper prescribed opioid medication for one patient, in nine instances, but did not document the prescription in the patient chart.

22. Dr. Hooper's professional, ethical and legal responsibilities dictate that he maintain a complete record documenting all aspects of each patient's dental care, pursuant to the Dental Recordkeeping Guidelines (November 2019) (attached at Appendix D), and s. 38 of Regulation 547. In particular, the College's Dental Recordkeeping Guidelines state that the progress notes for each visit should provide a concise and complete description of all services rendered and include any drugs prescribed, dispensed or administered, including the quantity and dose of each. Dentists must also document the patient's condition, a diagnosis and treatment plan, and justification for treatment recommendations (which would include medication prescriptions).

23. In addition, the Opioid Guidelines require dentists to document the following information when issuing a prescription: name of the

patient, full date (day, month and year), name of the drug, drug strength and quantity or duration of therapy, full instructions for use of the drug, refill instructions, if any, printed name of prescriber, address and telephone number of the dental office where the patient's records are kept, signature of prescriber or appropriate electronic identifier.

24. Dr. Hooper acknowledges that he did not document a prescription, or retain a copy, on numerous occasions. In other cases, he did not include the required information about the prescription including instructions for the use of the medication prescribed.

25. Dr. Hooper acknowledges that he breached his professional, ethical and legal responsibilities that required him to maintain a complete record documenting all aspects of each patient's dental care, per the College's Dental Recordkeeping Guidelines, and s. 38 of Regulation 547.

26. Therefore, Dr. Hooper admits that he failed to keep records as required by the Regulations relative to the patients listed in the Notice of Hearing dated June 15, 2020, contrary to paragraph 25 of Section 2 of Regulation 853, as set out in Allegation 3 of the Notice of Hearing.

A. Allegation 4 – Lack of Professional Judgment

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

28. Dr. Hooper acknowledges that he failed to demonstrate reasonable professional judgment in his prescribing practices with respect to his patient T. D , in light of the high number and frequency of narcotics prescribed to her (40 prescriptions for Percocet over a two year period, totaling 1392 tablets). He also did not demonstrate any awareness of the potential of harm to her, [redacted] and the possibility that she may be working while taking high volumes of narcotics.

29. If Dr. Hooper were to testify, he would state that T.D. suffers from gastrointestinal issues, and as a result is unable to tolerate

nonsteroidal anti-inflammatory drugs ("NSAIDS") for pain relief. During T.D. time as Dr. Hooper's patient, she suffered from severe dental pain from her numerous dental procedures, as well as from her chronic bruxism, and was provided with medications for pain relief at a number of appointments. The use of NSAIDs was contraindicated. T.D. treatment needs became increasingly complex and invasive as she required more root canals and extractions, particularly between the years 2009 and 2017. In assessing T.D, Dr. Hooper determined that Tylenol #3 was not sufficient to address her increased pain levels. In these circumstances, Dr. Hooper prescribed T.D. Percocet for pain relief. Dr. Hooper would testify that his only motivation was to address T.D's dental pain and had no improper purpose in prescribing any medications to T.D.

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

31. Given that he was prescribing T.D. at least 3 tablets per day, he further admits that he did not demonstrate awareness of the potential harm that the over-prescription of opioid medication could have on his patient [redacted].

32. Therefore, Dr. Hooper admits that he engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical, contrary to paragraph 59 of Section 2 of Ontario Regulation 853.

Past History

33. Dr. Hooper has no prior findings of professional misconduct.

Summary

34. Dr. Hooper admits the facts as set out in the Allegations and particulars in the Notice of Hearing, to which he has pleaded guilty, and admits the facts as set out above.

35. Dr. Hooper further admits that these acts constitute professional misconduct.

36. Dr. Hooper has obtained independent legal advice with respect to his admissions.

DECISION AND REASONS FOR DECISION

In light of the parties' agreement as to the facts and the Member's admissions, the Panel finds that Dr. Hooper engaged in professional misconduct as alleged in the Notice of Hearing.

The Member admitted the four (4) allegations of professional misconduct as set out in the Notices of Hearing and accepted the facts as presented in the Agreed Statement of Facts.

The Panel is of the view that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations that Dr. Hooper committed the acts of professional misconduct outlined therein and in particular, that he:

- contravened a standard of practice or failed to maintain the standards of practice of the profession
- prescribed, dispensed or sold a drug for an improper purpose, or otherwise used improperly, the authority to prescribe, dispense or sell drugs
- failed to keep records as required
- failed to demonstrate reasonable professional judgement when prescribing narcotics

PENALTY SUBMISSIONS

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

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

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

(b) directing the Registrar to suspend the Member's certificate of registration for a period of two (2) months, to be served consecutively, such suspension to commence within sixty (60) days of this Order becoming final;

(c) that the Registrar impose the following terms, conditions and limitations on the Member's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 1(b) above has been fully served, namely:

(i) while the Member's certificate of registration is under suspension, the Member shall immediately inform the following people about the suspension:
   a. staff in the offices or practices in which the Member works, including other regulated professionals and administrative staff
   b. dentists with whom the Member works, whether the Member is a principal in the practice or otherwise associated with the practice
   c. dentists or other individuals who routinely refer patients to the Member
   d. faculty members at Faculties of Dentistry, if the Member is affiliated with the Faculty in an academic or professional capacity
   e. owners of a practice or office in which the Member works
   f. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Member may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

(ii) while suspended, the Member must not engage in the practice of dentistry, including but not limited to:
   a. acting in any manner that suggests the Member is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Member must ensure that administrative or office staff do not suggest to patients in any way that the Member is entitled to engage in the practice of dentistry
   b. giving orders or standing orders to dental hygienists

c. supervising work performed by others
d. working in the capacity of a dental assistant or performing laboratory work
e. acting as a clinical instructor;

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

(iv) while suspended, the Member must not benefit or profit, directly or indirectly from the practice of dentistry.
a. The Member may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Member may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.
b. The Member is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.
c. The Member must not sign insurance claims for work that has been completed by others during the suspension period;

(v) the Member shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Member has complied with the Suspension Conditions. The Member must provide the College with access to any records associated with the practice that the College may require to verify that the Member has not engaged in the practice of dentistry or profited during the suspension; and

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

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

(i) requiring that the Member successfully complete, at his own expense, a one-on-one comprehensive pharmacology course with a focus on: prescribing analgesics, including opioids; a review of the College's Guidelines on the Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice; and recordkeeping, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

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

(iii) the Member's practice shall be monitored by the College by means of office visit(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the date of the finalization of this Order and ending twenty-four (24) months from the College receiving proof of the Member's successful completion of the course(s) referred to above, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(iv) that the Member shall cooperate with the College during the office visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1,000.00 per office visit, such amount to be paid immediately after completion of each of the office visit(s);

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

(vi) the Practice Conditions imposed by virtue of subparagraphs (1)(d)(i)-(ii) above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses described in subparagraphs (1)(d)(i)-(ii) above have been completed successfully;

(vii) the Practice Condition imposed by virtue of subparagraph (1)(d)(iii) above shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the

Registrar that the requirements set out in subparagraphs (1)(d)(i)-(ii) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

(e) that the member pay costs to the College in the amount of $5,000.00 in respect of this discipline hearing, such costs to be paid in full within six (6) months of this Order becoming final.

2. The panel accepts the voluntary undertaking signed by the Member on May 18, 2021 permitting his practice to be monitored by the College through the Narcotics and Controlled Drug Claims on the Narcotics Monitoring System (NMS) from the time the order of the Discipline Committee becomes final until the end of the monitoring period.

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

4. This joint submission on penalty and costs was reached as a result of a pre-hearing conference held with respect to these matters and it received the endorsement of the pre-hearing conference presider.

5. Dr. Gregory Hooper has not previously appeared before the Discipline Committee of the College.

The parties also filed an Undertaking signed by the Member (Exhibit 5) in which he agreed to permit his practice to be monitored through the College through the Narcotics and Controlled Drugs Claims on the Narcotics Monitoring System until the end of the monitoring period set out in the joint submission on penalty.

PENALTY DECISION

The Panel accepts the Joint Submission on Penalty and accordingly orders:

.

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

(b) The Registrar is directed to suspend the Member's certificate of registration for a period of two (2) months, to be served consecutively, such suspension to commence within sixty (60) days of this Order becoming final;

(c) The Registrar shall impose the following terms, conditions and limitations on the Member's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 1(b) above has been fully served, namely:

(i) while the Member's certificate of registration is under suspension, the Member shall immediately inform the following people about the suspension:
   a. staff in the offices or practices in which the Member works, including other regulated professionals and administrative staff
   b. dentists with whom the Member works, whether the Member is a principal in the practice or otherwise associated with the practice
   c. dentists or other individuals who routinely refer patients to the Member
   d. faculty members at Faculties of Dentistry, if the Member is affiliated with the Faculty in an academic or professional capacity
   e. owners of a practice or office in which the Member works
   f. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Member may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

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

(iii) while suspended, the Member must not be present in offices or practices where the Member works when patients are

present, except for emergencies that do not involve patients. The Member must immediately advise the Registrar in writing about any such emergencies;

(iv) while suspended, the Member must not benefit or profit, directly or indirectly from the practice of dentistry.
   a. The Member may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Member may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.
   b. The Member is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.
   c. The Member must not sign insurance claims for work that has been completed by others during the suspension period;

(v) the Member shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Member has complied with the Suspension Conditions. The Member must provide the College with access to any records associated with the practice that the College may require to verify that the Member has not engaged in the practice of dentistry or profited during the suspension; and

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

(d) The Registrar is directed to also impose the following additional terms, conditions and limitations on the Member's Certificate of Registration (the "Practice Conditions"), namely:

(i) requiring that the Member successfully complete, at his own expense, a one-on-one comprehensive pharmacology course with a focus on: prescribing analgesics, including opioids; a review of the College's Guidelines on the *Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice*; and recordkeeping, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(ii) requiring that the Member successfully complete, at his own expense, the ProBE Program on Professional/Problem-Based

Ethics, to be completed with an "unconditional pass" within twelve (12) months of this Order becoming final;

(iii) the Member's practice shall be monitored by the College by means of office visit(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the date of the finalization of this Order and ending twenty-four (24) months from the College receiving proof of the Member's successful completion of the course(s) referred to above, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(iv) that the Member shall cooperate with the College during the office visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1,000.00 per office visit, such amount to be paid immediately after completion of each of the office visit(s);

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

(vi) the Practice Conditions imposed by virtue of subparagraphs (1)(d)(i)-(ii) above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses described in subparagraphs (1)(d)(i)-(ii) above have been completed successfully;

(vii) the Practice Condition imposed by virtue of subparagraph (1)(d)(iii) above shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in subparagraphs (1)(d)(i)-(ii) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

(e) that the member pay costs to the College in the amount of $5,000.00 in respect of this discipline hearing, such costs to be paid in full within six (6) months of this Order becoming final.

3. The panel accepts the voluntary undertaking signed by the Member on May 18, 2021 permitting his practice to be monitored by the College through the Narcotics and Controlled Drug Claims on the Narcotics Monitoring System (NMS) from the time the order of the Discipline Committee becomes final until the end of the monitoring period.

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

REASONS FOR PENALTY DECISION

The Panel is aware that joint submissions should be respected unless they fall so far outside the range of an appropriate sanction that they would bring the administration of justice at the College into disrepute or are otherwise contrary to the public interest.

The Panel found that the Joint Submission on Penalty and Costs was appropriate. A 2 month suspension and 2 years of office monitoring at the Member's expense will adequately serve to protect the public and serve as specific and general deterrents. The decision on penalty sends a strong message to the profession that conduct of this nature will not be tolerated by the College.

Courses in Pharmacology, specifically prescribing practices of narcotics and ProBe (ethics) will assist in remediation.

In reaching this decision, the Panel is mindful of the seriousness of the misconduct and is deeply concerned by disregard demonstrated by the Member for his patients' well being. Inappropriate narcotic prescribing practices is unacceptable.

Mitigating factors the Panel considered was the Member's self reporting to the College and his cooperation with the investigation. This is Dr. Hooper's first appearance before the Discipline Committee and he pled guilty preventing a more costly and lengthy hearing.

Following the completion of the hearing, the Member confirmed that he was prepared to receive his reprimand and so the Panel delivered the reprimand, a version of which is attached to the end of these Reasons as Appendix A.

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

Dr. Richard Hunter

June 23, 2021

Date

Appendix "A"
RCDSO v. DR. GREGORY HOOPER

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

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

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

The panel has found that you have engaged in multiple acts of professional misconduct. The misconduct relates to improper prescribing of narcotics to a large number of patients in your practice, including a lack of proper - and sometimes any - basis for the prescriptions and a failure to limit the prescriptions in accordance with the requirements for proper patient care and College guidelines. You also failed to keep proper records to justify the prescriptions you wrote. In so doing, you failed to maintain the standards of practice of the dental profession which requires dentists to carefully follow the proper guidance when prescribing drugs, especially ones with serious potential consequences for patients, like opioids. The public relies on our profession to exercise reasonable professional judgment when conducting this type of activity. You failed to do so. The cumulative effect of your conduct would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy. However, we recognize that these matters came to the Colleges attention as a result of your self-reporting and that you

have cooperated with the College and we recognize those positive steps on your part.

Of special concern to us is the fact that the professional misconduct in which you engaged has involved

- A failure on your part to be aware of the College's current guidelines on opioids which is something that every dentist must be aware of in order to maintain basic competence
- The degree to which to which your prescribing practices put patient well-being at risk

We are satisfied that the penalties that we have ordered are consistent with the College's mandate of public protection, in light of the serious nature of your conduct.

I trust that this hearing has been a learning experience for you and that the College will never again see you appear before the Discipline Committee.

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

Do you have any questions or do you wish to make any comments?

Thank you for attending today. We are adjourned.