Ohio State Dental Board
77 S. High Street, 17th Floor
Columbus, Ohio 43215-6135

(614) 466-2580 Tel
(614) 752-8995 Fax
Dental.Ohio.Gov

NOTICE OF OPPORTUNITY FOR HEARING
Case # 2024-00078

September 11, 2024

Peter Andrews, D.D.S (aka "Khaled Emile Hashem")
1263 Patriot Way
Beavercreek, Ohio 45434

VIA: RPost Registered Email
peteran2016@gmail.com; peterable2015@gmail.com

Dear Dr. Andrews,

In accordance with Chapter 119. of the Ohio Revised Code ("O.R.C."), you are hereby notified that the Ohio State Dental Board ("Board") proposes under the authority of O.R.C. Sections 4715.30 and 4715.03 to suspend, place on probationary status, revoke, refuse to renew, or refuse to reinstate, or censure your license to practice dentistry for the following reasons:

1. On or about January 12, 2021, you submitted a new license application to the Board, (Application) and on the Application answered, "No," to a question asking if you have been "suspended from practice, reprimanded, censured, or otherwise disciplined or disqualified as a dentist or a member of any profession? If yes, please state the dates, the facts, the disposition of the matter and the names and address of the authority in possession of the record thereof."

   Despite this, on or about June 18, 2014, the Royal College of Dental Surgeons of Ontario issued a Decision revoking your license to practice dentistry. The license to practice dentistry in Ontario was issued under a previous name, Dr. Khaled Emile Hashem. On October 15, 2014, the Ontario Superior Court of Justice issued an Order refraining you from using the titles, "dentist", "dental surgeon", "doctor", and practicing as a dentist. *Certified copies of the Royal College of Dental Surgeons of Ontario Decision and the Order of the Ontario Superior Court of Justice are attached hereto and incorporated herein.*

Section 4715.30(A)(1), O.R.C., authorizes the Board to discipline the holder of a license issued under this Chapter for, "Employing or cooperating in fraud or material deception in applying for

or obtaining a license or certificate." Section 4715.30(A)(15), O.R.C., authorizes the Board to discipline the holder of a license issued under this Chapter for, "Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand. The conduct alleged in paragraph (1) constitutes violations of Section 4715.30(A)(1), O.R.C., and Section 4715.30(A)(15), O.R.C.

Pursuant to Chapter 119. of the Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request a hearing, the request must be made in writing and must be received in the offices of the Board within thirty days of the date of service of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such a hearing in person, or by your attorney, or you may present your position, arguments or contentions in writing. At the hearing, you may present evidence and examine witnesses appearing for or against you.

If you timely request a hearing, you are entitled to receive a copy, if so requested, of each item the Board procures or creates in the course of the investigation at least sixty (60) days in advance of the hearing. Such items may include, but are not limited to, the one or more complaints filed with the Board, correspondence, reports and statements; deposition transcripts; and the patient(s) dental records. The Board may charge a reasonable fee for providing copies. Before providing the copies, the Board shall determine whether the investigative items contain any personal identifying information regarding a complainant. If the Board determines that the investigative items contain such personal identifying information, or any information that would reveal the identity of a complainant, the Board shall redact the information from the copies it provides. The Board shall not provide any information that is subject to the attorney-client privilege or work product doctrine, or that would reveal the investigatory processes or methods of investigation used by the Board. The Board shall not provide any information that would constitute a confidential law enforcement investigatory record.

If you do not request a hearing within thirty (30) days of the date of service of this Notice, the Board may, in your absence and upon consideration of the foregoing charges, determine whether or not to limit, suspend, place on probationary status, revoke, refuse to renew, or refuse to reinstate, or censure your license to practice dentistry.

BY THE ORDER OF THE OHIO STATE DENTAL BOARD

Supervisory Investigative Panel

KATHY BRISLEY-SEDON, DDS
Secretary

PAUL M. KELLEY, DDS
Vice Secretary

S E A L

CC: Katherine Bockbrader, Esq., Assistant Section Chief, Health and Human Services Section

I, Harry Kamdar, Executive Director of the Ohio State Dental Board, hereby certify that the foregoing Notice of Opportunity for Hearing was emailed to Peter Andrews, D.D.S, by RPost Registered Email on this 16th day of September 2024.

HARRY KAMDAR, MBA
Executive Director

S E A L

Royal College of
Dental Surgeons of Ontario

6 Crescent Road, Toronto, ON M4W 1T1
T: 416-961-6555 F: 416-961-5814
Toll Free: 1-800-565-4591 www.rcdso.org

March 13, 2024

Sent by email: Jerry.Zachariah@Den.Ohio.Gov
Hard copy to follow by registered mail

Jerry Zachariah
Enforcement Officer
Ohio State Dental Board
77 South High Street, 17th Floor,
Columbus, OH 43215

Dear Jerry Zachariah,

I write in response to your request dated February 28, 2024 for a certified copy of Dr. Khaled Emile Hashem's disciplinary decisions.

Please find attached a Certificate signed by the Registrar of the Royal College of Dental Surgeons of Ontario (RCDSO), Daniel Faulkner, on March 13, 2024. To his Certificate, Mr. Faulkner has attached four documents which are true copies of the originals:

1. The Decision of the Discipline Committee of the RCDSO for files H120011, H130001 and H130004 (undated)
2. The Reasons for Decision of the Discipline Committee of the RCDSO for files H120011, H130001 and H130004, signed on August 7, 2013
3. The Reasons for Decision of the Discipline Committee of the RCDSO for file H130016 signed on May 1, 2014
4. The Decision and Reasons – Penalty of the Discipline Committee of the RCDSO for file H130016 signed on June 18, 2014.

In addition, please find attached a copy of the order of the Honourable Justice Chapnick of the Ontario Superior Court of Justice in the matter of *RCDSO* v. *Khaled Emile Hashem* dated October 15, 2014. Sought by the RCDSO, this court order requires Khaled Emile Hashem to comply with the *Dentistry Act* and the *Regulated Health Professions Act, 1991*. In particular, Mr. Hashem must refrain from:

1. using the title "dentist", "doctor" or variations of such;
2. holding himself out as a person qualified to practise in Ontario as a dentist, dental surgeon or in a specialty of dentist;
3. performing any authorized of controlled acts related to the practise of dentistry; and

4. treating or advising a person about their health where foreseeable serious physical harm may result from such treatment or advice or omission thereof.

The Registrar of RCDSO has no oversight vis-à-vis the Ontario Superior Court of Justice. Accordingly, the copy of the court's order is not certified by the Registrar.

Please contact me if you have any other questions.

Sincerely,

Gillian Slaughter
Director, Professional Conduct and Regulatory Affairs
Royal College of Dental Surgeons of Ontario
Tel: (416) 934-5623
Email: gslaughter@rcdso.org

Attachments (2): Certificate of Registrar dated March 13, 2024
Copy of the Order of the Ontario Superior Court of Justice dated Oct. 15, 2014

Royal College of
Dental Surgeons of Ontario

6 Crescent Road
Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814
Toll Free: 1.800.565.4591 www.rcdso.org

CERTIFICATE OF REGISTRAR

I, Daniel Faulkner, Registrar of the Royal College of Dental Surgeons of Ontario, certify that the four attached documents, listed below, are true copies of the originals.

Decision H120011/H130001/H130004 (undated)

Reasons for Decision H120011/H130001/H130004 signed on August 7, 2013

Reasons for Decision H130016 signed on May 1, 2014

Decision and Reasons - Penalty H130016 signed on June 18, 2014

This Certificate is issued under the authority of section 88 of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991,* from information contained in records kept by me in the course of my duties.

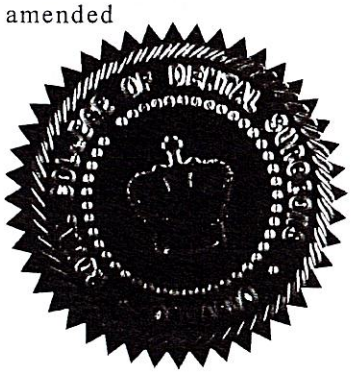
Date: March 13, 2024

Daniel Faulkner
Registrar

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. KHALED EMILE HASHEM**, of the City of Ottawa 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").



Certified True Copy

Members in Attendance: Dr. Rick Bohay (Chair)
Dr. Mark Cohen
Dr. Lance Burnham
Ms. Evelyn Laraya
Mr. Manohar Kanagamany

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Ms. Johanna Braden
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
- and -	)	Surgeons of Ontario
	)	
	)	Ms. Linda Rothstein
	)	For the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. KHALED EMILE HASHEM	)	Mr. Earl Heiber
	)	For Dr. Hashem

Hearing held on June 24, 2013.

DECISION

FINDING

Dr. Khaled Hashem ("the Member") pleaded guilty to the following specified allegations of professional misconduct:

Notice of Hearing #1 dated July 5, 2012 (File No. H120011)

1. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you failed to maintain the standards of practice of the profession in relation to one of your patients, namely K. P., contrary to paragraph 1 of section 2 of the Dentistry Act Regulation.

2. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991* in that, during the year 2011, you recommended or provided an unnecessary dental service in relation to one of your patients, namely K. P., contrary to paragraph 6 of section 2 of the Dentistry Act Regulation.

3. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent, in relation to one of your patients, namely K. P., contrary to paragraph 7 of section 2 of the Dentistry Act Regulation.

4. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you failed to keep records as required by the regulations in relation to one of your patients, namely K. P., contrary to paragraph 25 of section 2 of the Dentistry Act Regulation.

5. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you charged a fee that was excessive or unreasonable in relation to the service performed for one of your patients, namely K. P., contrary to paragraph 31 of section 2 of the Dentistry Act Regulation.

6. You committed an act or acts of professional misconduct as provided by

subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading in relation to one of your patients, namely K. P., contrary to paragraph 33 of section 2 of the Dentistry Act Regulation.

7. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical in relation to one of your patients, namely K. P., contrary to paragraph 59 of section 2 of the Dentistry Act Regulation.

Notice of Hearing #2 dated January 17, 2013 (File No. H130001)

1. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2012, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to your infection prevention and control practices, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

2. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2011 and/or 2012, 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 with respect to your infection prevention and control practices, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Notice of Hearing #3 dated March 25, 2013 (File No. H130004)

1. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, 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 the Dentistry Act Regulation:

Patients	Years
A. A.	2011, 2012
J. B.	2011
M. B.	2011, 2012
M. D.	2011, 2012
N. E.	2012

Patients	Years
S. E.	2012
C. G.	2011, 2012
E. H.	2010, 2011, 2012
M. H.	2010, 2011
J. I.	2010, 2011, 2012
V. L.	2012
C. L.	2011, 2012
C. L.	2011, 2012
C. L.	2011, 2012
C. L.	2011, 2012
W. L.	2011, 2012
N. M.	2011, 2012
A. P.	2011
V. P.	2012
T. S.	2011, 2012
M. V.	2012

2. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, 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 the Dentistry Act Regulation:

Patients	Years
B. A.	2011, 2012
J. B.	2011
M. B.	2011, 2012
M. D.	2011, 2012
N. E.	2012
S. E.	2012
C. G.	2011, 2012
E. H.	2010, 2011, 2012
M. H.	2010, 2011
J. I.	2010, 2011, 2012
V. L.	2012
C. L.	2011, 2012
C. L.	2011, 2012
C. L.	2011, 2012
C. L.	2011, 2012
W. L.	2011, 2012
N. M.	2011, 2012

Patients	Years
A. P.	2011
V. P.	2012
T. S.	2011, 2012
M. V.	2012

3. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, 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 the Dentistry Act Regulation:

Patients	Years
K. A.	2011
R. A.	2011
A. A.	2011, 2012
J. B.	2011
M. B.	2012
M. D.	2011
N. E.	2012
S. E.	2012
C. G.	2011, 2012
M. H.	2012
E. H.	2011
M. H.	2011
J. I.	2011, 2012
V. L.	2012
C. L.	2012
W. L.	2012
A. M.	2012
N. M.	2011
J. P.	2011
V. P.	2012
T. S.	2011, 2012
C. S.	2010, 2012

4. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2011 and 2012, you recommended and/or provided an unnecessary dental service relative to the following patients, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation:

Patients	Years
A. A.	2011, 2012
J. B.	2011
M. D.	2011
C. G.	2011, 2012
E. H.	2011
M. H.	2011
J. I.	2011, 2012
C. L.	2012
W. L.	2012
N. M.	2011
T. S.	2011, 2012

5. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, you failed to reply to a written enquiry made by the College, relative to the following patients, contrary to paragraph 58 of Section 2 of the Dentistry Act Regulation:

Patients	Years
A. A.	2010
M. B.	2010
E. H.	2011
M. H.	2010
G. M.	2012
N. M.	2012
J. P.	2011
C. S.	2012
M. V.	2012

6. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, you failed to keep records as required by the Regulations relative to the following patients, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation:

Patients
A. A.
K. A.
R. A.
J. B.
M. B.
M. D.

Patients

N. E.
S. E.
R. F.
C. G.
M. H.
E. H.
M. H.
J. I.
V. L.
C. L.
C. L.
C. L.
C. L.
W. L.
G. M.
A. M.
N. M.
A. P.
J. P.
V. P.
T. S.
C. S.
A. T.
M. V.

PENALTY

The panel of the Discipline Committee accepted a joint submission from the parties and imposed the following penalty upon the Member, namely:

1. That the Member appear before the panel of the Discipline Committee to be reprimanded, on a date to be fixed by the Registrar.

2. That the Registrar of the College suspend the Member's certificate of registration for a period of five (5) months. The suspension shall commence on the date of this Order and shall run without interruption.

3. That the Registrar impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 2 above has been fully served, namely:

(a) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

(b) during the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry during the suspension;

(c) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in the connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

(d) the conditions imposed in clauses 3(a)-(c) above shall be removed at the end of the period the Member's certificate of registration is suspended.

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

(a) the Member shall successfully complete, at his own expense, a course approved by the Registrar, in Periodontics, specifically, the diagnosis and management of periodontal disease, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(b) the Member shall successfully complete, at his own expense, the ProBE Program for Professional/Problem-Based Ethics, and provide proof of successful completion in writing to the Registrar within nine (9) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(c) the Member's practice shall be monitored by the College by means of inspection(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 that the College

received written proof of completion of the courses referred to in subparagraphs 4(a) and (b), and ending twenty-four months thereafter, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(d) the Member shall cooperate with the College during the inspection(s) and, further, shall pay to the College in respect of the cost of monitoring, the amount of $600.00 per monitoring, such amount to be paid immediately after completion of each of the inspections, provided that the overall cost of monitoring paid by the member does not exceed $2,400.00, regardless of the number of inspections performed;

(e) the representative or representatives of the College shall report the results of those inspections 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; and

5. the Member shall pay costs to the College in the amount of $1,500.00, within one (1) month of the completion of the period of suspension set out in paragraph 2.

Pursuant to the *Code*, the College's publication of this matter will include the Member's name and address.

The Discipline panel's reasons for the above decision will follow.

PUBLICATION BAN

The panel of the Discipline Committee also made an Order that there shall be a ban on the publication or broadcasting of the identity of any patients of the Member, or any information that could disclose the identity of any patients that are named in the Notices of Hearing and/or the Agreed Statement of Facts and/or any of the exhibits in this matter.

H120011, H130001, H130004

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. KHALED HASHEM**, of the City of Ottawa, in the Province of Ontario;

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

Members in Attendance: Dr. Richard Bohay (Chair)
Dr. Mark Cohen
Dr. Lance Burnham
Ms. Evelyn Laraya
Mr. Manohar Kanagamy

Certified True Copy

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Ms. Johanna Braden
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
- and -	)	Surgeons of Ontario
	)	
	)	Ms. Linda Rothstein
	)	For the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. KHALED HASHEM	)	Mr. Earl Heiber
	)	For Dr. Hashem

Hearing held on June 24, 2013.

REASONS FOR DECISION

This matter came on for hearing before a panel of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on June 24, 2013.

PUBLICATION BAN

At the commencement of the hearing, the panel of the Discipline Committee made an Order that there shall be a ban on the publication or broadcasting of the identity of any patients of the Member, or any information that could disclose the identity of any patients of the Member, that are named in the Notices of Hearing and/or the Agreed Statement of Facts and/or any of the exhibits in this matter.

THE ALLEGATIONS

There were three Notices of Hearing containing allegations against Dr. Khaled Hashem (the "Member"). They alleged as follows.

Notice of Hearing #1 (H120011)

1. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you failed to maintain the standards of practice of the profession in relation to one of your patients, namely K.P., contrary to paragraph 1 of section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about August 26, 2011, you took a periapical radiograph without providing the patient with radiation protection.
   - On or about August 26, 2011, you diagnosed tooth 47 as requiring endodontic treatment to relieve the patient's pain and recommended a pulpectomy even though your progress notes of that same date do not support that tooth 47 required endodontic intervention.
   - On or about August 26, 2011, you failed to use a rubber dam for the pulpectomy.
   - On or about August 26, 2011, you used instruments for the patient's treatment that were not properly sterilized.
   - On or about August 26, 2011, during the course of treatment you left the patient with your surgical gloves on to use the telephone, and subsequently returned to the patient with the same surgical gloves on and continued providing treatment.
   - On or about August 26, 2011, you provided a substandard pulpectomy in that:

- you failed to adequately remove the roof of the pulp chamber, remove the pulpal and radicular tissue and expose all the canals in the tooth and
- you failed to provide an adequate endodontic access opening by not directing the opening properly into the pulp chamber and instead directing it too much to the mesial of the tooth.

2. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991* in that, during the year 2011, you recommended or provided an unnecessary dental service in relation to one of your patients, namely K.P., contrary to paragraph 6 of section 2 of the Dentistry Act Regulation.

Particulars:

- On or about August 26, 2011, you performed a pulpectomy the need for which was not justified by your records.
- On or about August 26, 2011, you performed surgical curettage the need for which was not justified by your records.
- On or about August 26, 2011, you performed surgical incision and drainage and/or exploration the need for which was not justified by your records.

3. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent, in relation to one of your patients, namely K.P., contrary to paragraph 7 of section 2 of the Dentistry Act Regulation.

Particulars:

- On or about August 26, 2011, you failed to properly obtain the patient's informed consent to the pulpectomy. Although the patient specifically instructed you not to perform endodontic treatment, you failed to explain that an emergency pulpectomy was necessary, and that a pulpectomy was the first stage of endodontic treatment, such that the patient would be committed to having endodontic treatment completed in the tooth or having the tooth extracted once a pulpectomy was performed.
- On or about August 26, 2011, you failed to properly obtain the patient's informed consent to perform surgical curettage, and surgical incision and drainage and/or exploration.

4. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you failed to keep records as required by the regulations in

relation to one of your patients, namely K.P., contrary to paragraph 25 of section 2 of the Dentistry Act Regulation.

Particulars:

- On or about August 26, 2011, you took and billed for a periapical radiograph of the patient; however, this radiograph was not contained in the patient's records.

5. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you charged a fee that was excessive or unreasonable in relation to the service performed for one of your patients, namely K.P., contrary to paragraph 31 of section 2 of the Dentistry Act Regulation.

Particulars:

- On or about August 26, 2011, you billed and claimed the Ontario Dental Association Suggested Fee Guide for General Practitioners™ (ODA) code 32313 for "Pulpectomy, Permanent Teeth/Retained Primary Teeth, three canals" that was not needed.

- On or about August 26, 2011, you billed and claimed ODA code 42111 for "Surgical Curettage" that was not needed.

- On or about August 26, 2011, you billed and claimed ODA code 75111 for "Surgical Incision and Drainage and/or Exploration, Intraoral Soft Tissue" that was not needed.

6. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading in relation to one of your patients, namely K.P., contrary to paragraph 33 of section 2 of the Dentistry Act Regulation.

Particulars:

- On or about August 26, 2011, you billed and claimed the ODA code 32313 for "Pulpectomy, Permanent Teeth/Retained Primary Teeth, three canals" that was not needed.

- On or about August 26, 2011, you billed and claimed ODA code 42111 for "Surgical Curettage" that was not needed.

- On or about August 26, 2011, you billed and claimed ODA code 75111 for "Surgical Incision and Drainage and/or Exploration, Intraoral Soft Tissue" that was not needed.

7. You committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Regulated Health Professions Act, 1991*, in that, during the year 2011, you engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical in relation to one of your patients, namely K.P., contrary to paragraph 59 of section 2 of the Dentistry Act Regulation.

Particulars:

- You attempted to mislead the College by providing a periapical radiograph in the patient's records that was not a radiograph of the patient's tooth 47, but that of another person.

Notice of Hearing #2 (H130001)

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2012, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to your infection prevention and control practices, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

Particulars:

- On May 8, 2012, the Registrar of the College authorized an investigation into your conduct with respect to your infection prevention and control protocols, pursuant to Section 75(1)(a) of the *Regulated Health Professions Act* (Code).
- On or about May 24, 2012, an investigator with the College attended your office as part of a Section 75(1)(a) investigation into your infection prevention and control practices.
- The Section 75(1)(a) report of the investigation identified serious concerns with your infection control practices, including:
  - Deficiencies in your sterilization protocols and procedures.
  - Inadequate monitoring of sterilization.
  - Spore testing (biologic indicators) not being used.
  - A failure to use protective barriers.
  - Ultrasonic equipment not being available or properly used.
  - Unlabelled bottles of liquid being used in the sterilization process

- Dirty instruments being taken from one office to another office for apparent sterilization elsewhere.
- Water lines not routinely and properly flushed.
- A cluttered laboratory area with food, coffee cups, towels, dishes and electronic equipment being present along with an implant with particulate matter on the threads. New implants and instruments were also in the area along with other dental supplies (cements, bonding systems).
- Inadequate disposal of sharps.

2. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2011 and/or 2012, 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 with respect to your infection prevention and control practices, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Particulars:

- On December 6, 2011, a panel of the College's Inquiries, Complaints and Reports Committee, issued a decision and reasons concerning a Section 75(1)(a) investigation into your practice identifying significant infection control deficiencies in your practice and ordered you to undergo a one-on-one assessment and complete a course in infection prevention and control protocols.
- On or about March 24, 2012, you took an infection control course at the University of Toronto titled "Infection Control for Dental Offices: A Guide to Best Practices for All Oral Health Professionals."
- On May 8, 2012, the Registrar of the College authorized another investigation into your conduct with respect to your infection prevention and control protocols, pursuant to Section 75(1)(a) of the *Regulated Health Professions Act* (Code).
- On or about May 24, 2012, an investigator with the College attended your office as part of a Section 75(1)(a) investigation into your infection prevention and control practices.
- The Section 75(1)(a) report of the investigation identified serious concerns with your infection control practices, including:
  - Deficiencies in your sterilization protocols and procedures.
  - Inadequate monitoring of sterilization.
  - Spore testing (biologic indicators) not being used.
  - A failure to use protective barriers.

- Ultrasonic equipment not being available or properly used.
- Unlabelled bottles of liquid being used in the sterilization process.
- Dirty instruments being taken from one office to another office for apparent sterilization elsewhere.
- Water lines not routinely and properly flushed.
- A cluttered laboratory area with food, coffee cups, towels, dishes and electronic equipment being present along with an implant with particulate matter on the threads. New implants and instruments were also in the area along with other dental supplies (cements, bonding systems).
- Inadequate disposal of sharps.

- Despite knowing the College's concerns regarding your infection prevention and control practices and taking a course in infection control you demonstrated a complete and utter disregard for the necessary infection prevention and control protocols, which would be reasonably regarded by members as disgraceful, dishonorable, unprofessional or unethical.

Notice of Hearing #3 (H130004)

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, 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 the Dentistry Act Regulation:

Patients	Years
A.A.	2011, 2012
J. B.	2011
M. B.	2011, 2012
M. D.	2011, 2012
N. E.	2012
S. E.	2012
C. G.	2011, 2012
E. H.	2010, 2011, 2012
M. H.	2010, 2011
J. I.	2010, 2011, 2012
V. L.	2012
C. L.	2011, 2012
C. L.	2011, 2012
C. L.	2011, 2012
C. L.	2011, 2012

W. L.	2011, 2012
N. M.	2011, 2012
A. P.	2011
V. P.	2012
T. S.	2011, 2012
M. V.	2012

Particulars

- you billed for services for which there were no chart notations to indicate that the following services were provided, which was false or misleading or improper:
    - examinations (A.A.– 2011, 2012; M.B.– 2011; M.D.– 2011; C.G.– 2011; M.H.– 2011; J.I.– 2010, 2011, 2012; C.L.– 2012; C. L.– 2011, 2012; C.L.– 2012; W.L.– 2011, 2012; A.P. – 2011; V.P.– 2012)
    - x-rays (A.A.– 2011, 2012; J.B.– 2011; M.B.– 2011, 2012; N.B.– 2012; C.G.– 2012; M.H.– 2011; J.I.– 2010, 2011, 2012; C.L.– 2012; C.L.– 2012; W.L.– 2011, 2012; N.M.– 2011, 2012; A.P.– 2011; V.P.– 2012; T.S.– 2011, 2012)
    - hygiene treatment (A. A. – 2011, 2012; M. B. – 2011, 2012; C. G. – 2011, M. H. – 2010; J. I. – 2010, 2011, 2012; V. L. – 2012; C. L. – 2011, 2012; C. L. – 2011; C. L. – 2011; C. L. – 2011; W. L. – 2011, 2012)
    - periodontal surgery – gingivectomy or curettage (J. I. – 2011; N. M. – 2012)
    - periodontal appliance (N. M. – 2012)
    - restorative and caries control/sedative protective dressings (A. A. – 2011, 2012; M. D. – 2012, C. G. – 2011, 2012; E. H. – 2011; M. H. – 2011; J. I. – 2011, 2012; C. L. – 2012; C. L. – 2012; W. L. – 2012; N. M. - 2012)
    - exodontia (S. E. – 2012; C. L. – 2012; C. L. – 2011, 2012; C. L. – 2012)
    - endodontia (E. H. – 2012; V. P. – 2012; M. V. - 2012)
    - surgical exploration (S. E. – 2012; V. P. – 2012)
    - surgical excision (C. L. – 2012; C. L. – 2012; C. L. – 2012; C. L. – 2012)
    - exploratory flap (E. H. – 2012)
    - management of oral disease (A. A. – 2011; A. P. - 2011)
    - delivery of nitrous oxide and oxygen (S. E. – 2012)
- you billed for osteoplasties (2 x $670.07) when your chart entry indicates you performed a "curettage all mouth" which was false or misleading or improper

(E.H. – 2010)

2. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, 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 the Dentistry Act Regulation:

Patients	Years
A.A.	2011, 2012
J.B.	2011
M.B.	2011, 2012
M.D.	2011, 2012
N.E.	2012
S.E.	2012
C.G.	2011, 2012
E.H.	2010, 2011, 2012
M.H.	2010, 2011
J.I.	2010, 2011, 2012
V.L.	2012
C.L.	2011, 2012
C.L.	2011, 2012
C.L	2011, 2012
C.L.	2011, 2012
W.L.	2011, 2012
N.M.	2011, 2012
A.P.	2011
V.P.	2012
T.S.	2011, 2012
M.V.	2012

Particulars

- you billed for services for which there were no chart notations to indicate that the following services were provided:, which was false or misleading:

  - examinations (A. A. – 2011, 2012; M. B. – 2011; M. D. – 2011; C. G. – 2011; M. H. – 2011; J. I. – 2010, 2011, 2012; C. L. – 2012; C. L. – 2011, 2012; C. L. – 2012; W. L. – 2011, 2012; A. P. – 2011; V. P. – 2012)

  - x-rays (A. A. – 2011, 2012; J. B. – 2011; M. B. – 2011, 2012; N. E. – 2012; C. G. – 2012; M. H. – 2011; J. I. – 2010, 2011, 2012; C. L. – 2012; C. L. – 2012; W. L. – 2011, 2012; N. M. – 2011, 2012; A. P. – 2011; V. P. – 2012; T. S. – 2011, 2012)

  - hygiene treatment (A. A. – 2011, 2012; M. B. – 2011, 2012; C. G. – 2011, M. H. – 2010; J. I. – 2010, 2011, 2012; V. L. – 2012; C. L. – 2011, 2012; C.

L. – 2011; C. L. – 2011; C. L. – 2011; W. L. – 2011, 2012)

- periodontal surgery – gingivectomy or curettage (J. I. – 2011; N. M. – 2012)

- periodontal appliance (N. M. – 2012)

- restorative and caries control/sedative protective dressings (A. A. – 2011, 2012; M. D. – 2012, C. G. – 2011, 2012; E. H. – 2011; M. H. – 2011; J. I. – 2011, 2012; C. L. – 2012; C. L. – 2012; W. L. – 2012; N. M. - 2012)

- exodontia (S. E. – 2012; C. L. – 2012; C. L. – 2011, 2012; C. L. – 2012)

- endodontia (E. H. – 2012; V. P. – 2012; M. V. - 2012)

- surgical exploration (S. E. – 2012; V. P. – 2012)

- surgical excision (C. L. – 2012; C. L. – 2012; C. L. – 2012; C. L. – 2012)

- exploratory flap (E. H. – 2012)

- management of oral disease (A. A. – 2011; A. P. - 2011)

- delivery of nitrous oxide and oxygen (S. E. – 2012)

- you billed for osteoplasties (2 x $670.07) when your chart entry indicates you performed a "curettage all mouth" which was false or misleading (E H. – 2010)

3. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, 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 the Dentistry Act Regulation:

Patients	Years
K. A.	2011
R. A.	2011
A. A.	2011, 2012
J. B.	2011
M. B.	2012
M. D.	2011
N. E.	2012
S. E.	2012
C. G.	2011, 2012
M. H.	2012
E. H.	2011
M. H.	2011
J. I.	2011, 2012
V. L.	2012
C. L.	2012

W. L.	2012
A. M.	2012
N. M.	2011
J. P.	2011
V. P.	2012
T. S.	2011, 2012
C. S.	2010, 2012

Particulars

- you billed for the maximum fee or in some cases close to the maximum fee (as per the relevant ODA Suggested Fee Guide for General Practitioners), for complete examinations without documentation to justify the fees charged and therefore the fees were excessive or unreasonable (K. A. – 2011; R. A. – 2011; N. E. – 2012; M. H. – 2012; V. L. – 2012; A. M. – 2012; V. P. – 2012; T. S. – 2011)

- you billed for the maximum fee (as per the current ODA Suggested Fee Guide for General Practitioners) for specific and emergency examinations without documentation to justify the fees charged and therefore the fees were excessive or unreasonable (M. B. – 2012; S. E. – 2012; M. H. – 2011);

- N. M. – 2011; J. P. – 2011; V. P. – 2012; T. S. – 2012; C. S. – 2012)

- you billed for surgical extraction of an impacted tooth when the pre-operative radiograph appears to demonstrate the tooth was supra-erupted, and as such the fee was excessive or unreasonable (C. S. – 2010)

- you billed for sedative/protective dressings on multiple occasions, for multiple patients, with no indication as to why the sedative dressings were placed, and these procedures appear to have been billed for monetary gain (A. A. – 9 in 2011; 9 in 2012; J. B. – 4 in 2011; M. D. – 1 in 2011; C. G. – 3 in 2011, 4 in 2012; E. H. – 6 in 2011; M. H. – 6 in 2011; J. I. – 2 in 2011, 2 in 2012; C. L. – 4 in 2012; W. L. – 3 in 2012; N. M. – 2 in 2011; T. S. – 3 in 2011; 2 in 2012)

4. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2011 and 2012, you recommended and/or provided an unnecessary dental service relative to the following patients, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation:

Patients	Years
A. A.	2011, 2012
J. B.	2011
M. D.	2011
C. G.	2011, 2012
E. H.	2011
M. H.	2011
J. I.	2011, 2012

C. L.	2012
W. L.	2012
N. M.	2011
T. S.	2011, 2012

Particulars

- you billed for sedative/protective dressings on multiple occasions, for multiple patients, with no indication as to why sedative dressings were placed, and these procedures appear to have been billed for monetary gain (A. A. – 9 in 2011; 9 in 2012; J. B. – 4 in 2011; M. D. – 1 in 2011; C. G. – 3 in 2011, 4 in 2012; E. H. – 6 in 2011; M. H. – 6 in 2011; J. I. – 2 in 2011, 2 in 2012; C. L. – 4 in 2012; W. L. – 3 in 2012; N. M. – 2 in 2011; T. S. – 3 in 2011; 2 in 2012)

5. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, you failed to reply to a written enquiry made by the College, relative to the following patients, contrary to paragraph 58 of Section 2 of the Dentistry Act Regulation:

Patients	Years
A. A.	2010
M. B.	2010
E. H.	2011
M. H.	2010
G. M.	2012
N. M.	2012
J. P.	2011
C. S.	2012
M. V.	2012

Particulars

- you failed to provide the College with the information it requested, as follows:
  - A. A. – 2010 lab invoice and financial ledger entries;
  - M. B. – 2010 financial ledger entries;
  - E. H. – 2011 lab invoice;
  - M. H. – 2010 financial ledger entries;
  - G. M. – 2012 lab invoice;
  - N. M. 2012 lab invoice;
  - J. P. – 2011 lab invoice;
  - C. S. – 2012 lab invoice;
  - M. V. – 2012 financial ledger entry

6. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011 and 2012, you failed to keep records as required by the Regulations relative to the following patients, contrary to

paragraph 25 of Section 2 of the Dentistry Act Regulation:

Patients

A. A.; K.A.; R.A.; J.B.; M.B.; M.D.; N.E.; S.E.; R.F.; C.G.; M.H.; E.H.; M.H.; J.I; V.L.; C.L.; C.L.; C.L.; C.L.; W.L.; G.M.; A.M.; N.M.; A.P.; J.P.; V.P.; T.S.; C.S.; A.T.; and M.V.

Particulars:

For the above-named patients, for the years 2010 – 2012:

- you failed to record examination findings, for some patients, when you billed for examinations
- some radiographs were found but you failed to record you had taken them
- the labelling of your radiographs was inadequate, in that you failed to record the patient's name and/or the day and/or the month and/or the year for several patients
- the labelling of your radiographs was inadequate for a few patients, in that you wrote directly on the films
- you billed for a gingivectomy where you failed to record the details of the surgical procedure
- your account statement for one patient indicates a $2000 payment but you failed to record any corresponding clinical chart entries indicating the services provided
- some or all of the balances on your ledgers are negative balances, that keep increasing with each payment
- dental records of members of families were placed in the same folder, rather than in individual folders, in 4 cases
- you failed to record a medical history for one patient.
- you failed to ensure all the medical history questions were answered for one patient
- you failed to ensure the medical history questionnaire was dated for one patient
- you failed to initial or sign patients' medical histories to indicate if you had reviewed them
- in many cases, you failed to update the patients' medical histories
- in some cases, you failed to date your chart entries

- you usually failed to obtain patient's consent – no record of discussions with patients, including treatment options, benefits/risks, etc.
- you usually failed to indicate the type and quantity of local anaesthetic you used
- you usually failed to record information about materials you used providing dental treatment
- you did not indicate the use of a rubber dam when you rendered endodontic treatment
- you failed to indicate the details of the prescriptions you prescribed on May 21, 2011, including does, quantity and directions for patient M. H.

THE MEMBER'S PLEA

The Member orally admitted the allegations of professional misconduct as set out above. He also made admissions in writing in the Agreed Statement of Facts, which had been signed by him, and in which he expressly admitted having committed the acts alleged in the Notices of Hearing and that those acts constituted professional misconduct. The panel found that the Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, College Counsel introduced into evidence an Agreed Statement of Facts which substantiated the allegations and read as follows.

1. Dr. Khaled Hashem has been registered with the Royal College of Dental Surgeons of Ontario (the "College") since 1985 as a general dentist. At all relevant times, he owned and operated dental practices in Ottawa, Ontario.

2. In 2011-2012, Dr. Hashem operated four dental clinics in the Ottawa area:

   a. a clinic located on Bank Street (the "Bank Street Clinic");

   b. a clinic located on Cyrville Road (the "Cyrville Road Clinic");

   c. a clinic located on Merivale Road in a Wal-Mart complex (the "Merivale Road Clinic"); and

   d. a clinic located on Baseline Road, (the "Baseline Road Clinic") (together, the "Clinics").

3. Dr. Hashem employed receptionists, dental assistants and associate dentists at the Clinics. There was significant and frequent turnover at the Clinics.

4. In the winter of 2013, Dr Hashem sold the Clinics. Dr. Hashem now acts as a locum dentist.

5. This Agreed Statement of Facts addresses allegations that Dr. Hashem engaged in professional misconduct arising out of the following:

   a. a complaint filed with the College by K. P. (the "Complainant") and her husband, R. F. They alleged that Dr. Hashem completed a partial root canal without informed consent and failed to maintain appropriate infection control and radiation procedure when treating K. P. They also alleged that he billed an excessive amount for his care of her. The K.P/R.F. complaint formed the basis of the specified allegations in Notice of Hearing H120011;

   b. a Registrar's investigation regarding Dr. Hashem's infection prevention and control procedures and his practices in relation to informed consent. This s. 75 investigation formed the basis of the specified allegations in Notice of Hearing H130001;

   c. a further Registrar's investigation regarding Dr. Hashem's billing practices and financial and general recordkeeping. This s. 75 investigation formed the basis of the specified allegations in Notice of Hearing H130004.

Prior Proceedings

6. Prior to the referral to the Discipline Committee of the specified allegations in Notices of Hearing H120011, H130001 and H130004, Dr. Hashem was the subject of several complaints and investigations between 1996 and 2011:

   a. In 1996, the Inquiries Complaints and Reports Committee ("ICRC") reviewed a complaint from a client with respect to emergency treatment of a client for a cracked back tooth. The client alleged Dr. Hashem failed to explain the treatment to her, drilled when she was not anesthetised, and that she was left with extreme discomfort. She also complained that the bill was more than the quote she had obtained, and included a charge for services that Dr. Hashem had not provided, namely a pulpotomy. The ICRC dispensed with some of the client's concerns, but concluded that Dr. Hashem had not performed the pulpotomy (although he may have attempted it), and should not have billed for it. The ICRC ordered that Dr. Hashem be cautioned;

b. In 2010, a client, M.B., complained to the College about Dr. Hashem's orthodontic treatment of her daughters ("M.B. Complaint"). M.B. complained that Dr. Hashem had billed her insurance without her authorization and for services that she paid directly to Dr. Hashem by agreement, and failed to provide her with a statement of work performed. The client also complained that Dr. Hashem's staff had been loud and abusive to her. Finally, the client complained that Dr. Hashem had not scheduled follow-up appointments after removal of her daughter's braces, and when they were seen twelve months later, he advised that additional work was needed.

   In early May 2012, the ICRC reviewed this complaint. To address its concerns about Dr. Hashem's financial recordkeeping, it ordered Dr. Hashem to take a course in recordkeeping, engage a mentor approved by the College to provide one-on-one review and assessment of his recordkeeping, and submit to monitoring by the College for a period of 24 months. The ICRC also cautioned Dr. Hashem. In addition, the ICRC was concerned that the issues raised in the M.B. complaint may not be isolated. It requested that the Registrar review the matter. As a result, the Registrar appointed as investigator to conduct a s. 75 investigation, being the Registrar's Investigation re: Recordkeeping set out below (Notice of Hearing H130004);

c. In May 2011, a s. 75 investigator was appointed to investigate Dr. Hashem's infection prevention and control protocols. This investigation arose from information received from a former staff member. At the conclusion of the investigation, the ICRC had concerns about Dr. Hashem's infection control protocols, specifically that his offices were unsanitary and disorganized. As a result, in December 2011, the ICRC ordered Dr. Hashem to take a course on infection prevention and control protocols, to undertake a one-on-one course/assessment with an approved assessor regarding infection prevention and control, and to submit to monitoring by the College for a period of 24 months. The ICRC also ordered a caution. Dr. Hashem completed a course on course on infection prevention and control protocols in March 2012 and received his caution. Dr. Hashem has not completed the one-on-one assessment or subsequent practice monitoring.

H120011: The K.P/R.F. Complaint

A. Dr. Hashem's Treatment of the Complainant

7. On Friday, August 26, 2011, at approximately seven o'clock in the evening, K.P. consulted Dr. Hashem at the Merivale Road Clinic, on an emergency basis. R.F., her husband, attended with her.

8. Dr. Hashem was not K.P.'s regular dentist. Neither she nor R.F. had been treated by Dr. Hashem before.

9. K.P. complained of an infected and swelling gum. She requested that Dr. Hashem remove food particles from her gums which she believed were causing pain. She had previously experienced tooth and gum pain caused by food particles.

10. Upon examination, Dr. Hashem documented the following:

> *Pain lower right region 1 P.a. swelling #47 tested positive to percussion and cold test .[sic] pulp vitality test required root canal treatment.*

11. Dr. Hashem took a periapical radiograph of the K.P.'s tooth 47. He did not provide her with a radiation protection vest before he took the radiograph.

12. Dr. Hashem advised her that she needed a root canal. She declined to have Dr. Hashem complete the root canal, and indicated that she would visit her regular dentist during working hours. K.P. requested that Dr. Hashem complete emergency dental work to alleviate her pain. She understood that Dr. Hashem would remove food particles from her gums.

13. Dr. Hashem did not explain to K.P. that he intended to complete an emergency pulpectomy and other interventions, why he believed an emergency pulpectomy to be necessary, or that by agreeing to the pulpectomy, she would be required to undergo further endodontic treatment or tooth extraction. In short, Dr. Hashem failed to obtain informed consent from the Complainant.

14. Dr. Hashem began the procedure by giving the Complainant a local anaesthetic. He documented the following:

> *2 carpules (2 x 1.8ml) xylocaine 1/100 emergency pulpectomy*
>
> *I & D curettage lower right formo/ zoe* [sic]

15. Dr. Hashem did not isolate the tooth with a rubber dam during the pulpectomy.

16. During the pulpectomy, Dr. Hashem failed to adequately remove the roof of the pulp chamber, remove the pupal and radicular tissue, and expose all canals of the tooth. Dr. Hashem did not provide an adequate endodontic access opening. He did not direct the opening properly into the pulp chamber and instead directed too much to the mesial of the tooth.

17. During the procedure, Dr. Hashem's telephone rang. Dr. Hashem answered the telephone while wearing sterile gloves. After the telephone call, Dr. Hashem returned to his patient and continued his procedure, without changing his gloves.

18. Dr. Hashem prescribed the Complainant a pain reliever and a course of antibiotics.

19. Dr. Hashem advised R.F. and his patient that he would bill their insurance provider. R.F. spoke to his insurance agent to ensure coverage.

20. Dr. Hashem billed R. F. a total of $735.06 for his treatment of the Complainant, 80% of which was covered by R. F.'s insurance:

Procedure Description	Provider Fee	Insurance Covered	Amount Owing
Emergency Exam	$122.07	$97.60	$24.47
Pulpectomy	$164.16	$131.33	$32.83
Incision and drainage	$85.91	$68.73	$17.18
Gingival curettage	$339.54	$271.63	$67.91
Periapical Radiograph 1	$23.38	$18.70	$4.68
TOTAL	**$735.06**	**$587.99**	**$147.07**

B. The Complainant's Subsequent Dental Care

21. K. P. saw her regular dentist, Dr. K., on September 8, 2011 because she was still in pain. Dr. K. determined that Dr. Hashem commenced but failed to complete the pulpectomy appropriately in that he failed to remove all of the pupal and radicular tissue. Dr. K. also found no evidence that K. P. required

a pulpectomy. Dr. K completed the root canal of the tooth on September 19, 2011.

C. Dr. Hashem's Provision of Records to the College

22. Dr. Hashem provided the College with a copy of K. P.'s treatment records. The records included one unlabelled periapical radiograph showing of a tooth 47 and with teeth 46 and 48 missing (ie. they had been extracted). K. P. is not missing teeth 46 and 48. This radiograph is not a radiograph of the Complainant's mouth.

23. Dr. Hashem cannot locate the Complainant's radiograph. Dr. Hashem asserts that the missing radiograph is a result of misconduct or negligence of his staff.

D. Admissions with respect to the R.F / K.P ***Complaint***

24. Dr Hashem admits that he failed to maintain appropriate infection prevention and control techniques by failing to:

    a. change his gloves after speaking on the telephone; and

    b. use a rubber dam during the pulpectomy.

25. Dr. Hashem admits that he failed to maintain appropriate radiation protection protocols by taking a periapical radiograph without providing the Complainant with radiation protection.

26. Dr. Hashem admits that he diagnosed and undertook endodontic treatment without documented clinical and radiographical justification that such treatment was necessary, that he failed to obtain informed consent for such treatment, and that he provided substandard treatment to the Complainant. He also admits that he charged excessive fees for his services.

27. Dr. Hashem admits that he was ultimately responsible to maintain complete treatment records for the Complainant, and that he failed to do so. Dr. Hashem admits that it was disgraceful, dishonourable, unprofessional and unethical to include in K. P.'s records a periapical radiograph that did not belong to her.

28. Accordingly, Dr. Hashem admits that he committed the acts of professional misconduct as set out in paragraphs 1 to 7 of the Notice of Hearing H120011.

H130001: Registrar's Investigation re: Infection Control

A. Background

29. As set out in paragraph 6(c), in May 2011, the College had investigated Dr. Hashem's infection prevention and control protocols. In December 2011, The ICRC cautioned Dr. Hashem and ordered, among other things, that Dr. Hashem take a course on infection prevention and control protocols, and a one-on-one course/assessment with an approved assessor regarding infection prevention and control.

30. In compliance with this order of the ICRC, in March 2012, Dr. Hashem completed a course at the University of Toronto titled: Infection Control for Dental Offices: A Guide to Best Practices in Oral Health."

31. One month later, in April 2012, the College received a complaint from a client that Dr. Hashem had repaired her denture on an emergency basis using an extracted human tooth in late March 2012. The College is investigating this complaint. It has not yet been reviewed by ICRC nor referred to the Discipline Committee. As a result of this complaint, in May 2012, the Registrar of the College authorized a second s. 75 investigation into Dr. Hashem's infection prevention and control protocols.

32. On May 24, 2012, the College's investigator conducted the s. 75 investigation by visiting Dr. Hashem's four clinics. As part of the investigation, the College's investigator interviewed Dr. Hashem's current receptionists and dental assistants, a former dental assistant, and a dentist practising at one of the Clinic locations.

33. The investigator observed the following deficiencies in Dr. Hashem's infection prevention and control practices at the Clinics:

    a. Inadequate monitoring of sterilization;

    b. Spore testing (biologic indicators) not being used;

    c. Failure to use protective barriers;

    d. Ultrasonic equipment not being available or not being used;

    e. Unlabelled bottles of liquid being used in the sterilization process;

    f. Waterlines not routinely and properly flushed;

g. A cluttered laboratory area with food, coffee cups, towels, dishes and electronic equipment being present along with implant materials;

h. Storage of implant materials with particulate matter on the threads;

i. Storage of new implant materials and instruments in a cluttered laboratory area along with other dental supplies; and

j. Inadequate disposal of sharps.

B. Admissions with respect to the Registrar's Investigation re: Infection Control

34. Dr. Hashem admits that he failed to maintain the standards of practice with respect to infection prevention and control. All of the deficiencies set out in paragraph 34 fall below the standards of practice.

35. Moreover, given that by May 2012, (a) Dr. Hashem was well aware that the College was concerned that his infection control practices were substandard and (b) he had just completed a course which ought to have addressed any deficiencies in his knowledge, his continued failure to maintain the standards of practice with respect to infection prevention and control demonstrates a disregard for his professional obligations. The Member acknowledges that his conduct would be reasonably regarded by members as disgraceful, dishonourable, unprofessional and unethical.

36. Accordingly, Dr. Hashem admits that he committed acts of professional misconduct as set out in paragraphs 1 and 2 of the Notice of Hearing H130001.

H130004: Registrar's Investigation re: Recordkeeping

A. Background

37. As noted in paragraph 6(b), in early May 2012, the ICRC requested the Registrar to review the issues raised by the M.B. complaint. As a result, the Registrar of the College authorized an investigation into Dr. Hashem's conduct with respect to record-keeping in May 2012.

38. Dr. Hashem completed a course in record-keeping ordered by the ICRC in the M.B. Complaint on March 30, 2012, however, he has yet to retain a mentor for recordkeeping, as also required by that Order.

39. On May 24, 2012, the College's investigator visited the Clinic locations (accompanied by the investigator appointed on the Registrar's Investigation

re: Infection Control). The investigator obtained 31 patient records of clients seen between 2010-2012, selected randomly.

40. Many of these client files were incomplete. The investigator requested missing laboratory invoices and financial ledgers in respect of 14 of the 31 clients. Dr. Hashem failed to provide laboratory invoices for six of those clients and financial ledgers for four of those clients.

41. The investigation revealed significant deficiencies with respect to Dr. Hashem's financial and general record-keeping, and his billing practices.

42. With respect to his general record-keeping, a review of the records of the 31 clients demonstrates that Dr. Hashem failed to keep complete and accurate patient records, including one or more occurrences of the following deficiencies:

    a. failing to record examination findings;

    b. failing to record that radiographs were taken;

    c. inadequate labelling of radiographs (missing patient's name and/or the day and/or the month and/or the year or writing directly on films);

    d. keeping the dental records of members of families in the same folder, rather than in individual folders;

    e. failing to record a medical history;

    f. failing to ensure that all the medical history questions were answered and dated;

    g. failing to initial or sign patients' medical histories to indicate if Dr. Hashem had reviewed them;

    h. failing to update the patients' medical histories;

    i. failing to date chart entries;

    j. failing to record that Dr. Hashem has obtained patient's consent (ie. discussions with patients, including treatment options, benefits/risks, etc.);

    k. failing to indicate the type and quantity of local anaesthetic used;

    l. failing to record information about materials used providing dental treatment;

m. failing to indicate the use of a rubber dam during endodontic treatment; and

n. failing to indicating the details of the prescriptions prescribed (dose, quantity and directions).

43. With respect to his financial record-keeping, Dr. Hashem billed for services not provided or billed excessive fees as follows:

a. for 21 clients (on one or more occasions), Dr. Hashem billed for services for which there were no chart notations to indicate that Dr. Hashem saw the client and/or provided the billed services;

b. for one client, Dr. Hashem billed for osteoplasties (X2) when the chart entry indicated that he performed a "curettage all mouth";

c. for eight clients, Dr. Hashem billed the maximum fee, or in some cases close to the maximum fee, (as per the relevant ODA Suggested Fee Guide for General Practitioners), for complete examinations without documentation to justify the fees charged;

d. for eight clients, Dr. Hashem billed the maximum fee, or in some cases close to the maximum fee, (as per the relevant ODA Suggested Fee Guide for General Practitioners), for emergency or specific examinations without documentation to justify the fees charged;

e. for one client, Dr. Hashem billed for surgical extraction of an impacted tooth when the pre-operative radiograph appears to demonstrate the tooth was supra-erupted;

f. for eleven clients, on multiple occasions, Dr. Hashem billed for sedative/protective dressings on multiple occasions, for multiple patients, with no indication as to why the sedative dressings were placed;

g. for one client, Dr. Hashem's account statement for one patient indicates a $2000 payment without any corresponding clinical chart entries indicating the services provided; and

h. some or all of the balances on Dr. Hashem's ledgers were negative balances which keep increasing with each payment.

B. Admissions with respect to the Registrar's Investigation re: Record-Keeping

44. Dr. Hashem admits that he failed to maintain records as required by the Dentistry Act Regulations as particularized in paragraphs 43 and 45.

45. Dr. Hashem admits that he billed for services not provided, and by doing submitted false and misleading accounts and issued accounts that he knew contained false, misleading and improper statements.

46. Dr. Hashem also admits that he charged unreasonable and excessive fees by billing maximum fees or close to maximum fees for routine and emergency examinations without justification; by billing a surgical extraction for a supra-erupted tooth; and by billing for sedative/protective dressings without justification.

47. Dr. Hashem admits that he failed to provide information to the College in the course of its investigation by failing to provide laboratory results and financial invoices requested by the College.

48. Dr. Hashem admits that he committed acts of professional misconduct as set out in paragraphs 1-6 of the Notice of Hearing dated March 25, 2013, and in particular that he failed to adopt and maintain acceptable general and financial record-keeping and billing practices at his Clinics from 2010-2012.

DECISION

Having considered the evidence and submissions of the parties, the panel finds that the Member committed professional misconduct as alleged in the allegations contained in the three Notices of Hearing, reprinted above.

REASONS FOR DECISION

The evidence contained in the Agreed Statement of Facts clearly substantiated the allegations. The Member pleaded guilty, and thus did not dispute the allegations, particulars or facts in the Notice of Hearing and the Agreed Statement of Facts.

The Panel unanimously accepted the Agreed Statement of Facts which clearly demonstrated to the Panel that the Member had committed acts of professional misconduct as alleged.

PENALTY SUBMISSIONS

The parties jointly submitted that the panel should order that:

1. The Member appear before the Panel of the Discipline Committee to be reprimanded, on a date to be fixed by the Registrar;

2. The Registrar of the College suspend the Member's certificate of registration for a period of five (5) months. The suspension shall commence on the date of this Order and shall run without interruption;

3. The Registrar impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served, namely:

   (a) upon commencement of the suspension, the Member shall advise all of the staff as well as any other dentist in any office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

   (b) during the suspension, the Member shall not do anything that would suggest to patients or prospective patients that the Member is entitled to engage in the practice of dentistry, including holding himself out as a locum dentist entitled to practice during the suspension;

   (c) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in this connection, the Member shall provide access to any records associated with any office location in which the Members has practiced in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

   (d) the Conditions imposed in subparagraphs 3(a) and (c) above shall be removed at the end of the period during which the Member's certificate of registration is suspended; and

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

(a) the Member shall successful complete, at his own expense, a course approved by the Registrar in Periodontics, specifically, the diagnosis and management of periodontal disease, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(b) the Member shall successfully complete, at his own expense, the ProBE Program for Professional/Problem-Based Ethics, and provide proof of successful completion in writing to the Registrar within nine (9) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(c) that the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine, with advanced notice to the Member, during the period commencing with the date that the College receives written proof of completion of the courses referred to in subparagraphs (4)(a) and (b), and ending twenty-four months thereafter, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(d) that the Member shall cooperate with the College during the inspection(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $600.00 per monitoring, such amount to be paid immediately after completion of each of the inspections, provided that the overall cost of monitoring paid by the Member shall not exceed $2,400.00, regardless of the number of inspections performed; and

(e) the representative or representatives of the College shall report the results of those inspections 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; and

5. The Member shall pay costs to the College in the amount of $1,500.00 within one (1) month of the completion of the period of suspension set out in paragraph 2.

PENALTY DECISION

The panel of the Discipline Committee accepted the joint submission from the parties and imposed the following penalty upon the Member:

1. The Member shall appear before the Panel of the Discipline Committee to be reprimanded, on a date to be fixed by the Registrar;

2. The Registrar of the College is directed to suspend the Member's certificate of registration for a period of five (5) months. The suspension shall commence on the date of this Order and shall run without interruption;

3. The Registrar of the College is directed to impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served, namely:

    (a) upon commencement of the suspension, the Member shall advise all of the staff as well as any other dentist in any office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

    (b) during the suspension, the Member shall not do anything that would suggest to patients or prospective patients that the Member is entitled to engage in the practice of dentistry, including holding himself out as a locum dentist entitled to practice during the suspension;

    (c) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in this connection, the Member shall provide access to any records associated with any office location in which the Members has practiced in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

    (d) the Conditions imposed in subparagraphs 3(a) and (c) above shall be removed at the end of the period during which the Member's certificate of registration is suspended; and

4. The Registrar of the College is directed to impose the following additional terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), namely:

(a) the Member shall successful complete, at his own expense, a course approved by the Registrar in Periodontics, specifically, the diagnosis and management of periodontal disease, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(b) the Member shall successfully complete, at his own expense, the ProBE Program for Professional/Problem-Based Ethics, and provide proof of successful completion in writing to the Registrar within nine (9) months of this Order becoming final, or such further time as may be permitted by the Registrar;

(c) that the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine, with advanced notice to the Member, during the period commencing with the date that the College receives written proof of completion of the courses referred to in subparagraphs (4)(a) and (b), and ending twenty-four months thereafter, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(d) that the Member shall cooperate with the College during the inspection(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $600.00 per monitoring, such amount to be paid immediately after completion of each of the inspections, provided that the overall cost of monitoring paid by the Member shall not exceed $2,400.00, regardless of the number of inspections performed; and

(e) the representative or representatives of the College shall report the results of those inspections 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; and

5. The Member shall pay costs to the College in the amount of $1,500.00 within one (1) month of the completion of the period of suspension set out in paragraph 2.

Pursuant to the Health Professions Procedural Code of the *Regulated Health Professions Act, 1991*, the College's publication of this matter will include the Member's name and address.

REASONS FOR PENALTY DECISION

The Panel unanimously agreed that the Joint Submission on Penalty meets the objectives of protecting the public, serving as specific deterrence for the Member and general deterrence for the profession, rehabilitating the Member, and maintaining public confidence in the profession.

The Panel considered the following aggravating circumstances:

i) The Member has been the subject of previous complaints and investigations by the Inquiries Complaints and Reports Committee between 1996 and 2011.

ii) The Member demonstrated blatant disregard for proper infection control practices even after receiving a prior decision by the Inquires, Complaints and Reports Committee that required him to undergo assessment and complete a course in Infection Control.

iii) Initially, the Member did not co-operate with the College in their investigations.

iv) The Member admitted to a total of 15 charges of unprofessional and fraudulent acts including a failure to obtain consent, providing unnecessary treatment, failing to maintain adequate records, failing to maintain acceptable standards of infection control, exposing a patient to unnecessary radiation and submitting false or misleading fees and providing false or misleading information to the College in the investigation of the Member.

The Panel also considered the mitigating factors presented in this hearing which included:

i) The Member ultimately did accept responsibility for his actions and with his guilty plea eliminated the need for a lengthy hearing that would have likely inconvenienced and negatively impacted former patients and staff.

ii) By entering into an Agreed Statement of Facts and Joint Submission on Penalty, the Member has reduced the time and costs associated with a full hearing.

The reprimand, length and terms of the suspension and the publication of this decision, including the name and address of the Member, directly address the penalty objectives of deterrence for both the Member and general deterrence for the profession.

The requirement for the Member to attend courses in Infection Control, Record Keeping and Ethics as well as the requirement for practice monitoring by the College serve to remediate the Member and protect the public.

The Panel found the length of the suspension and the length of the practice monitoring provision was reasonable and appropriate given that the Member plead guilty to 15 charges and has had previous complaints and investigations over an extended period of time.

The Panel accepted the joint submission on costs, recognizing that this amount only partially reimburses the College for costs related to the investigation and hearing in relation to this matter.

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

	7 August 2013
Chairperson	Date

H130016

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. KHALED HASHEM**, of the City of Ottawa, in the Province of Ontario;

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

Members in Attendance: Dr. Richard Bohay (Chair)
Dr. Peter Kalman
Dr. Michael Perelgut
Mr. Jose Saavedra
Mr. Manohar Kanagamy

Certified True Copy

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Ms. Linda Rothstein and Emily Lawrence (with Dr. Chris Swayze)
- and -	)	For the Royal College of Dental Surgeons of Ontario
	)	
DR. KHALED HASHEM	)	Not in attendance
	)	
	)	Mr. Brian Gover
	)	Independent Counsel for the Discipline Committee of the Royal College of Dental Surgeons of Ontario

Hearing held on March 24, 2014.

REASONS FOR DECISION

INTRODUCTION and OVERVIEW

This matter came on for hearing before a panel of the Discipline Committee ("Panel") of the Royal College of Dental Surgeons of Ontario ("College") in Toronto on March 24, 2014.

Dr. Khaled Hashem ("Member") did not attend. College Counsel invited the Panel to proceed in the Member's absence. After reviewing the Affidavit of Emily Lawrence (Exhibit 2), the Affidavit of Phil Gittins (Exhibit 3) and the Further Affidavit of Emily Lawrence (Exhibit 3A), the Panel was satisfied that the Member had been given fair notice of the hearing, and that it was appropriate to proceed with the hearing despite the Member's absence. Consequently, the hearing proceeded on the basis that the Member denied the allegations.

Although as discussed below, the Notice of Hearing sets out 8 allegations against the Member, the case involves a single treatment of a single patient. Essentially, the College alleged that the Member cemented two human teeth from someone else into the mouth of his patient, K.W. The allegations included breaching the standards of practice by failing to maintain proper infection control protocols, failure to obtain informed consent, failure to keep records, misrepresentation, charging fees that are unreasonable, submitting a false or misleading account and charging a laboratory fee that is greater than the commercial laboratory cost.

The evidence disclosed that on Saturday, March 24, 2012, K.W., then a 23 year old student at Carlton University, went to the Member's office for an emergency appointment. K.W. was missing two lateral teeth, 1-2 and 2-2. She saw the Member at his office at approximately 8:30 p.m. on Saturday, March 24, 2012. The Member charged K.W. $763.00 for the procedures reflected in the standard claim form.[1] Dissatisfied with the appearance of the teeth that the Member cemented into her mouth, K.W. returned to the dentist who had previously treated her. That dentist concluded that fragments of human teeth from someone else had been cemented into K.W.'s mouth. Expert opinion testimony at the hearing confirmed this fact.

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[1] Exhibit 4

The Panel therefore concluded that the College had proven each of the 8 allegations on a balance of probabilities, based on clear and convincing evidence. The Panel therefore made findings of professional misconduct in relation to each of Allegations 1 through 8 and directed that the hearing resume on a date to be fixed by the Registrar, for penalty submissions to be heard.

THE ALLEGATIONS

The Notice of Hearing (Exhibit 1) alleged as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2012, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely K.W., contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about March 24, 2012, you cemented one or more human teeth that did not belong to the patient into the patient's mouth. The result was clinically and aesthetically unacceptable and not in keeping with proper infection control protocols.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2012, you treated a patient, namely K.W., 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 the Dentistry Act Regulation.

   Particulars:

   - On or about March 24, 2012, you cemented one or more human teeth that did not belong to the patient into the patient's mouth. You did not inform the patient that the materials you were employing were human teeth.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2012, you made a misrepresentation about a remedy, treatment, device or procedure or failed to reveal the exact nature of a remedy, treatment, device or procedure following a patient's request to do so, relative to one of your patients, namely K.W., contrary to paragraph 12 of Section 2 of the Dentistry Act Regulation.

   Particulars:

- On or about March 24, 2012, you cemented one or more human teeth that did not belong to the patient into the patient's mouth. You did not inform the patient that the materials you were employing were human teeth.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2010, you failed to keep records as required by the regulations, relative to one of your patients, namely K.W., contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

Particulars:

- You failed to maintain or lost the dental records for your patient, K.W.

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2010, you charged a fee that was excessive or unreasonable in relation to the service performed, relative to one of your patients, namely K.W., contrary to paragraph 32 of Section 2 of the Dentistry Act Regulation.

Particulars:

- On or about March 24, 2012 you charged the patient for the following dental services that were not performed: code 56521 (therapeutic tissue conditioning, partial maxillary denture), code 55401 (repairs/additions partial denture, impressions required), and 99111 (commercial laboratory procedures).

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2010, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading, relative to one of your patients, namely K.W., contrary to paragraph 33 of Section 2 of the Dentistry Act Regulation.

Particulars:

- On or about March 24, 2012 you submitted a claim in respect of the patient for the following dental services that were not performed: code 56521 (therapeutic tissue conditioning, partial maxillary denture), code 55401 (repairs/additions partial denture, impressions required), and 99111 (commercial laboratory procedures).

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2010, you charged a laboratory fee for a dental appliance or device that was more than the commercial laboratory cost actually incurred by you, relative to one of your patients, namely K.W., contrary to paragraph 35 of Section 2 of the Dentistry Act Regulation.

Particulars:

- On or about March 24, 2012 you charged the patient $54.00 under code 99111 (commercial laboratory procedures), but no commercial laboratory procedures were actually performed and no costs incurred.

8. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2010, you engaged in conduct or performed an act relative to one of your patients, namely K.W., that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional, or unethical, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Particulars:

- On or about March 24, 2012, you cemented one or more human teeth that did not belong to the patient into the patient's mouth. The result was clinically and aesthetically unacceptable and not in keeping with proper infection control protocols.

- On or about March 24, 2012 you charged the patient and submitted a claim for the following dental services that were not performed: code 56521 (therapeutic tissue conditioning, partial maxillary denture), code 55401 (repairs/additions partial denture, impressions required), and 99111 (commercial laboratory procedures)

THE MEMBER'S PLEA

The hearing proceeded on the basis that although not present, the Member denied the allegations.

THE EVIDENCE

The College's Witnesses

The College called 5 witnesses to testify at the hearing. They were:

1. The patient, K.W.;
2. Dr. Tadeusz Henike, a dentist in general practice in Ottawa, with expertise in crown, bridge and implant procedures;
3. Mr. Anthony Bunbury, who at the relevant times was employed by the College as an investigator;
4. Dr. Chris Swayze, the College's dental advisor in connection with this case; and

5. Dr. Grace Chau Bradley, an oral pathologist whom the Panel ruled was qualified to give expert opinion evidence in relation to oral pathology and oral medicine and the standards of practice of dentistry in Ontario.

Events Leading up to K.W.'s Attendance at the Member's Office

The patient, K.W. had a congenital problem with the lateral teeth to the left and right of her front teeth. On one side, she had not lateral tooth at all; on the other, she had only a peg tooth. For approximately 6 years, she used a permanent and then a temporary retainer.

By early 2012, K.W. was interested in a permanent solution. She decided to obtain implants. In January, 2012, K.W. met with Dr. Henike, whom she had found over the internet. K.W. explained that she was looking for alternative treatment to continuing with orthodontics.

On March 22, 2012, K.W. underwent surgery at Dr. Henike's office, under a local anesthetic. As part of the procedure, K.W. had two stitches on the left side of her mouth. It was Dr. Henike's evidence that the surgery went very well, and K.W. was to return to his office for follow-up 7-10 days later.

Although the surgery went well, her mouth was swollen afterwards. K.W.'s mother had travelled to Ottawa to be with her daughter during her convalescence. They were staying in a hotel. However, while there, K.W. lost her retainer.

K.W. was concerned. She was hoping to have a "full smile". However, without her retainer, K.W. had what she described in her testimony as "two gaping holes". She was hoping that two crowns could be cemented into the spaces as soon as possible. To that end, K.W. called and left messages at two emergency dental offices that she located on line, one of which was the Member's office.

Treatment Provided by the Member on March 24, 2012

The Member returned K.W.'s call. In the ensuing conversation, the Member agreed to devise a solution. They agreed to meet at 8:30 p.m. at his office. It was Saturday, March 24, 2012. K.W. testified that she was not particularly concerned about the cost; what she wanted was a "full smile".

K.W. went to the Member's office at 8:30 p.m., as had been arranged. It was her evidence that the Member examined her without washing his hands or wearing gloves. Then they discussed what K.W. described as "gluing crowns in". She believed that the Member would glue in false teeth. The Member did not advise

her that he would be cementing human teeth into her mouth, nor did K.W. consent to him doing so.

In the course of the procedure, the Member used cement to adhere the teeth and used an ultraviolet gun to ensure that the area was dry. No other material was used to protect her gums.

As is reflected in the standard dental claim form[2] and a Visa slip,[3] K.W. paid the Member $763.00. By reference to the Ontario Dental Association Fee Guide,[4] Dr. Swayze testified as to the meaning of the codes in the standard dental claim form and the monetary values assigned to them. This information is reflected in the following chart, together with what the Member actually charged K.W.

Code	Description	Value	Actual Charge[5]
01205	Examination and Diagnosis, Emergency	$36.00 - $125.00	$127.00
56521	Denture, Therapeutic Tissue Conditioning, per appointment, Partial Denture	$64.00 - $122.00	$122.00
55401	Denture Repairs/Additional Partial Denture, Impression Required	$96.00 - $180.00	$180.00
99111	"+L" Commercial Laboratory Procedures	I.C.	$280.00
94302	Office or Institutional Visit, Unscheduled, After Regular Scheduled Office Hours (in addition to service performed)	$54.00	$54.00

[2] Exhibit 4

[3] Exhibit 5 (Visa slip)

[4] Exhibit 22

[5] As per Exhibit 4 (Standard Dental Claim Form)

K.W.'s Return to Dr. Henike, March 26, 2012

Subsequently, K.W. was able to observe her appearance, and became dissatisfied. To her, it looked like a piece of chewed up gum had been put in her mouth. On either the night of Saturday, March 24 or the morning of Sunday, March 25, she took photographs to send to a friend.[6]

K.W. contacted Dr. Henike early on the Monday, March 26. Dr. Henike arranged to see her that day. Once at his office, K.W. explained to Dr. Henike that she had lost her retainer and saw an emergency dentist on the weekend.

On inspection, Dr. Henike "thought that the work was a little bit rough". There were resin-bonded edges. Dr. Heinike did not like what he saw on clinical examination. One tooth had a dark spot on it. Moreover, X-rays[7] confirmed that these were someone else's teeth. The tooth cemented into 1-2 had a broken endodontic file in it.

Dr. Henike testified that the surgery was fresh and did not look clean. He was concerned that the surgical site and K.W.'s health could be compromised. It was Dr. Henike's evidence that he had never before encountered the situation of someone else's teeth being cemented into a patient's mouth. He removed the resin-bonded bridges from K.W.'s mouth and preserved the tooth fragments.[8] On doing so, Dr. Henike noted that there was no evidence that the Member had used any tissue lining. Dr. Henike was upset and shocked. He informed K.W. that the dentist who had done this work had not met the standard of care in Ontario.

K.W. testified that on learning that Dr. Henike suspected that these were human teeth, she was "completely disgusted and mortified".

Dr. Henike recommended that K.W. obtain a refund from the Member and that she contact Telehealth Ontario. She was advised by Telehealth to go to a hospital emergency department, which she did. Once there, K.W. was given the option of taking an HIV prophylactic, which she declined because of possible side effects.

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[6] Exhibit 6

[7] Exhibits 13, 14

[8] Exhibit 7

Subsequent Events

K.W. returned to the Member's office to get a refund. She testified that as soon as she walked into the reception area, the Member went to the back potion of the office. Although she succeeded in obtaining a refund,[9] in order to do so K.W. had to sign what was characterized as a full and final release.[10] In addition, K.W. does not have an original of the dental claim form[11] because staff at the Member's office asked that it be returned.

In a telephone conversation with the Member on Tuesday, March 27, 2012, Dr. Henike expressed concern about the quality of the work that the Member performed on K.W. The Member confirmed that he had treated K.W. on March 24, and that he had cemented in teeth that had been extracted from someone else. It was Dr. Henike's evidence that during the call, the Member said that he did what he did because K.W. was "pleading for teeth".

Attempts to Obtain the Member's Chart re: K.W.

The evidence of Mr. Bunbury, a former College investigator, related primarily to his attempts to obtain the Member's chart in relation to his treatment of K.W. The Member claimed that the chart had gone missing due to a theft or fraud that had been perpetrated by two former receptionists and provided their names and contact information and the name of the police officer to whom he had reported the crime. However, the contact information for the two receptionists did not assist Mr. Bunbury in locating either of the receptionists. Further, neither the Ottawa Police Service nor the College was able to obtain any information corroborating that there had been a theft or fraud.

The Member's Response to K.W.'s Complaint

In an attachment to an email to Mr. Bunbury dated June 4, 2012, the Member responded to K.W.'s complaint.[12] In his response the Member stated, among other things, that he explained all options of treatment to her and that she approved of the treatment and signed the consent form. Further, the Member stated that "every

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[9] Exhibit 5 (Visa refund)

[10] Exhibit 8

[11] Exhibit 4

[12] Exhibit 16

step of the way was explained to her" and that not once did K.W. express any displeasure. He confirmed that K.W. returned to his office and asked for a refund, and stated, "I regret giving her a penny back."

Expert Opinion Evidence

The Panel ruled that Dr. Grace Chau Bradley was qualified to give expert opinion evidence in oral pathology and oral medicine, and also as to the standards of practice of dentistry in Ontario.

As detailed in her report[13] and her testimony, Dr. Bradley concluded that the two items she examined[14] were fragments of human teeth. Dr. Bradley explained the indicia of these being human tooth fragments as follows:

1. Careful gross examination of the items was consistent with the conclusion that they were fragments of human teeth;
2. The radiographic density of the items made it clear that they were fragments of human teeth; and
3. One of the items had a fragment of human tooth root and gutta percha filling.

When asked to assume that these items were not from the patient but had been cemented into a patient's mouth, Dr. Bradley testified that she would find this very concerning. She has never seen that being taught as a procedure. The two fragments were very irregular. In her opinion, it is completely unacceptable to cement human teeth into someone else's mouth. It would still be unacceptable even if the teeth had been sterilized first.

In Dr. Bradley's view, there are risks attendant with such a procedure. If the tooth fragments are not properly sterilized, there would be a possibility of transmitting infection. The patient might aspirate or swallow the fragments. Also, as was apparent from this case, it may be distressing to the patient to learn that teeth from someone else had been cemented into their mouth.

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[13] Exhibit 19

[14] Exhibit 7

SUBMISSIONS OF COUNSEL AND ADVICE OF INDEPENDENT COUNSEL

College Counsel's Submissions

College counsel submitted that each of the 8 allegations of professional misconduct had been proven. She invited the Panel to begin with the most important issue in the case – whether the Member cemented human teeth into K.W.'s mouth – and to address the specific allegations after that.

In College counsel's submission, the evidence that the Member had cemented human teeth from someone else into K.W.'s mouth was "overwhelming". On the basis of clinical and radiographic examination, Dr. Henike concluded that what he removed from K.W.'s mouth (and became Exhibit 7) were human tooth fragments. It was Dr. Henike's evidence that when he asked the Member about his treatment of K.W., the Member admitted that he had cemented extracted teeth into her mouth. Dr. Bradley's evidence confirmed that these items were human tooth fragments.

College counsel also sought amendment of Allegations 4 through 8 as set out in the Notice of Hearing, in each case to change reference to the year 2010 to 2012, and amendment of the particular for Allegation 7 so that it would refer to $280.00 instead of $54.00. In doing so, College counsel referred to s. 40 of the *Health Professions Procedural Code*,[15] which provides as follows:

> ***Amendment of notice of hearing***
>
> **40.** A panel may at any time permit a notice of hearing of allegations against a member to be amended to correct errors or omissions of a minor or clerical nature if it is of the opinion that it is just and equitable to do so and the panel may make any order it considers necessary to prevent prejudice to the member.

In support of this submission, College counsel argued that these were errors of a minor or clerical nature and that there would be no prejudice to the Member in making the amendments.

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[15] Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18

Independent Legal Counsel's Advice

Independent legal counsel advised the Panel that although not present, the Member is deemed to have denied the allegations.

The College bears the burden of proof. In doing so, it must meet the standard of proof on a balance of probabilities, with the proviso that for evidence to meet that standard, it must be sufficiently clear and cogent.

The overarching issue in this case is whether these were human tooth fragments. Once the Panel determines that factual issue, it can then turn to the 8 allegations and determine them. Independent legal counsel then reviewed each of the allegations. In doing so, counsel referred to the distinct meanings ascribed to the terms "disgraceful", "dishonourable", "unprofessional" and "unethical" as they appear in Allegation 8. Specifically, the term "disgraceful" carries a stigma and a finding that a member's conduct could be so described would call into question that person's fitness to remain a member of the profession. "Dishonourable" also carries a stigma, although to a lesser extent, and also calls into question the continuing suitability of the member to remain involved in the profession. "Unprofessional" can describe a broad range of behaviour.

The Member's response to K.W.'s complaint[16] is evidence both for and against the Member and should be considered in determining whether the allegations have been proven.

Independent legal counsel advised the Panel that s. 40 of the Health Professions Procedural Code is similar to provisions found elsewhere that allow for allegations of misconduct or regulatory or criminal charges to be amended where there is no prejudice to the responding party. In this case, it does not appear that the Member was misled by the references to 2010 in Allegations 4 through 8, or to the erroneous reference to $54.00 in Allegation 7.

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[16] Exhibit 16

Finally, independent legal counsel advised the Panel that multiple findings of professional misconduct can be grounded in the same event or series of events, provided that the legal elements comprising the various forms of professional misconduct differ. In that respect, independent legal counsel further advised us that that the legal elements of the forms of professional misconduct set out in Allegations 1 through 8 do differ from each other. Consequently, it is possible for the Panel to make multiple findings of professional misconduct, and indeed up to 8 such findings in this case.

DECISION

Having considered the evidence, the submissions advanced on behalf of the College and the advice of its independent legal counsel, the panel found that the Member committed professional misconduct as alleged in each of the allegations contained in the Notice of Hearing.

REASONS FOR DECISION

Allegation 1 (Contravening a standard of practice or failing to maintain the standards of practice)

Based on the testimony of the patient's dentist, Dr. Henike, and the College's expert witness, Dr. Bradley, the Panel concluded that the Member did, in fact, cement human teeth obtained from an unknown source into the mouth of K.W. In addition to Dr. Bradley's expert opinion evidence that the two items sent to her for examination were fragments of human teeth, the Panel accepted Dr. Henike's testimony that during a telephone conversation on March 27, 2012, the Member admitted that he had cemented teeth that he had extracted from someone else in K.W.

The Panel also accepted Dr. Bradley's unchallenged expert evidence that in cementing teeth from another person into K.W.'s mouth, the Member failed to meet the standards of practice. Dr. Bradley described this as "completely unacceptable" and pointed to the risks of infection, aspiration or swallowing and attendant patient distress. Unsurprisingly, Dr. Bradley has never heard of this procedure being taught anywhere.

Allegation 2 (Failing to obtain consent for a cosmetic treatment of a patient)

K.W. testified that she had lost the retainer that was provided by Dr. Henike on Saturday, March 24, 2012 and that she was self conscious and unhappy with the gaps in her smile. She wanted the spaces filled with "glued" crowns as soon as possible. K.W. testified that she had explained this to Dr. Hashem over the telephone and that he agreed to see her in his office that evening. The witness testified that she presented to his office at around 8:30 p.m. and that Dr. Hashem met her there. It was K.W.'s evidence that they again discussed "glued" crowns and she expected that false teeth would be used. No other options, risks or benefits of treatment were discussed. K.W. was not told that Dr. Hashem intended to use human teeth as replacement crowns. She further testified that had she been asked to accept the use of human teeth, she would not have consented to the treatment.

The Panel found the detail and sequence of events described by K.W. concerning her initial contact and subsequent treatment at Dr. Hashem's office to be reliable and credible. As Dr. Hashem did not participate in this hearing, either personally or through counsel, the only information from Dr. Hashem related to this allegation was in the form of his letter of response to K.W.'s complaint[17] and subsequent e-mail messages to Mr. Bunbury. [18] Because Dr. Hashem chose not to participate in this hearing, the information he has provided was not received as sworn or solemnly affirmed testimony and was not tested by cross-examination. The Panel concluded that the evidence relied on by the College was more credible and reliable than the version of events provided by Dr. Hashem.

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[17] Exhibit 16

[18] Exhibit 17. The most salient aspect of his e-mail exchange with Mr. Bunbury was Dr. Hashem's email of June 18, 2012, in which he stated as follows:

> Dear Mr. Bunbury:
> I had a fraud/theft case with two receptionists.
> This File is missing.
> I waited to see if the police will turn up any files in the fraud case,
> Ottawa police file 12-136991 but nothing came up so far.
> As soon as I get the file, I will forward it to you.
> Dr. Hashem

Allegation 3 (Making a misrepresentation about a remedy, treatment, device or procedure or failing to reveal the exact nature of a remedy, treatment, device or procedure)

K.W. testified that she thought denture teeth would be used to fill the gaps in her front teeth. K.W. testified that Dr. Hashem did not inform her that human teeth would be used to fill the spaces and did not obtain consent to use human teeth to fill the spaces. She testified that she would have refused treatment had she known human teeth would be used. The Panel found that K.W.'s evidence with respect to her treatment on March 24, 2012 was more reliable and credible than the version of events provided to Mr. Bunbury by Dr. Hashem in the form of his response to the complaint[19] and subsequent e-mail messages.[20] The Panel concluded that the evidence presented by the witnesses called by the College and the exhibits entered as evidence by the College were more credible and reliable than the version of events provided by Dr. Hashem, which was not received on oath or affirmation and could not be subjected to cross-examination.

Allegation 4 (Failing to keep records as required)

It was Mr. Bunbury's evidence that he requested the dental records of K.W. from Dr. Hashem. Mr. Bunbury testified that Dr. Hashem advised, via e-mail, that he could not produce K.W.'s records because they were missing due to fraud/theft involving two of his receptionists and that he had reported the file stolen to police.[21] Mr. Bunbury followed up with the police and no evidence was produced that the chart was stolen by previous staff. No records regarding the treatment of K.W. were ever produced by Dr. Hashem. On June 4, 2012, Dr. Hashem sent Mr. Bunbury his letter of response to K.W.'s complaint.[22] In doing so, Dr. Hashem provided his version of the events that occurred during K.W.'s emergency visit to his office on the evening of March 24, 2012. Notably, it did not refer to the fact that his file was missing, although it referred to a consent form signed by the patient and an insurance claim form that he had completed. On June 4, 2012, Mr. Bunbury acknowledged receipt of Dr. Hashem's response to the complaint and sought all of Dr. Hashem's original records for K.W. and all financial and

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[19] Exhibit 16

[20] Exhibit 17

[21] Exhibit 17; see also note 18, above, for the relevant excerpt.

[22] Exhibit 16

insurance records pertaining to the patient. It was two weeks later, on June 18, 2012, when Dr. Hashem responded to Mr. Bunbury's request by stating for the first time that the file was missing.[23]

The Panel found the explanation that the patient chart was stolen and the events described by Dr. Hashem in his e-mail to Mr. Bunbury to lack credibility as compared to the description of events on March 24, 2012 provided by K.W. and the testimony of Dr. Henike and Dr. Bradley. Further, because Dr. Hashem failed to attend this hearing, insofar as his version of the events of March 24, 2012 was inconsistent with the sworn testimony of the College's witnesses, the Panel rejected Dr. Hashem's explanation. Further, the Panel considered that it was improbable that K.W.'s file had gone missing due to actions of Dr. Hashem's staff, as he claimed in his e-mail to Mr. Bunbury.

Allegation 5 (Charging a fee that was excessive or unreasonable in relation to the services performed)

The insurance claim form for patient K.W. prepared by Dr. Hashem for services provided on March 24, 2012 was entered into evidence.[24] This claim form included procedure codes for tissue conditioning, repairs to a partial denture and a commercial laboratory fee. Based on the testimony of K.W. and Dr. Henike, along with the photographs, radiographs, models and tooth specimens exhibited at the hearing,[25] the Panel concluded that the fees charged were excessive and unreasonable and not related to the procedures actually performed. Based on K.W.'s testimony (which was corroborated by Dr. Hashem in his response to the complaint[26]), the Panel concluded that Dr. Hashem attended to K.W. alone on March 24, 2012. The Panel therefore concluded that Dr. Hashem had to complete the Insurance Claim form himself – a fact that he admitted in his letter of response[27] – and therefore knew that the procedures and fees recorded on the form were not related to the procedure he had just completed for K.W.

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[23] Exhibit 17; see also note 18, above, for the relevant excerpt.

[24] Exhibit 4

[25] Exhibits 6, 7, 11, 12, 13 and 14

[26] Exhibit 16

[27] Exhibit 16, which states in part: "I filled in the insurance claim form with the codes for the work done."

<u>Allegation 6</u> (Submitting an account or charging for dental services that was false or misleading)

The insurance claim form[28] included procedure codes and fees for tissue conditioning, repairs to a partial denture and a commercial laboratory fee. Based on the testimony of K.W. and Dr. Henike, along with the photographs, radiographs, models and tooth specimens,[29] the Panel concluded that the fees charged for these procedures were not provided. In addition, the Panel found that Dr. Hashem completed the insurance claim form himself and would therefore have known that the procedures and fees were false and misleading.

<u>Allegation 7</u> (Charging a laboratory fee that was more than the actual laboratory cost incurred)

Based on the evidence that included witness testimony of K.W. and Dr. Henike along with photographs, radiographs, models and tooth specimens entered as exhibits,[30] the Panel concluded that no commercial laboratory fees were incurred and therefore no fee for laboratory costs should have been charged.

<u>Allegation 8</u> (Engaging in conduct or performing an act that would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional, or unethical)

Based on the evidence presented by K.W., Dr. Henike and Dr. Bradley and the exhibits that included photographs, radiographs, models and tooth specimens,[31] the Panel concluded that on or about March 24, 2012, Dr. Hashem cemented one or more human teeth that did not belong to K.W. in her mouth. The Panel was convinced that this was done without K.W.'s knowledge or consent. The Panel was provided evidence by Dr. Henike and in the form of photographs that demonstrated the treatment result was clinically and aesthetically unacceptable.[32] The Panel accepted the testimony of Dr. Bradley that the use of human teeth from another individual in another patient's mouth did not conform to accepted standards of

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[28] Exhibit 4

[29] Exhibits 6, 7, 11, 12, 13 and 14

[30] Exhibits 6, 7, 11, 12, 13 and 14

[31] Exhibits 6, 7, 11, 12, 13 and 14

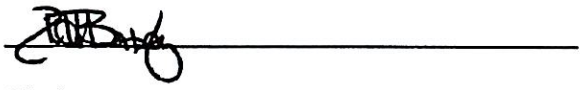
[32] Exhibits 6 and 13

treatment or infection control. The Panel concluded that Dr. Hashem then charged excessive fees that were also false and misleading; and finally that he failed to maintain any patient records related to K.W.'s emergency visit on or about March 24, 2012. The Panel unanimously found Dr. Hashem's acts and omissions in relation to the treatment of K.W. on or about March 24, 2012 to be disgraceful, dishonourable, unprofessional and unethical.

RECONVENING OF HEARING

The Panel directs that the hearing be reconvened on a date to be set by the Registrar for the penalty phase of the hearing to occur.

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



Chairperson

1 May 2014

Date

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. KHALED HASHEM**, of the City of Ottawa, in the Province of Ontario;

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

Members in Attendance: Dr. Richard Bohay (Chair)
Mr. Jose Saavedra
Mr. Manohar Kanagamy
Dr. Peter Kalman
Dr. Michael Perelgut

Certified True Copy

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Linda Rothstein and
	)	Emily Lawrence, for the
- and -	)	Royal College
	)	of Dental Surgeons of Ontario
	)	
	)	
DR. KHALED HASHEM	)	Not in attendance
	)	
	)	Brian Gover
	)	Independent Counsel to the
	)	Discipline Committee of the
	)	Royal College of Dental
	)	Surgeons of Ontario
	)	
	)	Hearing held on June 5, 2014.

DECISION AND REASONS - PENALTY

INTRODUCTION and OVERVIEW

In Reasons for Decision dated May 1, 2014, this panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("Panel") found that each of the 8 allegations of professional misconduct made against Dr. Hashem ("Member") in the Notice of Hearing (Exhibit 1) was proven.

Essentially, the College alleged that the Member cemented two human teeth from someone else into the mouth of his patient, K.W. The allegations included breaching the standards of practice by failing to maintain proper infection control protocols, failure to obtain informed consent, failure to keep records, misrepresentation, charging fees that are unreasonable, submitting a false or misleading account and charging a laboratory fee that is greater than the commercial laboratory cost. This occurred in March, 2012.

On June 5, 2014, the hearing was reconvened in order for the Panel to hear submissions as to the appropriate penalty to impose in this matter. As with the liability phase of the hearing, the Member did not appear, nor was he represented by counsel.

The Panel proceeded to hear submissions from College counsel.

Ms. Rothstein submitted that despite having received clear cautions and warnings from the Inquiries, Complaints and Reports Committee ("ICRC"), Dr. Hashem has carried on in a way that violates his professional obligations. Moreover, College counsel submitted, the Member has evinced an attitude toward the College that makes it apparent that he is ungovernable. It was her submission that revocation of the Member's certificate of registration is necessary to overcome the risk he presents to public safety.

After considering those submissions and the evidence tendered at the hearing (described below), the Panel unanimously determined that the appropriate penalty in this case is revocation of the Member's certificate of registration .
Our reasons for this decision are set out below.

EVIDENCE AT THE PENALTY PHASE OF THE HEARING

Additional evidence was received during the penalty phase of the hearing. This consisted of a binder of materials (Exhibit 21) which included the following:

1. Affidavit of Emily Lawrence, attaching correspondence to and from the Member, and attesting to the facts that the Member has not contacted College counsel's law firm since sending a letter dated March 21, 2014 ("March 21, 2014 Letter") and that the Member has not contacted the College in respect of the penalty phase of the hearing;
2. Decision and Reasons of the Complaints Committee dated April 11, 1996 concerning a complaint against the Member;
3. Decision and Reasons of the ICRC dated December 6, 2011 concerning a complaint against the Member;
4. Decision and Reasons of the ICRC dated December 7, 2011 concerning a complaint against the Member (Complainant: I. B.-T.);
5. Decision and Reasons of the ICRC dated December 7, 2011 concerning a complaint against the Member (Complainant: M.B.); and
6. Reasons for Decision of the Discipline Committee, dated August 7, 2013.

Cautions by the Complaints Committee/ICRC

The evidence disclosed that the Member has been cautioned on three occasions concerning inappropriate conduct. This conduct related to charging for services that were not performed, billing practices, inadequate infection control procedures and financial recordkeeping.

In its Decision and Reasons dated April 11, 1996, the Complaints Committee concluded that it was "evident ... that Dr. Hashem did not perform a pulpotomy although he may have attempted it, and therefore should not have charged for this procedure." [1] The amount charged was inappropriate. The Member was required to appear before the panel to be cautioned.

The ICRC's Decision and Reasons dated December 6, 2011 indicate that it was "very concerned about the adequacy of Dr. Hashem's infection control protocols."[2] It expressed concern that the Member's offices were "unsanitary and

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[1] Decision and Reasons of the Complaints Committee dated April 11, 1996, p. 4.

[2] Decision and Reasons of the ICRC dated December 6, 2011, p. 10.

disorganized", citing 9 specific issues.[3] The ICRC sent the Member an undertaking/agreement for his consideration, but the Member later advised that he had signed it with the proviso that the monitoring component be eliminated.[4] As a result, the ICRC required the Member to complete what it termed a "specified continuing education or remediation program" at his own expense.[5] It also cautioned the Member with respect to the inadequacy of his infection control protocol, something that it described as "a serious outcome for members of the dental profession".[6] Among other things, the Member was cautioned about "his obligation to implement effective infection prevention and control measures in his dental practice as an important part of safe patient care for himself, his staff and his patients".[7]

The Member was cautioned about his billing practices and financial recordkeeping as a result of the ICRC's Decision and Reasons dated December 7, 2011 regarding the complaint of M.B. The ICRC described the Member's financial recordkeeping as "completely inadequate".[8] Cheques from patients were deposited to a personal joint account held by the Member and his wife, and some services were billed for but not performed. The Member responded to the ICRC's offer of an undertaking/agreement by indicating, "I will only voluntarily consent to take the course that the college recommends, I will not consent to the monitor of my practice under the present circumstances."[9] By way of specified continuing education or mentorship programs, the ICRC required the Member to take the College's recordkeeping course and imposed a mentorship. The ICRC also cautioned the Member "with respect to his conduct in this case", stating that it had

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[3] Decision and Reasons of the ICRC dated December 6, 2011, p. 10

[4] Decision and Reasons of the ICRC dated December 6, 2011, p. 11.

[5] Decision and Reasons of the ICRC dated December 6, 2011, p. 11.

[6] Decision and Reasons of the ICRC dated December 6, 2011, p.12.

[7] Decision and Reasons of the ICRC dated December 6, 2011, p. 12.

[8] Decision and Reasons of the ICRC dated December 7, 2011 (Complainant: M.B.), p. 7.

[9] Decision and Reasons of the ICRC dated December 7, 2011 (Complainant: M.B.), p. 8.

"very serious concerns about his billing practices and his financial recordkeeping".[10]

It is striking that when he treated K.W. in March, 2012, the Member knew that his professional regulator had very serious concerns about deficiencies in his infection control and billing practices – deficiencies that appeared to be endemic.

Discipline History

As reflected by the Reasons for Decision of the Discipline Committee, dated August 7, 2013, the Member has a recent but substantial discipline history that includes findings of professional misconduct for

- failing to maintain the standards of practice of the profession (2 allegations);
- recommending or providing an unnecessary dental service (2 allegations);
- treating a patient without obtaining consent;
- failing to keep records as required (2 allegations);
- charging an excessive or unreasonable fee (2 allegations);
- submitting an account that he knew or ought to have known was false or misleading (2 allegations);
- signing or issuing a report, certificate or similar document that he knew or ought to have known contained a false, misleading or improper statement;
- failing to reply to a written enquiry made by the College; and
- engaging in conduct or an act that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional (2 allegations)

It is noteworthy that in the agreed statement of facts tendered in that case, the Member admitted that he failed to maintain the standards of practice with respect to infection control in May 2012, two months after K.W. visited his office.

Acting on a joint submission on penalty, the panel required the Member to appear before it to be reprimanded, and imposed a five (5) month suspension of the Member's certificate of registration and terms, conditions and limitations that included completion of a course on periodontics and the Program for

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[10] Decision and Reasons of the ICRC dated December 7, 2011 (Complainant: M.B.), p. 10.

Professional/Problem-Based Ethics (ProBE) course,11 and monitoring and inspection of the Member's practice.

Evidence of Ungovernability

College counsel pointed to several aspects of the record that disclose evidence of ungovernability on the Member's part.

One aspect of this is the Member's failure to participate in this hearing. At a minimum, this does not inspire confidence that the Member is prepared to recognize his professional obligations and his responsibilities to his professional regulator.

College counsel described the Member's March 21, 2014 letter (addressed to Ms. Lawrence) as having a defiant and sarcastic tone. In it, the Member wrote:

> I have written to your client on Feb. 15, 2014 informing him that I will not be attending any scheduled or prescheduled hearings as of Feb. 15, 2014. Your client should have informed you of that.
> In your letter(s) you mentioned that you will proceed in my absence, nothing stopped you client before so what is new!

Concerns about whether the Member is governable also arise from the Member's repeated refusal to voluntarily submit to monitoring of his practice. As Ms. Rothstein said at one point during the hearing, "We cannot monitor someone who will not cooperate with us."

COLLEGE COUNSEL'S SUBMISSIONS ON PENALTY

College counsel submitted that while the professional misconduct findings resulting in this hearing proceeding to the penalty phase are serious, were it only for those findings, revocation of the Member's certificate of registration may not be appropriate. Instead, it is the complete factual matrix in this case – including the Member's failures to change his practices after having been cautioned for conduct similar to the professional misconduct the Panel has found, his failure to engage and his attitude toward the College – that make revocation the appropriate penalty in this case. This is so, College counsel submitted, because a

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[11] College counsel informed us that the Member has successfully completed the periodontics course and has achieved only a conditional pass (the first such grade known to the College) on the ProBE course.

consideration of the facts leads to the conclusion that the Member is ungovernable and presents an unacceptable risk to public safety. The Panel cannot be confident that monitoring of the Member's practice and other remedial measures will be met with compliance and cooperation by the Member.

The Member's certificate of registration is currently the subject of an interim suspension that was imposed by the ICRC following K.W.'s complaint to the College.

College counsel submitted that the Member now refuses to engage with his professional regulator and that he made it very difficult for the College to provide disclosure in the case resulting from K.W.'s complaint. She submitted that this pattern of behaviour "must count against him".

College counsel referred to three decisions in which revocation has been imposed on bases that included ungovernability.

The first of these was the decision of the Discipline Committee in *Royal College of Dental Surgeons of Ontario v. Dr. David Chuang.*[12] In that case, the panel commented,

> Revocation of a member's certificate of registration is a very serious step. Each member of the Panel recognizes that this is the ultimate penalty but necessary to deal with the nature of the problems in this case. The Panel was gravely concerned about the Member's underlying attitude, which prevents him from improving his practice. He demonstrates little respect for authority or his regulating body and hence was viewed by the Panel as ungovernable. The degree of the misconduct warrants strong deterrence for both this specific member and other members of this College. In addition the panel viewed this penalty to be appropriate relative to its absolute obligation to protect the interest of the public.[13]

The other two cases also addressed the question of whether the particular member was governable and listed factors to be considered when revocation of a professional licence is at issue. These include

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[12] Released April 29, 2004.

[13] *Ibid.*, p. 55.

a) the nature, duration and repetitive character of the misconduct;[14]

b) any prior discipline history;[15]

c) any character evidence;[16]

d) the existence or lack of remorse. Remorse includes a recognition and understanding of the seriousness of the misconduct;[17]

e) the degree of willingness to be governed by the professional regulator;[18]

f) medical or other evidence that explains (but does not excuse) the misconduct;[19]

g) the likelihood of future misconduct, having regard to any treatment being undertaking, or other remedial efforts;[20]

h) the member's ongoing co-operation with the professional regulator in addressing the outstanding matters that are the subject of the misconduct.[21]

Applying those factors, the Discipline Committee of the Ontario College of Pharmacists concluded,

> Mr. Rosenberg's attitude, as represented by his blatant disregard of the College's authority to regulate his practice, by failing to reply or engage with the College in regard to the prior Order, makes it clear to the panel that he is ungovernable and unlikely to co-operate with the College in the future. Efforts to communicate with the Member have been ongoing for over two years which is unacceptable, given that the terms in the February 17, 2009 Order had specific timeframes for compliance. This suggests that the Member is not prepared to recognize his professional obligations and the regulator's role. He has demonstrated no

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[14] Cited in *Law Society of Upper Canada v. Fendik*, 2005 ONLSHP 25 (CanLII) ("*Fendik*") and *Ontario College of Pharmacists v. Rosenberg*, 2011 CanLII 99440 (ON CPDC) ("*Rosenberg*").

[15] Cited in both *Fendik* and *Rosenberg*.

[16] Cited in both *Fendik* and *Rosenberg*.

[17] Cited in both *Fendik* and *Rosenberg*.

[18] Cited in both *Fendik* and *Rosenberg*.

[19] Cited in *Fendik*.

[20] Cited in both *Fendik* and *Rosenberg*.

[21] Cited in both *Fendik* and *Rosenberg*.

remorse and no acceptance of his responsibilities by not attending the College for a reprimand, completing the required courses, or paying the required costs.[22]

ORDER AS TO PENALTY

The Panel determined that the appropriate penalty in this case is revocation of the Member's certificate of registration.

REASONS FOR ORDER AS TO PENALTY

In determining the appropriate penalty to impose in this case, the Panel took the following considerations into account:

1. The Panel concluded that the facts of this case are similar to other cases presented by the College (summarized above) for which a decision of ungovernability was determined.

2. Based on the factors that have been set out in other regulatory hearings(summarized above) in the determination of a Member's governability Dr. Hashem has failed on every point:

    a. The nature of the Member's history of misconduct is significant. Repeated concerns related to infection control practices, record keeping, and billing practices have been demonstrated and are at the centre of this hearing as well. Dr. Hashem has been before the Inquiries, Complaints and Reports Committee or its predecessor, the Complaints Committee, on three occasions, the first in 1996; and including this current hearing, before a Discipline Panel twice, in less than year. This repetitive and prolonged history of misconduct indicates that should Dr. Hashem be permitted to continue to practice dentistry, he will in all likelihood be the subject of future complaints. The evidence presented to the Panel has demonstrated a prolonged and repetitive nature of the Member's misconduct and led the Panel to conclude that deficiencies in his infection control, record keeping and billing practices are not related to a single case or incident, but are systemic within his practice of dentistry. Further, given the history and timing of the complaints and proceedings against Dr. Hashem, he has had every opportunity and reason to remediate his practice and

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[22] *Rosenberg*, "Penalty Reasons".

demonstrate this to the College. It is clear from the facts of this case that he has not learned from his past and there is no evidence that he will change in the future, if he were allowed to continue to practice dentistry.

b. Dr. Hashem has a prolonged history of appearances before the Inquiries, Complaints and Reports Committee and has been found guilty of professional misconduct by a Discipline Panel twice.

c. The Panel heard no mitigating character evidence and Dr. Hashem, himself, failed to present before this Panel to explain his actions or provide any mitigating reasons that the Panel should consider in the determination of a penalty that addresses the need to protect the public, remediate the Member's practice, deter both the Member and the membership as a whole and maintain public confidence in the regulation of the profession by the profession.

d. The failure of the Member to participate in this hearing, the difficulty he caused in the service of documents related to this complaint and the defiant, uncooperative message sent in his letter to Council for the College on March 21, 2014 are clear indications of this Member's lack of remorse or desire to remediate and change his unacceptable and unsafe practice of dentistry. The Panel considers these to be very serious aggravating factors in the determination of the penalty for this Member.

e. For the same reasons listed above, the Panel has concluded that the Member is no longer willing to be governed by the Royal College of Dentists of Ontario.

f. The Panel heard no evidence that would explain the Member's actions related to this complaint or his unwillingness to conform to current standards of practice of infection control and record keeping or his decision not to cooperate with the College and participate in this hearing.

g. Given the duration and repetitive nature of the complaints against the Member, his past unwillingness to participate in practice monitoring, which this Panel believes is essential in the remediation of a member, his failure to cooperate with the College in this hearing and his

defiant tone expressed in his correspondence with College Council indicate to this Panel that the Member has no interest or desire to change and that given the privilege to continue practising dentistry, the Member will almost certainly engage in misconduct in the future.

h. The Member has advised College counsel, in his letter of March 21, 2014 and in his actions related to this hearing that he will not co-operate with the College in matters related to his professional misconduct.

For all of these reasons the Panel concludes that the Member is ungovernable.

3. The Panel has concluded that if Dr. Hashem is allowed to continue to practice dentistry members of the public who attend his practice will be put at risk related to poor infection control, lack of informed consent to dental procedures and irregularities in charging of fees. The facts of this hearing, the past complaints to ICRC and the Member's discipline history indicate that the Member is not willing to remediate his practice to ensure that patients are treated in accordance with current standards of practice related to inflection control, informed consent, record keeping, and billing practices.

4. Protecting the public and maintaining public confidence in the profession's ability to responsibly discharge the duties involved in self-regulation are at the core of what it is to be a part of the profession of dentistry. This Panel has determined that to allow Dr. Hashem to continue to practise dentistry will place the public at risk. When a Member decides not to participate in the processes of the College that are in place to protect the public, remediate the Member and deter the Member from repeating professional misconduct, the Discipline Panel has but one choice and that is to revoke the Member's certificate of registration.

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

Chairperson

June 16, 2014

Date

Court File No. CV-14-505756

ONTARIO
SUPERIOR COURT OF JUSTICE

THE HONOURABLE JUSTICE CHARNICK) Wednesday, the 15th day
) of OCTOBER, 2014

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Applicant

-and-

KHALED EMILE HASHEM

Respondent

ORDER

THIS APPLICATION, made by the Applicant for a final Order directing the Respondent to comply with the *Regulated Health Professions Act, 1991* and the *Dentistry Act, 1991* and as further particularized in the Notice of Application, was heard this day at 393 University Avenue, Toronto, Ontario.

Sc. ✓ **ON READING** the Application Record and Factum of the Applicant, the Respondent, Khaled Emile Hashem having been duly served,
AND ON HEARING the submissions of counsel for the Applicant,

1. **THIS COURT ORDERS** that the Respondent, KHALED EMILE HASHEM, comply with section 9 of the *Dentistry Act, 1991* and sections 27, 30 and 33 of

the *Regulated Health Professions Act, 1991*, and in particular, that the Respondent refrain from the following:

i. using the title "dentist" or "dental surgeon" or a variation or abbreviation or an equivalent in another language;

ii. using the title "doctor" or a variation or abbreviation or an equivalent in another language, in the course of providing or offering to provide in Ontario health care to individuals;

iii. holding himself out as a person who is qualified to practise in Ontario as a dentist or dental surgeon or in a specialty of dentistry;

iv. performing any authorized acts set out in paragraphs 4.1 to 4.8 of the *Act* and/or any controlled acts set out in subsection 27(2) of the *RHPA*; and

v. treating or advising a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical injury may result from the treatment or advice or from an omission from them.

4. **THIS COURT FURTHER ORDERS** that costs are payable by the Respondent to the Applicant, fixed at $15,000.00 all inclusive.

THIS ORDER BEARS INTEREST at the rate of 3 per cent per year commencing on ~~July 31, 2014~~ this date.

Gordon Chapnik J.

Ohio State Dental Board
77 S. High Street, 17th Floor
Columbus, Ohio 43215-6135

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Dental.Ohio.Gov

BEFORE THE OHIO STATE DENTAL BOARD

IN THE MATTER OF:

PETER ANDREWS, D.D.S
(AKA "KHALED EMILE HASHEM")
License No. 30.026375
CASE NO. 2024-00078

ADJUDICATION ORDER

This matter came for consideration before the Ohio State Dental Board (hereinafter "Board") on January 29, 2025. A Notice of Opportunity for Hearing (Notice) was issued on September 11, 2024, which provided notice to PETER ANDREWS, D.D.S. ("DR. ANDREWS"), that under authority granted by R.C. 4715.30 and R.C. 4715.03, the Board proposed to suspend, place on probationary status, revoke, permanently revoke, refuse to renew, or refuse to reinstate, or censure his license to practice dentistry. The Notice further stated that DR. ANDREWS was entitled to a hearing if such request was made within thirty (30) days of the service of said Notice. In accordance with Chapter 119. of the Revised Code, said Notice was sent via RPost Registered Email, to the email address on file with the Board for DR. ANDREWS, and an alternate email provided to the Board's Enforcement Agent by Dr. Andrews on September 16, 2024. The email was delivered on September 19, 2024 to both email addresses, and opened by both email addresses on the same day. DR. ANDREWS did not request a hearing in this matter and more than thirty (30) days have elapsed since the service of the Notice. Accordingly, this matter proceeded in accordance with Chapter 119. of the Revised Code and Ohio case precedent, including *Goldman v. State Med. Bd. Of Ohio,* 110 Ohio App.3d 124 (10th Dist.1996). The Board reviewed the following evidence and testimony in consideration of this matter:

State's Exhibits

Notarized Affidavit of Jerry Zachariah

State's Exhibit 1: Notice of Opportunity for Hearing

State's Exhibit 2: RPost Authentication

State's Exhibit 3: New License Application of Dr. Peter Andrews

State's Exhibit 4: Royal College of Dental Surgeons of Ontario – certified discipline against Dr. Andrews (aka "Khaled Emile Hashem")

State's Exhibit 5: Canadian Broadcasting Corporation News Article, dated October 18, 2014

After having considered the evidence and testimony, and weighing the credibility of each, the Board made the following findings of fact, conclusions of law, and decision of the Board:

Findings of Fact

1. The Board has found that the legal and factual allegations in the Notice are proven by a preponderance of the evidence.

Conclusions of Law

Such conduct as set forth in paragraph one (1) in the Findings of Fact section, constitutes a violation of R.C. 4715.30(A)(1), "Employing or cooperating in fraud or material deception in applying for or obtaining a license or certificate." Further, such conduct as set forth in paragraph one (1) in the Findings of Fact section, constitutes a violation of R.C. 4715.30(A)(15), "Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand."

The conduct as set forth in paragraph one (1) of the Findings of Fact section, constitutes a violation R.C. 4715.30(A)(1) and R.C. 4715.30(A)(15).

Decision of the Board

Pursuant to R.C. 4715.30 and 4715.03, after consideration of the record, the Board ORDERS that PETER ANDREWS, D.D.S. license to practice dentistry, License Number 30.026375, be **PERMANENTLY REVOKED** effective immediately. The Board hereby certifies that this ORDER shall become effective immediately and is hereby entered upon the journal of the Board for the 29th day of January 2025.

TIME AND METHOD TO PERFECT AN APPEAL

Any party desiring to appeal shall file a Notice of Appeal with the Ohio State Dental Board, 77 S. High St., 17th Floor, Columbus, OH 43215, setting forth the order appealed from and stating that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law. The notice of appeal may, but need not, set forth the specific grounds of the party's appeal beyond the statement that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law.

The Notice of Appeal shall also be filed by the appellant with the court of common pleas of the county in which the place of business of the party is located or the county in which the party is a resident. If any party appealing from the order is not a resident of and has no place of business in this state, the party shall appeal to the Court of Common Pleas of Franklin County. In filing a notice of appeal with the agency or court, the notice that is filed may be either the original notice or a copy of the original notice. The party filing the appeal shall comply with all requirements of Ohio Revised Code Section 119.12. The notice of appeal shall be filed within fifteen days after the service of the notice of the Ohio State Dental Board's Order as provided in Section 119.05 of the Ohio Revised Code.

BY ORDER OF THE
OHIO STATE DENTAL BOARD

The State of Ohio
County of Franklin

I, the undersigned Miguel A. Santiago, Interim Executive Director for the Ohio State Dental Board, hereby certify that the foregoing is a true and exact reproduction of the original Order of the Ohio State Dental Board entered on its Journal, on the 29th day of January, 2025.

By:
Miguel A. Santiago, Esq.,
Interim Executive Director

Date 2/3/2025

(SEAL)

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing Order, concerning Dr. Peter Andrews, was sent electronically via RPost this 3rd day of February, 2025, to Dr. Peter Andrews, at the following email addresses: peteran2016@gmail.com; peterable2015@gmail.com

By _____
Miguel A. Santiago, Esq.
Interim Executive Director

cc: Katherine Bockbrader, Assistant Section Chief, Ohio Attorney General's Office

OHIO STATE DENTAL BOARD