Indexed as: Benchitrit (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE
OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Complaints Committee of The College of Physicians
and Surgeons of Ontario, pursuant to Section 26(2)
of the ***Health Professions Procedural Code***,
being Schedule 2 to the
Regulated Health Professions Act, 1991,
S.O. 1991, c.18, as amended

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. MOISE BENCHITRIT

PANEL MEMBERS: DR. M. SPRUYT (CHAIR)
DR. P. HORSHAM
DR. E. THOMPSON
P. BEECHAM
J. FREDERICK

Hearing Date(s): June 12 – 16, 2000
September 5 – 8, 2000
February 5, 2001

Decision/Released Date: February 20, 2001

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

This hearing commenced June 12 - 16, 2000 and continued September 5 - 8, November 6 - 10, 2000 and February 5, 2001, at the College of Physicians and Surgeons of Ontario at Toronto. The Committee released its Decision in writing on February 20, 2001, and indicated that further written reasons would follow.

THE ALLEGATIONS

In the Notice of Hearing it was alleged that Dr. Moise Benchitrit failed to maintain the standard of practice of the profession and engaged in conduct or an act relevant to the practice of medicine that having regard to all the circumstances would be reasonably regarded by members as disgraceful, dishonorable or unprofessional and therefore was guilty of professional misconduct for the period of before and after January 1, 1994.

It was further alleged that Dr. Benchitrit was incompetent in that he displayed in his professional care of a patient, a lack of knowledge, skill or judgment or a disregard for the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue in practice or that his practice should be restricted.

PLEA

Dr Benchitrit pleaded not guilty to the allegations.

PUBLICATION BAN

An order was made under s. 45(3) of the *Health Professions Procedural Code* prohibiting publication of any names or other identifying information with regard to any patients.

Background of the Case

Dr. Benchitrit is a psychiatrist in private practice with a special interest in Attention Deficit Hyperactivity Disorder (ADHD). He does not have hospital privileges.

Complainant #1 was the mother of a 15 year-old boy who was initially seen by Dr. Benchitrit in September 1992 and treated by him for ADHD until December 8, 1992.

The Complaints Committee requested Dr. M. Fahy review the care of this patient and her report was received in July 1994.

Compainant #2 was the mother of a 3-year-old child who was seen by Dr. Benchitrit in April 1994 and did not receive any further treatment, as the mother was unhappy with the initial assessment. Dr. Fahy also reviewed this file and submitted her report in February 1996.

Subsequent to this, the Executive Committee ordered a review of Dr. Benchitrit's practice and Dr. Harvey Alderton submitted his report in April 1997 after reviewing a total of 62 charts and meeting with Dr. Benchitrit to discuss his practice patterns. The specific questions asked of Dr. Alderton related to the physician's use of psychostimulant medications i.e. Ritalin (methylphenidate hydrochloride) and Dexedrine (dextroamphetamine sulphate).

Complainant #3 was a 45-year old man who initially saw Dr. Benchitrit in March 1994 and received treatment until November 1994. Dr. H. Alderton was asked by the College to review this complainant's file and his report was submitted in December 1998.

The key issues in this case were whether Dr. Benchitrit's care of these three complainants and of the patients whose charts were reviewed fell below what would be considered the standard of care for the prescribing and monitoring of individuals prescribed psychostimulant drugs and whether Dr. Benchitrit displayed in his care of these patients a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that he is unfit to continue in practice or that his practice should be restricted. What was not at issue was whether high dose stimulants may be appropriate for some individuals diagnosed with ADHD.

DECISION

The Panel found that Dr. Benchitrit failed to maintain the standard of practice for the period before and after January 1, 1994 and therefore was guilty of professional misconduct. The Panel also found that Dr. Benchitrit was incompetent in that for the period after January 1, 1994 he displayed in his care of patients a lack of knowledge skill and judgment and a disregard for the welfare of his patients to an extent that demonstrates that his practice should be restricted.

THE EVIDENCE

The Complainants:

Complainant #1's son was initially seen by Dr. Benchitrit in September 1992 because of school problems and was initially prescribed Dexedrine. On October 5, the patient chart records complaints of sensation of heat in his body and abdominal cramps. On October 6, there is a notation of a telephone call from the patient's mother indicating that her son is very talkative, depressed, cynical and does not know who he is. Apparently, the patient was advised to stop increasing Dexedrine according to a pre-arranged schedule and to use Buspar. On October 15, it was decided that he was not tolerating the Dexedrine and he was switched to Ritalin SR at 60 mg to increase to 80mg/day after one week. By October 22 he was complaining of blurred vision, double vision and diarrhea and the dosage was reduced back to 60 mg. However, the patient continued to complain of abdominal cramps, diarrhea and vomiting. There was some reported improvement in school performance and a note was made of a past investigation of the patient's problems.

On November 17, the patient was reported to be able to concentrate better on Ritalin 80mg SR. He did not use the additional fast release at 4 p.m. to assist him in doing homework. He had received an E and F on his report and then was advised to increase the Ritalin SR to 100mg/day. On November 26, it was noted that he was complaining of body smell, and felt there were computer chips in his brain. Although it was apparently explained to him this was a side effect of the Ritalin, he was given the option of

continuing on the current dose because his teachers had apparently stated that there was some improvement, despite his failing marks in all of his subjects.

By December 3, the patient's mother was stating that he was withdrawn, refused to go to school and was verbally aggressive. There was some confusion about whether the body odors symptom had preceded the initiation of Ritalin. When the patient stated that he had started hearing voices calling his name, Dr. Benchitrit concluded that the patient likely had paranoid schizophrenia and advised the complainant to contact their family physician to arrange hospital admission so that the patient could get an MMPI and commence neuroleptics treatment. Dr. Benchitrit advised the patient to discontinue Ritalin over 4 days. On December 8, the patient's mother cancelled all further appointments. Further notes in the chart indicate telephone calls made by Dr. Benchitrit and his office staff to the mother, who indicated her son had improved after medications had been stopped and arrangements had been made to see another psychiatrist.

Complainant #2's son was a 3-year old boy seen in April 1994 for assessment of possible ADHD. This child had a history of behavior problems and was attending a special school. He had previously been on a Mellaril with some improvement. The assessment was apparently not completed, as the mother did not make any further appointments. No treatment was given. The Panel concluded that there had not been a sufficient therapeutic relationship established to justify reliance on the complaint.

Complainant #3, a 45 year-old male, was referred to Dr. Benchitrit for assessment of mood disorder. He was first seen in May 1994. He was diagnosed as having ADHD and prescribed initially Zoloft 100 mg bid and Ritalin SR 60 mg daily to start after his mood was stabilized. The Zoloft was changed to Paxil 20-40 mg daily on May 16 according to the medication flow sheet. However, the clinical notes state he was doing fine on Zoloft. He was apparently hospitalized for a few days at the end of May for suicidal ideation and dismissed from his job. He was referred to a cardiologist prior to the initiation of Inderal LA 60 mg daily for impulse control and was advised to increase the dosage up to 160 mg daily during August 1994. He started Dexedrine 60 mg at end of August which was thus

increased to120 mg/day in September. On September 21, it was noted that the patient was changing his own medications. He was confronted about this. In October it was noted that he had still not adjusted to his medication. His Dexedrine was increased to 150 mg/day on October 4. He was admitted to hospital in October with an apparent psychotic episode. A friend of the complainant's notified the Doctor's office that the complainant was visiting different hospital emergency rooms and calling police. On October, the complainant's Dexedrine was reduced and his Paxil was changed back to Zoloft 50 tid and he was given Immovane hs. He was twice again admitted to hospital with paranoid reaction in October. His final visit was November 3 to advise Dr. Benchitrit of his concerns. At this time he was apparently only taking Zoloft 100 mg tid.

EXPERT EVIDENCE OF THE COLLEGE:

The Panel received expert evidence from Dr. Fahy regarding the care of Complainants 1and 2. Dr. Fahy's background is in community psychiatry and she had some experience with ADHD. The Panel found her evidence to be credible and of assistance in relation to history taking, development of a differential diagnosis, record-keeping, prescribing patterns and ongoing monitoring of individuals who are prescribed psychoactive substances.

The Panel also heard expert evidence from Dr. Alderton regarding Complainant 3 and with respect to his review of approximately 40 charts randomly selected from Dr. Benchitrit's office files. Dr. Alderton had extensive experience in child psychiatry, predominantly in an academic centre.

The following concerns were expressed by both the experts and extensively documented with examples from the numerous files.

Dr. Benchitrit uses a computer generated assessment format, making consultation notes that were surprisingly similar. His assessment may often take several visits but the typed note appears to be completed at the time of the first visit and diagnosis. The management plan and prescriptions also appear to be decided on that first visit. For this reason the

records were difficult to follow and consequently the diagnostic reasoning was not clear. For example, in the chart of Complainant #3, the typed consultation note appeared to be dictated on the first visit (dictated on May 4 notation at the bottom of the document) and states the next visit date to be May 5. However, the handwritten progress notes for May 5 state "The assessment was revised and Zoloft up to 100 mg po bid". A progress note for May 10 states "childhood history was revised " and a further note on May 11 states "the assessment was revised". In addition there is a medication flow sheet which in this case notes that Zoloft 100 mg bid for two months was prescribed on May 5. As in many of the other charts reviewed it appears that treatment was commenced before an assessment was even completed. According to the initial typed note of May 5, Complainant #3 was also "given Methylphenidate S.R. for 60 mg po q am to try to start after the patient will be more stable with his mood". There is no note as to when Complainant #3 actually started this or of any monitoring of side effects within the progress notes, but the medication flow sheet suggests it was increased to 80 mg q am and 40 mg after lunch on August 11. At the same time he was started on Inderal LA 60 mg for impulse control. The poor quality and the confusing nature of the records made it difficult to determine if there was any rational treatment and/or prescribing pattern. In addition the computer-generated format of the assessment made most of the assessments and treatment plans look very similar. The Panel concluded that the diagnosis and treatment plan would be decided on the first visit and would be essentially the same regardless of the additional information acquired on subsequent visits.

The following paragraphs were included verbatim in almost every chart, regardless of the age of the individual, individual circumstances or of other diagnosis mentioned:

> "It appears that this is a familial type of Attention Deficit Disorder that needs to be addressed at first. As this is a Biophysiological Disorder, mostly of the Limbic System, but not exclusively it need to be looked after before one can address the behaviour of the children as well as the family dynamics. This is also a chronic disorder which does not disappear in Adulthood and needs therefore to be medically attended to before a Psychotherapeutic intervention can occur with the

> family and or the patient. As a consequence of the unrecognized and untreated or not properly attended Attention Deficit Hyperactivity Disorder in _____, the patient has developed a low self esteem and a labile mood as well as School Difficulties, which is also developing. _____'s School Difficulties will have to be addressed in Short Term Psychotherapy, together with behaviour modification program, and a Psychopharmacological approach."

Dr. Alderton testified that he interviewed Dr. Benchitrit regarding his approach to history-taking and Dr. Benchitrit admitted to using a list of the criteria for ADHD for the family to tick off the symptoms that they noted were present. However, the list of symptoms of other possible diagnoses e.g. depression, was not presented to individuals in the same way. This introduces significant bias into the history taking because of suggestibility. Both experts testified to persistent errors in Dr. Benchitrit's use of the DSM IV-5 axis diagnostic system. He frequently used Axis I as a "presenting complaint" type of diagnosis and often listing ADHD on Axis II. Frequently comorbid diagnoses were not listed at all. Despite the observation that not all psychiatrists use this system, the Panel accepted the evidence that when this system is used it should be used correctly. Both experts testified that Dr. Benchitrit's knowledge in this regard fell below the standard of knowledge for even a medical student.

Dr. Alderton testified regarding the 48 charts that had been reviewed in 1999. Concerns were expressed regarding poor prescribing patterns, lack of adequate monitoring, and poor documentation. The following were noted throughout the charts reviewed, were illustrated with multiple examples, and were accepted by the Committee:

a) initiation of psychostimulants at much higher than usual doses and rapidly increasing dosages on a predetermined pattern with very little monitoring of response to treatment or of appearance of side-effects;
b) intermittent recording of weight with very little if any action taken if it dropped substantially;

c) lack of documentation of pulse and blood pressure for patients taking psychostimulants or beta blockers;

d) more than one drug started or adjusted at the same time thereby making it difficult to attribute side effects or perceived benefit to a particular medication;

e) individuals developing symptoms on medications which were consistently attributed to part of the disorder unmasked by the treatment of the ADHD, with little if any consideration that these symptoms might be side effects of the medication;

f) frequent prescribing of multiple medications with little if any documentation of co-morbid conditions to justify their use;

g) changing back and forth from one medication to another with very little documentation of reasons and little time allowed to monitor response to medication. (This occurred both with psychostimulants and anti-depressants.)

h) no attempt to decrease dosage when side effects appeared, to see if there might be some benefit. The routine seemed to be to add another medication to counteract the side effects;

i) lack of documentation that labwork or physical assessments were done either by Dr. Benchitrit or any other physician;

j) no apparent cardiac or other monitoring done while patients remained on these drugs although cardiology consults were obtained on many individuals before using beta-blockers;

k) teacher ratings were obtained usually at the beginning of therapy but were used inconsistently to monitor response to treatment and often medications were increased despite improvement in teacher ratings;

l) demonstration of "tunnel vision" throughout the records in that Dr. Benchitrit appeared to seek out symptoms of ADHD in order to confirm a predetermined diagnosis: despite the fact that one of the criteria for the diagnosis of ADHD is that the symptoms not be attributable to any other disorder, there was little if any effort to rule out other diagnoses causing attentional problems such as depression, family stresses or personality disorders; and

m) starting of most individuals on long acting psychostimulants without any trial of short acting medications: patients were directed to continue titrating upwards on a

weekly basis according to the written prescription and the medication record, yet there was no evidence that they were seen or reassessed prior to each medication adjustment even when using high doses.

DEFENCE EVIDENCE

In his defence Dr. Benchitrit claimed that he did motitor his patients, that they had regular check-ups with their family physicians and that "they were never sick". However, there was no clear documentation to confirm this. In the cases of the complaintants the evidence indicated that Dr. Benchitrit failed to consider that the stimulant medication he had prescribed could be the cause of serious psychotic behaviour requiring admission to hospital. In case the case of Complainant #3, Dr. Benchitrit reintroduced stimulant medications shortly after discharge from hospital only to have the individual experience the same side effects again. Dr. Benchitrit provided a single scientific paper that suggested some patients might benefit from higher doses. However, Dr. Alderton testified that even this paper states "careful monitoring and reliable feedback are essential".

The expert witness called by the defence was Dr. Jain, a pyschiatrist at an Academic Centre with a special interest in attentional and impulse disorders. His testimony was focussed mainly on pharmacotherapeutics, in particular relating to ADHD. Dr. Jain displayed an excellent knowledge of the research literature and he provided the panel with a clear and cogent understanding of the use of psychostimulants and other drugs used in attentional disorders. Although the panel found his testimony to be informative in an educational sense, Dr. Jain, did not assist the Panel on the issue of Dr. Benchitrit's competence. He did not review the patient files and was not in a position to answer the question whether Dr. Benchitrit's care of patients fell below the standard of care. He did testify that he was aware of Dr. Benchitrit's reputation for using higher than usual doses of psychostimulants and stated that given the emerging literature there was some evidence to suggest that some individuals might benefit from higher doses. He stated that Dr. Benchitrit should establish himself with a research institution in order that the concepts could be scientifically monitored and perhaps published.

Dr. Jain also testified that he had had the opportunity to assess some patient s of Dr. Benchitrit over the years, many of whom were on high doses of psychostimulants without any apparent harm. These patients were functioning reasonably well.

Counsel for Dr. Benchitrit characterized Dr. Benchitrit's practice as unique, in that he was referred the worst cases and was a doctor of last resort. However the evidence did not support this. According to the records reviewed many of these individuals had not been assessed by a psychiatrist previously and for those who had there was no apparent attempt to obtain evidence of previous treatment failures. It appears that Dr Benchitrit had a reputation in the community and a special interest in the area of ADHD. Many patients struggling with personal problems appear to have requested that their family physicians refer them to Dr. Benchitrit because they themselves believed that they may have ADHD.

Evidence Relating to Dr. Benchitrit's Credibility:

Evidence was presented and not disputed that Dr. Benchitrit had repeatedly denied being convicted of any offense on his annual CPSO re-application. However it was revealed that he had been convicted of spousal assault. Dr. Benchitrit stated that he had failed to report this as he felt it was a minor infraction similar to a parking ticket. He also failed to reveal on the same application that he had been asked to leave (had privileges removed) his internship in Montreal. He misrepresented the truth regarding his qualifications on his CV in stating he was Board eligible for psychiatry in New York when in fact he had failed the New York Board exams in 1988. He also stated on the same CV that he had passed the FMGEMS but admitted under cross-examination that he had failed the Basic Science section of this examination.

FINDINGS

In coming to a decision, the Committee considered the issue of new medical developments and changing standards of practice and how this may apply to a standard

case when a physician is alleged to have failed to maintain the standard of care. What is required is that a physician must meet the standard of care at the time the patient is treated. Certain conditions should be met before using a therapy that has not been accepted as the standard of care. Such therapy must occur in the context of properly approved clinical research which meets scientific standards and allows for effective and objective observation, assessment and evaluation. There should be clear and overwhelming evidence that the individual is suffering from a condition that has not responded to all treatments and therapies that currently fall within the standard of care. A detailed informed consent clearly outlining potential benefits and risks to the individual must be obtained. Very close monitoring of the individual undergoing the treatment must occur. Any untoward responses must be considered to be a possible response to the treatment and a trigger a serious analysis of the risks and benefit of the individual continuing in treatment. These conditions are necessary in clinical research and in the introduction of new therapies.

The evidence presented to the Committee clearly demonstrated that in his treatment of patients Dr. Benchitrit failed to meet these conditions and consequently exposed his patients to unjustifiable risk.

On the basis of the evidence, the Panel concluded that Dr. Benchitrit failed to maintain the standard of practice for the period before and after January 1, 1994 and therefore the allegations of professional misconduct were proved. The Committee further concluded for the period after January 1, 1994 that Dr. Benchitrit was incompetent under s. 52(1) of the *Health Professions Procedure Code*, in that he displayed in his professional care of his patients a lack of knowledge, skills and judgment and a disregard for the welfare of his patients, such that his practice should be restricted.

PENALTY

The Committee made the following order as to the penalty which it believes addresses the deficiencies in Dr. Benchitrit's practice and will protect the public.

1. Dr. Benchitrit is to be reprimanded and such reprimand is to be recorded on the register;

2. The Registrar was directed to suspend Dr. Benchitrit's Certificate of Registration effective March 26, 2001 (at 12:01 a.m.) except as hereinafter provided, until he has successfully completed at his own expense, with a practise supervisor, a program that is designed or approved by the College that establishes that he has the appropriate knowledge, skill and judgment in the following areas:
   a) history taking and differential diagnosis;
   b) appropriate use of DSM IV diagnostic criteria and axis diagnosis;
   c) monitoring patient prescription drug use in accordance with current standards;
   d) appropriate record keeping with respect to patient encounters and medications prescribed; and
   e) psychopharmacology.

3. Dr. Benchitrit shall be permitted to retain a restricted form of certificate of registration, which will limit his practice to the examination of patients under direct supervision of a preceptor in an academic setting for as long as he is taking the program specified in this Order.

4. The preceptor shall be the practice supervisor for the purpose of the program specified in this Order and the program shall involve assessment, remediation and reassessment in the areas of concern identified under paragraph 2. The College shall require as a measure of successful completion of the program the delivery by the preceptor of a written report satisfactory to the Registrar that states that Dr. Benchitrit has the appropriate knowledge, skill and judgment in the areas identified in paragraph 2 above.

5. Upon Dr. Benchitrit's return to practice following the Registrar being satisfied with the written report confirming Dr. Benchitrit's successful completion of the program specified in this Order, the Registrar shall be directed to impose the following terms, conditions and limitations on Dr. Benchitrit's Certificate of Registration:

a) Dr. Benchitrit will consent to a review of his clinical practice. This review together with a review of the pharmacy records will be performed by an assessor satisfactory to the Registrar who will report the findings to the Registrar initially at six months after Dr. Benchitrit returning to practice and thereafter at six month intervals for a total of two years and then annually for a period of three years. Dr. Benchitrit will be responsible for all costs associated with these assessments and reports. If the reports are not satisfactory to the Registrar during the period of monitoring, the Registrar will take such actions as are deemed appropriate. The assessor will review the practice generally and in particular with respect to the parameters (a) to (e) identified in the remediation program as described in paragraph 2 above.

b) Dr. Benchitrit will implement in his practice the treatment guidelines established by the American Academy of Child Psychiatry Practice Parameters on ADHD (1996) or equivalent guidelines as may be subsequently published.

c) Dr. Benchitrit will provide to the Registrar on an annual basis proof of participation in ongoing education in accordance with the Guidelines of the Royal College of Physicians and Surgeons of Canada in effect from time to time.

6. The Registrar shall be directed to further suspend indefinitely the Certificate of Registration of Dr. Benchitrit if he breaches the terms, conditions and limitations on his Certificate of Registration as set out in paragraph 5 (a) to (c) of this Order.

Indexed as: Benchitrit (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Complaints Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(1), and Section 26(2) of the ***Health Professions Procedural Code,*** being Schedule 2 to the ***Regulated Health Professions Act 1991***, S.O.1991, c. 18 as amended, and the

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. MOÏSE BENCHITRIT

PANEL MEMBERS: DR. M. SPRUYT (CHAIR)
DR. P. HORSHAM
DR. E. THOMPSON
P. BEECHAM
J. FREDERICK

HEARING DATES: June 12-16, 2000
September 5-8, 2000
November 6-10, 2000
February 5-6 & 8-9 2001

DECISION DATE: February 8, 2001

PENALTY DECISION RELEASED: February 20, 2001

PENALTY AND REASONS FOR PENALTY

This matter was heard before the Discipline Committee of the College of Physicians and Surgeons of Ontario, on February 5-9, 2001, at Toronto.

ALLEGATIONS

With respect to the first allegation in the Notice of Hearing, for the period before and after January 1, 1994, the panel has determined that Dr. Benchitrit has failed to maintain the standard of practice and therefore has committed an act of professional misconduct. Having so found, the panel dismisses the alternative allegation on page 2 of the Notice of Hearing related to disgraceful, dishonourable or unprofessional conduct. The panel further finds for the period after January 1, 1994, Dr. Benchitrit is incompetent under section 52(1) of the *Health Professions Procedure Code*. Further written reasons will follow.

PENALTY

The Committee has carefully considered the evidence and the submissions of counsel for the College and for the defence. In the particular circumstances of this case, which will be elaborated in further written reasons for decision and penalty to follow, the Committee does not consider revocation to be an appropriate penalty. Therefore the Discipline Committee makes the following Order as to penalty:

6. Dr. Benchitrit is to be reprimanded and such reprimand is to be recorded on the register;

7. The Registrar is directed to suspend Dr. Benchitrit's Certificate of Registration effective March 26, 2001 (at 12:01 a.m.) except as hereinafter provided, until he has successfully completed at his own expense, with a practise supervisor, a program that is designed or approved by the College that

establishes that he has the appropriate knowledge, skill and judgment in the following areas:

a) history taking and differential diagnosis;
b) appropriate use of DSM IV diagnostic criteria and axis diagnosis;
c) monitoring patient prescription drug use in accordance with current standards;
d) appropriate record keeping with respect to patient encounters and medications prescribed; and
e) psychopharmacology.

8. Dr. Benchitrit shall be permitted to retain a restricted form of certificate of registration, which will limit his practice to the examination of patients under direct supervision of a preceptor in an academic setting for as long as he is taking the program specified in this Order.

9. The preceptor shall be the practice supervisor for the purpose of the program specified in this Order and the program shall involve assessment, remediation and reassessment in the areas of concern identified under paragraph 2. The College shall require as a measure of successful completion of the program the delivery by the preceptor of a written report satisfactory to the Registrar that states that Dr. Benchitrit has the appropriate knowledge, skill and judgment in the areas identified in paragraph 2 above.

10. Upon Dr. Benchitrit's return to practice following the Registrar being satisfied with the written report confirming Dr. Benchitrit's successful completion of the program specified in this Order, the Registrar shall be directed to impose the following terms, conditions and limitations on Dr. Benchitrit's Certificate of Registration:

a) Dr. Benchitrit will consent to a review of his clinical practice. This review together with a review of the pharmacy records will be performed by an

assessor satisfactory to the Registrar who will report the findings to the Registrar initially at six months after Dr. Benchitrit returning to practice and thereafter at six month intervals for a total of two years and then annually for a period of three years. Dr. Benchitrit will be responsible for all costs associated with these assessments and reports. If the reports are not satisfactory to the Registrar during the period of monitoring, the Registrar will take such actions as are deemed appropriate. The assessor will review the practice generally and in particular with respect to the parameters (a) to (e) identified in the remediation program as described in paragraph 2 above.

b) Dr. Benchitrit will implement in his practice the treatment guidelines established by the American Academy of Child Psychiatry Practice Parameters on ADHD (1996) or equivalent guidelines as they may be subsequently published.

c) Dr. Benchitrit will provide to the Registrar on an annual basis proof of participation in ongoing education in accordance with the Guidelines of the Royal College of Physicians and Surgeons of Canada in effect from time to time.

6. The Registrar shall be directed to further suspend indefinitely the Certificate of Registration of Dr. Benchitrit if he breaches the terms, conditions and limitations on his Certificate of Registration as set out in paragraph 5 (a) to (c) of this Order.