DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Rubinoff, 2024 ONRCDSO 3
Date: 2024-10-01
File No.: 21-1031

IN THE MATTER OF: A Hearing held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*)

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

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Dr. J. Corey Rubinoff

FINDING AND PENALTY REASONS

RESTRICTION ON PUBLICATION

In the matter of the Royal College of Dental Surgeons of Ontario and Dr. J. Corey Rubinoff the Discipline Panel ordered, under ss 45(3) of the Health Professions Procedural Code, that no person shall publish or broadcast the identity of any patients of the Registrant, or any information that could disclose the identity of any patients who are named in the exhibits marked at the hearing.

PANEL REGISTRANTS:
Ms. Judy Welikovitch, Public Member (Chair)
Dr. Nalin Bhargava, Professional Member
Dr. Virginia Luks, Professional Member

APPEARANCES:
Emily Lawrence, for the College
Jordan Glick, for Dr. J. Corey Rubinoff
Andrea Gonsalves, Independent Legal Counsel

Heard: October 1, 2024, by videoconference
Decision Date: October 1, 2024
Release of Written Reasons: December 5, 2024

REASONS FOR DECISION

[1] This matter came on for hearing before a Panel of the Discipline Committee (the "**Panel**") of the Royal College of Dental Surgeons of Ontario (the "**College**") in Toronto on October 1, 2024. This matter was heard electronically.

[2] At the outset of the hearing, the College sought an order that no person shall publish or broadcast the identity of the patient of the Registrant, or any information that could disclose the identity of the patient named in the exhibits marked at the hearing or in the submissions made orally at the hearing. The Registrant consented to the request. The Panel granted the order.

The Allegations

[3] The College's allegations of professional misconduct against Dr. Rubinoff (the "**Registrant**") are set out in a notice of hearing dated November 24, 2021, as follows:

1. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2018, 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 relative to one of your patients, namely A.A., contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - Prior to the patient's appointment with you on November 21, 2018, a treatment plan was developed and agreed-upon by you, the referring dentist (Dr. Dale Nixon), and the patient, for the extraction of four teeth (15, 22, 23, and 25), and the eventual insertion of five titanium implants with screw-retained porcelain crowns. A temporary prosthesis was designed by Dr. Nixon in accordance with this plan.

   - At the appointment of November 21, 2018, you extracted four additional teeth (13, 12, 11, and 21) that were not part of the established treatment plan. You did not

obtain the patient's consent to alter the treatment plan and/or to extract these additional teeth.

- You did not consult with Dr. Nixon prior to altering the patient's treatment plan.

- There was no clinical reason to support the extraction of teeth 13, 12, 11, and 21.

The Registrant's Plea

[4] The Registrant admitted the allegation of professional misconduct contained the Notice of Hearing. The Chair conducted an oral plea inquiry on the record at the hearing and a written plea inquiry signed by the Registrant was entered into evidence at the hearing. Based on the Registrant's responses, the Panel was satisfied that his admissions were voluntary, informed and unequivocal.

The Evidence

[5] On consent of the parties, the College introduced into evidence an Agreed Statement of Facts ("**ASF**") (Exhibit 3). The Agreed Statement of Facts provides as follows:

The Registrant

1. Dr. J. Corey Rubinoff (the "Registrant") has been registered with the Royal College of Dental Surgeons (the "College") as a general dentist since 1991.

2. At all relevant times, the Registrant practiced at two different locations: Willowdale Dental Group, 12 Finch Avenue West, Toronto, ON and Kilislian Dentistry Professional, 5160 Yonge Street, Toronto, ON.

Notice of Hearing

3. The allegations of professional misconduct against the Registrant are set out in the Notice of Hearing dated June 15, 2020.

4. The College and the Registrant have agreed to resolve the allegations on the basis of the facts and admissions set out below.

Facts and admissions

A. The Complaint and Investigation

5. The facts giving rise to the allegations in the Notice of Hearing came to the attention of the College through a complaint received February 19, 2019, from patient, Mr. A. Mr. A's complaint alleged that, without his consent, Dr. Rubinoff extracted eight teeth in November 2018 when he had only consented to the extraction of four teeth. He also complained of pain and suffering resulting from therapies rendered by the Registrant, and that he was repeatedly denied access

to the records surrounding his own care, and when provided, he received fraudulent documentation, including consent forms that had been changed to include the extractions of eight teeth instead of four.

6. Through the course of its investigation, the College obtained Dr. Rubinoff's records for Mr. A and records from Mr. A's referring dentist, Dr. Dale Nixon.

B. The Registrant's Treatment of Mr. A

7. In early 2018, Mr. A and his treating dentist, Dr. Nixon, first discussed a plan for treatment after Mr. A lost a crown.

8. On May 17, 2018, Dr. Nixon proposed a treatment plan for the extraction of teeth 15, 22, 23 and 25 and insertion of implants at sites 16, 14, 23, 25 and 26. This plan called for an endodontic consultation, the creation of models and implant surgery.

9. Dr. Nixon referred Mr. A to Dr. Rubinoff for the extraction and implantation of implants. Dr. Rubinoff first met Mr. A on May 30, 2018 for a consultation and review of the treatment plan suggested by Dr. Nixon. Dr. Rubinoff sent Mr. A for a second CBCT scan. Following the CBCT scan, Dr. Rubinoff met again on September 5, 2018 with Mr. A to advise him that bone grafting would be required, along with the tooth extractions, followed by a healing period and the insertion of the implants.

10. In September and October 2018, Dr. Nixon met with Mr. A to discuss the costs of the proposed treatment plan. Dr. Nixon submitted a predetermination of benefits to Mr. A's insurer for crowns on teeth 17, 13, 12, 11, and 21 and implant-supported retainers/crowns and/or pontics for teeth 16, 15, 14, 22, 23, 24, 25, 26.

11. Mr. A's oral surgery was scheduled for November 21, 2018. The treatment plan prepared by Dr. Nixon was to retain teeth 17, 13, 12, 11 and 21 and insert implant-supported retainers/crowns and/or pontics for teeth 14, 15, 16, 22, 23, 24, 25, 26. This would require the extraction of teeth 15, 22, 23, and 25 and insertion of implants at sites 16, 14, 23, 25 and 26. Mr. A understood and consented to this treatment plan. The Registrant also understood this was the agreed upon treatment plan.

12. The Registrant and Dr. Nixon met on November 19, 2018 to discuss Mr. A's treatment plan and planned surgery. Dr. Nixon and Dr. Rubinoff agreed that Dr. Nixon would section Mr. A's bridge just prior to the surgery. Dr. Nixon prepared a temporary denture.

13. Mr. A's oral surgery proceeded on November 21, 2018. Dr. Nixon removed Mr. A's bridge and the Registrant performed oral surgery on Mr. A. It is undisputed that during this surgery the Registrant extracted all of teeth 22, 23, 25, 15, 13, 12, 11, 21, leaving tooth 17, and completing socket preservation for teeth 23, 22, 15 and bone grafting near tooth 16, 14, 25, and 26.

14. In advance of the surgery, Mr. A executed two consent forms, both witnessed by Rhonda Hosch, staff in the office:

    (a) A Consent for Removal of a Tooth or Teeth which included the following typed statement: “I have been explained the benefits of removal of tooth number(s)” and the following insertion in handwriting: “22, 23, 25, 15 + 13, 12, 11, 21 --> AS PER PATIENT IN CHAIR SEE CHART NOTES AS PER DR RUBINOFF”

    (b) A Consent for Bone Graft which included the following typed statement: “I understand that a bone substitute material…will be placed into my jaw area near tooth number(s)” and the following insertion in handwriting: “23, 22, 15, 16, 14, 25-26, 13-21”

15. If Mr. A were to testify, he would state that he understood that the Registrant would be performing the extractions and bone grafting as set out in the treatment plan. The Consent for Removal of Teeth that he executed included handwritten notations to remove teeth 22, 23, 25, 15 only.

16. If the Registrant were to testify, he would state that on November 21, 2018, prior to the treatment and while in the treatment room, the Registrant and Mr. A discussed the patient’s wishes for white teeth and Dr. Nixon’s recommendation to replace the crowns at teeth 13, 12, 11 and 21 at a later date to match the implants to be inserted. Mr. A advised the Registrant that he was considering amending his treatment plan to extract all maxillary teeth to be replaced by an implant-supported prosthesis as more cost-effective. This would ensure all maxillary teeth “matched” and it would be a more affordable treatment plan. The Registrant suggested that he could complete a “Teeth-in-a-day” treatment instead of Mr. A completing Dr. Nixon’s proposed treatment. Mr. A understood this would mean that he would not have a transitional denture on that day. After this discussion, Mr. A gave verbal consent to include extraction of four additional teeth, which the Registrant documented. The Registrant asked the clinic receptionist to update the already executed consent form with notation of the additional teeth requiring extraction. The Registrant then completed the eight extractions and bone grafting. He did not charge for the additional extractions or graft placement, as a “gesture of kindness.”

17. The Registrant produced documentation to the College of his treatment of Mr. A on November 21. His charting on the discussion he asserts he had with Mr. A about the change of a treatment plan is detailed and consistent with the preceding information to which he would have testified. It included confirmation that Mr. A orally agreed to change the treatment plan and to transfer his care to the Registrant.

18. After the surgery, the Registrant submitted an account for the extraction of teeth 15, 22, 23, 25 and socket preservation for teeth 23, 22, 15, and ridge reconstructions for teeth 16, and 14.

19. That evening, the Registrant advised Dr. Nixon's office that Mr. A had "insisted" that Dr. Rubinoff remove all remaining teeth except one, and that he hoped Dr. Nixon would understand. The following day, the Registrant advised Dr. Nixon that Mr. A wished to remain with the Registrant for the surgery and prosthetics.

20. On November 22, 2018, the Registrant charted that he had met with Mr. A on that day for a post-operative examination and discussion about the next treatment steps for a one-piece screw-retained restoration. Mr. A had significant swelling, and the insertion of his transitional denture was postponed. The Registrant charted that "Pt left happy with his wife." If the Registrant were to testify, he would state that Mr. A's wife was displeased with Mr. A's decision to change his treatment plan.

21. If Mr. A were to testify, he would state he was not happy. On November 26, 2018, Mr. A wrote to administrative staff at the Willowdale Group to request a refund for the "unauthorized extraction" of teeth. He advised Dr. Nixon that he did not want to see the Registrant again.

C. Allegation 1: Failure to Obtain Informed Consent

22. The Registrant admits that he proposed a treatment that was a significant change to a finalized treatment plan, while Mr. A was in the treatment room on the day of surgery, and then he completed the proposed treatment immediately thereafter. The Registrant admits and acknowledges that he did not provide Mr. A with an adequate opportunity to consider his proposed alteration to the treatment plan, which represented a significant change to the treatment plan that Mr. A had developed over several months. The Registrant also acknowledges that he may not have been as clear in his explanation of the extractions that were required under his proposal, despite his position that he did communicate the change in the number of extractions to Mr. A. The Registrant acknowledges that, in hindsight, he should have provided Mr. A with time to consider his proposed change in the treatment plan and consulted with Dr. Nixon and Mr A before proceeding with it, to ensure that Mr. A was fully informed of what his proposed treatment entailed.

23. The Registrant admits that he did not obtain Mr. A's fully informed consent before extracting eight teeth and that doing so constituted professional misconduct contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing as alleged.

General

24. The Registrant admits that the acts described above constitute professional misconduct and he accepts responsibility for his actions and the resulting consequences.

25. The Registrant has had the opportunity to take independent legal advice with respect to his admissions.

Decision

[6] Having considered the evidence and submissions of the parties, the Panel found that the Registrant committed professional misconduct as set out in the Notice of Hearing.

Reasons for Decision

[7] The Registrant appeared before this Panel of the Discipline Committee pursuant to a Notice of Hearing that contained a single allegation of misconduct with respect to a single patient, namely Mr. A.

Allegation: Professional Misconduct

[8] The College alleged that Dr. Rubinoff committed an act of professional misconduct within the meaning of s. 51(1)(c) of the *Health Professions Procedural Code* (the “Code”), being Schedule 2 of the Ontario *Regulated Health Professions Act, 1991*, as amended (the “RHPA”).

[9] In particular, the College alleged that on November 18, 2018, the Registrant developed a treatment plan for his patient, Mr. A, in collaboration with Mr. A, and Mr. A’s referring dentist, Dr. Dale Nixon. This treatment plan called for the extraction of four (4) teeth (numbers 15, 22, 23 and 25) and the eventual insertion of five (5) titanium implants with screw-retained porcelain crowns. Dr. Nixon designed a temporary prosthesis for Mr. A in accordance with this plan.

[10] The College alleged that at Mr. A’s appointment with the Registrant on November 21, 2018, the Registrant extracted an additional four (4) teeth (numbers 13, 12, 11, and 21). The extraction of these four (4) additional teeth was not part of the established treatment plan and, moreover, there was no clinical reason to support the extraction of these additional teeth.

[11] More significantly, it was alleged that Dr. Rubinoff did not obtain the patient’s informed consent to alter the treatment plan and/or extract the additional teeth, nor did he consult with Dr. Nixon prior to altering Mr. A’s treatment plan.

[12] It was thus alleged that Dr. Rubinoff committed professional misconduct in that he treated Mr. A for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in which consent is required by law, without first obtaining such consent, contrary to paragraph 7 of Section 2 of *Ontario Regulation 853/93*, as amended.

[13] The ASF presented to the Panel (Exhibit 3) contained the evidence tendered by the College to prove the allegations.

[14] The Panel notes that the ASF reflects some factual inconsistencies as between the account of Mr. A and that of the Registrant. In particular, with respect to the treatment provided by the Registrant, the ASF provides that Mr. A would state that:

1. On November 21, 2018, he understood that Dr. Rubinoff would be performing the extractions and bone grafting as set out in the treatment plan developed in collaboration with Dr. Nixon; and

2. On November 22, 2018, when Mr. A and his wife left Dr. Rubinoff's office following a post-operative appointment, he was not happy with the treatment he had received.

[15] By contrast, according to the ASF, Dr. Rubinoff would state that:

1. prior to the commencement of treatment, but while in the treatment room, he and the patient discussed Mr. A's desire for white teeth and Dr. Nixon's recommendation to replace the crowns at teeth 13, 12, 11, and 21 at a later date to match the implants to be inserted;

2. Dr. Rubinoff suggested that he could complete "teeth in a day" instead of following Dr. Nixon's treatment plan. "Teeth in a day" involved the removal of an additional four (4) teeth, meaning that A would have eight teeth (8) removed in a single surgery; and

3. Following this discussion, Mr. A gave oral consent to extract the four additional teeth which the Registrant documented.

[16] Regardless of the differing accounts of what transpired on November 21 and 22 of 2018, Dr. Rubinoff did make the following admissions in the ASF:

1. He proposed a treatment that was a significant change to the finalized treatment plan while Mr. A was in the treatment room on the day of the surgery, and the Registrant completed the newly-proposed treatment immediately thereafter;

2. He did not provide Mr. A with an adequate opportunity to consider the proposed alteration to the treatment plan which he admits represented a significant change to the treatment plan that Mr. A had developed over several months together with his treating dentist, Dr. Nixon, and later, Dr. Rubinoff. The Registrant admitted to this fact notwithstanding his position that he did communicate the change in the number of extractions to the patient;

3. Dr. Rubinoff acknowledged that, in hindsight, he should have provided Mr. A with adequate time to consider his proposed changes to the treatment plan and that he should have consulted with Dr. Nixon and Mr. A together before proceeding with the

treatment on November 21, 2018, to ensure that Mr. A was fully informed of what the Registrant's proposed treatment would entail.

[17] Overall, Dr. Rubinoff admitted that he did not obtain Mr. A's fully informed consent before extracting eight (8) teeth and that doing so constituted professional misconduct, contrary to paragraph 7 of Section 2 of the *Dentistry Act Regulation*, being *Regulation 853/93*, as amended.

[18] The Panel has reviewed the evidence, including the statements given by Dr. Rubinoff during the oral plea enquiry and the admissions he made at paragraphs 22 and 23 of the ASF. We have considered the legal requirement that when treating a patient, a dentist *must* obtain the informed consent of the patient. Treating a patient in the absence of such consent constitutes professional misconduct within the meaning of s. 51(1)(c) of the *Code* when read with s. 2(7) of *Ontario Regulation 853/93*.

[19] The admissions made by Dr. Rubinoff at paragraphs 22 and 23 of the ASF are sufficient to support this Panel's finding, on a balance of probabilities, that Dr. Rubinoff did not have Mr. A's fully informed consent before he proceeded to execute on a significantly altered treatment plan on November 21, 2018. Dr. Rubinoff performed complex dental surgery as described in the Notice of Hearing (Exhibit 1) and the ASF (Exhibit 3) without first obtaining Mr. A's fully informed and meaningful consent. The treatment plan relating to Patient A was developed over a period of months in consultation with his treating dentist, Dr. Nixon. The changes proposed by Dr. Rubinoff on the day of the surgery were significant, involving the extraction of an additional four (4) teeth. Indeed, in the view of the Panel, it was not possible for Mr. A to give meaningful, informed consent and proceed with this newly-revised, complex, and involved treatment plan under the circumstances as they were on the day of the procedure. Dr. Rubinoff should have recognized that his patient would need time to duly consider the proposal. Mr. A should have been given an opportunity by Dr. Rubinoff to consult with Dr. Nixon about the proposed changes to the treatment plan, and to consider the advantages and disadvantages of the newly presented plan. None of this was afforded to Mr. A.

Penalty Submissions

[20] The parties presented the Panel with a Joint Submission with respect to Penalty and Costs (Exhibit 4) ("**JSPC**"), and asked the Panel to make an order as follows:

1. Requiring the Registrant to appear before the Panel of the Discipline Committee to be reprimanded within fifteen (15) days of the date this Order becomes final.

2. Directing the Registrar to suspend the Registrant's certificate of registration for a period of three (3) months. The suspension shall commence on October 2, 2024 at 12:01 am, and shall run without interruption.

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

   a. while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

      i. staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;

      ii. dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;

      iii. dentists or other individuals who routinely refer patients to the Registrant; faculty Registrants at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;

      iv. owners of a practice or office in which the Registrant works; and

      v. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

   b. while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

      i. acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;

      ii. giving orders or standing orders to dental hygienists;

      iii. supervising work performed by others;

      iv. working in the capacity of a dental assistant or performing laboratory work; or

      v. acting as a clinical instructor;

   c. while suspended, the Registrant must not be present in offices or practices where the Registrant works when patients are present, except for

emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

d. while suspended, the Registrant must not benefit or profit, directly or indirectly from the practice of dentistry

   i. the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.

   ii. the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.

   iii. the Registrant must not sign insurance claims for work that has been completed by others during the suspension period;

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

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

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

Remedial Courses

a. the Registrant is to successfully complete a course on informed consent approved by the College within six (6) months of the date of the Panel's order;

b. the Registrant is to successfully complete a recordkeeping course approved by the College within six (6) months of the date of the Panel's order; and

c. the Registrant is to successfully complete one-on-one instruction in ethics with an instructor approved by the College within six (6) months of the date of the Panel's order. The College will provide the Notice of Hearing, Agreed Statement of Facts, Joint Submission on Penalty and the Discipline Committee's reasons in this matter to the instructor. Prior to instruction commencing, the instructor will provide the College the educational objectives for the instruction in writing for approval by the College.

d. the Practice Conditions imposed in paragraphs 4a, 4b, and 4c will be removed from the Registrant's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing

acceptable to the Registrar that the requirements above have been completed successfully.

Compliance Monitoring

e. The Registrant shall inform the College of each and every location at which he practices ("Practice Locations") within five (5) days of commencing practice at that location, until all of the Practice Conditions have been satisfied.

Practice Mentoring

f. The Registrant will submit to Practice Mentoring for a period of six (6) months, as follows:

   i. the Registrant may not practice unless and until a practice mentor has been approved by the College (the "Practice Mentor");

   ii. the Registrant will meet with the Practice Mentor approved by the College on the topics of informed consent and recordkeeping generally and in relation to implant dentistry;

   iii. During the practice mentorship, the Registrant must meet with the practice mentor in person or online at the Registrant's practice location or another location approved by the practice mentor on at least five (5) occasions within six (6) months during which the Practice Mentor will review at least 50 charts;

   iv. For the first three (3) months of the Practice Mentoring, the Practice Mentor:

      1. must review at least 10 patient charts every month to verify that the Registrant has appropriately obtained informed consent from each patient and adhered to the standard of dental recordkeeping for such; and

      2. must report to the College each month, within two (2) weeks of each meeting with the Registrant. Such reports will detail the date of the meeting, summarize their discussions and the Registrant's progress on informed consent and recordkeeping; summarize all patient charts reviewed; list any recommendations made to the Registrant about informed consent and recordkeeping and whether the Registrant implemented such recommendations.

   v. For the last three (3) months of practice mentoring, the Practice Mentor:

      1. must review at least 10 patient charts every six weeks to verify that the Registrant. has appropriately obtained informed consent from each patient and adhered to the standard of dental recordkeeping for such;

2. must report to the College each month within two (2) weeks of each meeting with the Registrant. Such reports will detail the date of the meeting, summarize their discussions and the Registrant's progress on informed consent and recordkeeping; summarize all patient charts reviewed; list any recommendations made to the Registrant about informed consent and recordkeeping and whether the Registrant implemented such recommendations.

vi. If fewer than 10 patients have been seen either before the first meeting with the Practice Mentor and or since the last meeting with the Practice Mentor, the Registrant must provide all available patient charts to the Practice Mentor to review;

vii. The Practice Mentor has the sole discretion to select the patient charts for review;

viii. At the conclusion of six (6) months of practice mentoring during and where the Practice Mentor has delivered at least five (5) reports, reviewed at least 50 patient charts, and met with the Registrant on at least five (5) occasions, the Practice Mentor may recommend to the College in writing that the practice mentoring cease. Where the College accepts this recommendation, the practice mentoring will cease and the term, condition and limitation specified in paragraph 4e will be removed from the Registrant's certificate of registration;

ix. The Registrant shall pay to the Practice Mentor in respect of the cost of Practice Mentoring, the amount of $1,000.00 per meeting, such amount to be paid immediately after completion of each meeting.

Practice Monitoring

g. The Registrant will be subject to practice monitoring with a College-approved practice monitor ("the Practice Monitor") for a period of thirty-six (36) months commencing immediately after the completion of the practice mentoring, as follows:

i. The practice monitoring will relate to the topics of informed consent and recordkeeping;

ii. The Practice Monitor will conduct practice visits at least quarterly for first year and semi-annually in the second year, for a minimum of six (6) visits;

iii. The Practice Monitor will review six (6) patient charts at each practice monitoring visit;

iv. The Practice Monitor will submit a report to the College after each visit detailing the Registrant's progress, summarizing the six (6) patient charts reviewed, listing any recommendations made to the Registrant and whether the Registrant implemented such recommendations;

v. The Registrant shall pay to the College in respect of the cost of Practice Monitoring, the amount of $1,000.00 per inspection or chart

review, such amount to be paid immediately after completion of each inspection or review; and

vi. At the conclusion of 36 months of practice monitoring, if the Practice Monitor reports to the College in writing that the Registrant is progressing well and recommends that the practice monitoring cease, and if approved by the College, the term, condition and limitation specified in paragraph 3f will be removed from the Registrant's certificate of registration.

5. The Registrant shall pay costs to the College in the amount of $7,500.00 within ninety (90) days of the date of the Discipline Hearing, being December 30, 2024.

Penalty Decision

[21] The Panel accepted the JSPC, and made the following order (the "**Order**"):

1. Requiring the Registrant to appear before the Panel of the Discipline Committee to be reprimanded within fifteen (15) days of the date this Order becomes final.

2. Directing the Registrar to suspend the Registrant's certificate of registration for a period of three (3) months. The suspension shall commence on October 2, 2024 at 12:01 am, and shall run without interruption.

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

   a. while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

      i. staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;

      ii. dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;

      iii. dentists or other individuals who routinely refer patients to the Registrant; faculty Registrants at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;

      iv. owners of a practice or office in which the Registrant works; and

v. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

b. while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

i. acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;

ii. giving orders or standing orders to dental hygienists;

iii. supervising work performed by others;

iv. working in the capacity of a dental assistant or performing laboratory work; or

v. acting as a clinical instructor;

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

d. while suspended, the Registrant must not benefit or profit, directly or indirectly from the practice of dentistry

i. the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.

ii. the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.

iii. the Registrant must not sign insurance claims for work that has been completed by others during the suspension period;

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

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

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

Remedial Courses

a. the Registrant is to successfully complete a course on informed consent approved by the College within six (6) months of the date of the Panel's order;

b. the Registrant is to successfully complete a recordkeeping course approved by the College within six (6) months of the date of the Panel's order; and

c. the Registrant is to successfully complete one-on-one instruction in ethics with an instructor approved by the College within six (6) months of the date of the Panel's order. The College will provide the Notice of Hearing, Agreed Statement of Facts, Joint Submission on Penalty and the Discipline Committee's reasons in this matter to the instructor. Prior to instruction commencing, the instructor will provide the College the educational objectives for the instruction in writing for approval by the College.

d. the Practice Conditions imposed in paragraphs 4a, 4b, and 4c will be removed from the Registrant's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements above have been completed successfully.

Compliance Monitoring

e. The Registrant shall inform the College of each and every location at which he practices (“Practice Locations”) within five (5) days of commencing practice at that location, until all of the Practice Conditions have been satisfied.

Practice Mentoring

f. The Registrant will submit to Practice Mentoring for a period of six (6) months, as follows:

   i. the Registrant may not practice unless and until a practice mentor has been approved by the College (the “Practice Mentor”);

   ii. the Registrant will meet with the Practice Mentor approved by the College on the topics of informed consent and recordkeeping generally and in relation to implant dentistry;

   iii. During the practice mentorship, the Registrant must meet with the practice mentor in person or online at the Registrant’s practice location or another location approved by the practice mentor on at least five (5) occasions within six (6) months during which the Practice Mentor will review at least 50 charts;

   iv. For the first three (3) months of the Practice Mentoring, the Practice Mentor:

      1. must review at least 10 patient charts every month to verify that the Registrant has appropriately obtained informed consent from each patient and adhered to the standard of dental recordkeeping for such; and

      2. must report to the College each month, within two (2) weeks of each meeting with the Registrant. Such reports will detail the date of the meeting, summarize their discussions and the Registrant’s progress on informed consent and recordkeeping; summarize all patient charts reviewed; list any recommendations made to the Registrant about informed consent and recordkeeping and whether the Registrant implemented such recommendations.

   v. For the last three (3) months of practice mentoring, the Practice Mentor:

1. must review at least 10 patient charts every six weeks to verify that the Registrant. has appropriately obtained informed consent from each patient and adhered to the standard of dental recordkeeping for such;

2. must report to the College each month within two (2) weeks of each meeting with the Registrant. Such reports will detail the date of the meeting, summarize their discussions and the Registrant's progress on informed consent and recordkeeping; summarize all patient charts reviewed; list any recommendations made to the Registrant about informed consent and recordkeeping and whether the Registrant implemented such recommendations.

vi. If fewer than 10 patients have been seen either before the first meeting with the Practice Mentor and or since the last meeting with the Practice Mentor, the Registrant must provide all available patient charts to the Practice Mentor to review;

vii. The Practice Mentor has the sole discretion to select the patient charts for review;

viii. At the conclusion of six (6) months of practice mentoring during and where the Practice Mentor has delivered at least five (5) reports, reviewed at least 50 patient charts, and met with the Registrant on at least five (5) occasions, the Practice Mentor may recommend to the College in writing that the practice mentoring cease. Where the College accepts this recommendation, the practice mentoring will cease and the term, condition and limitation specified in paragraph 4e will be removed from the Registrant's certificate of registration;

ix. The Registrant shall pay to the Practice Mentor in respect of the cost of Practice Mentoring, the amount of $1,000.00 per meeting, such amount to be paid immediately after completion of each meeting.

Practice Monitoring

g. The Registrant will be subject to practice monitoring with a College-approved practice monitor ("the Practice Monitor") for a period of thirty-six (36) months

commencing immediately after the completion of the practice mentoring, as follows:

i. The practice monitoring will relate to the topics of informed consent and recordkeeping;

ii. The Practice Monitor will conduct practice visits at least quarterly for first year and semi-annually in the second year, for a minimum of six (6) visits;

iii. The Practice Monitor will review six (6) patient charts at each practice monitoring visit;

iv. The Practice Monitor will submit a report to the College after each visit detailing the Registrant's progress, summarizing the six (6) patient charts reviewed, listing any recommendations made to the Registrant and whether the Registrant implemented such recommendations;

v. The Registrant shall pay to the College in respect of the cost of Practice Monitoring, the amount of $1,000.00 per inspection or chart review, such amount to be paid immediately after completion of each inspection or review; and

vi. At the conclusion of 36 months of practice monitoring, if the Practice Monitor reports to the College in writing that the Registrant is progressing well and recommends that the practice monitoring cease, and if approved by the College, the term, condition and limitation specified in paragraph 3f will be removed from the Registrant's certificate of registration.

5. The Registrant shall pay costs to the College in the amount of $7,500.00 within ninety (90) days of the date of the Discipline Hearing, being December 30, 2024.

Reasons for Penalty Decision

[22] It is settled law that a decision-maker should not lightly depart from an agreement that has been reached by the parties with respect to an appropriate penalty. The test is not one of "fitness of sentence" but rather, the more stringent test of whether the jointly proposed penalty

would bring the administration of justice into disrepute or would otherwise be contrary to the public interest."[1]

[23] For the reasons that follow, the Panel accepted the JSPC and concluded that the proposed penalties and the costs award to the College are reasonable and appropriate in the circumstances of this case.

[24] The Discipline Committee's goal in imposing penalties is not to punish the Registrant. It is not intended to be punitive. The goal of a penalty is to protect the public from dentists who have committed professional misconduct. It is also to maintain public confidence in the profession and in its ability to self-regulate.

[25] A penalty must serve as a measure of general deterrence, in that it sends a clear and unequivocal message to all registrants of the dental profession that the type of misconduct cannot and will not be tolerated. It must also serve as a measure of specific deterrence with respect to the dentist concerned.

[26] An appropriate penalty should also provide for remediation or rehabilitation of the dentist concerned, where possible and appropriate.

[27] Counsel for the College and for the Registrant urged the Panel to accept the JSPC. They argued that the jointly proposed penalty reflects the seriousness of Dr. Rubinoff's misconduct, and the terms are appropriate having regard to the objectives of penalty, the aggravating and mitigating factors in this case, and the interests of the public, the profession, and the Registrant himself.

[28] In reaching its decision, the Panel considered the principles of penalty, the submissions of the parties and the advice of its independent legal counsel, the mitigating and aggravating factors, and the circumstances of the case as a whole.

[29] This case involves unique issues of penalty because although Dr. Rubinoff has no prior discipline history, the Inquiries, Complaints, and Reports Committee of the RCDSO (the **"ICRC"**) has considered complaints and concerns about his practice and professionalism on twelve (12) separate occasions dating back to 2005. A summary of those matters is set out below. As that summary demonstrates, issues about which the ICRC expressed concerns, or for

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[1] *R v Anthony Cook*, 2016 SCC 43, applied in the professional discipline context in *Ontario College of Teachers v Merolle,* 2023 ONSC 3453 at para 32

which Specified Continuing Education or Remediation Programs ("**SCERPs**") were required and/or cautions delivered, recurred over time in Dr. Rubinoff's practice.

[30] The Panel reviewed the JSPC with a view to ensuring that the proposed penalty would provide an element of protection for Dr. Rubinoff's current and future patients. To that end, the Registrant has been ordered to take the remedial courses referred to above. The Panel expects that Dr. Rubinoff will incorporate and implement his learnings into his practice of dentistry. It also expects that the requirement to take these remedial courses will function as a specific deterrent of future misconduct for Dr. Rubinoff, and as a general deterrent for the profession at large.

[31] Dr. Rubinoff is also required to submit to Compliance Monitoring and Practice Mentoring. The Panel expects that these elements of the penalty will reinforce Dr. Rubinoff's remediation and rehabilitation. They should also bolster the general and specific deterrent effects of the penalty.

[32] The Panel has imposed on Dr. Rubinoff a practice monitoring requirement for period of thirty-six (36) months. The Panel expects that this element of the penalty will similarly support Dr. Rubinoff's rehabilitation and remediation, that it will have a specific deterrent effect on the Registrant and on the profession at large, and that it will provide protection to the public. It will also send a clear and unequivocal message to the public that this type of conduct will not and cannot be tolerated by the profession.

[33] In reaching its conclusion that the penalty proposed by the parties is appropriate in this case, the Panel also considered the mitigating and aggravating factors brought to its attention by the parties.

[34] The mitigating factors present in this case include that:

1. Dr. Rubinoff did take accountability for his conduct and avoided the necessity of a contested hearing on the merits;

2. he acknowledged his deficiencies;

3. although registered as an Ontario dentist since 1991, Dr. Rubinoff has not previously been called to appear before a Discipline Panel of the RCDSO.

[35] Against these mitigating factors, the Panel weighed the aggravating factors present in this case. These include that:

1. The misconduct to which Dr. Rubinoff has admitted is serious. He proposed significant changes to a well-developed treatment plan without providing his patient with sufficient time to consider the advantages and disadvantages of the proposal or to consult with his referring dentist, Dr. Nixon. Thus, the consent that Dr. Rubinoff received from Mr. A cannot truly be described as "informed";

2. This misconduct caused harm to Mr. A. This harm might have been avoided had Dr. Rubinoff ensured that Mr. A had an opportunity to consider the proposed treatment-plan changes in a meaningful way;

3. Although Dr. Rubinoff has not previously been before a Panel of the RCDSO Discipline Committee, complaints about his practice and professionalism have been considered by the Inquiries, Complaints, and Reports Committee of the RCDSO (the **"ICRC**") on twelve (12) separate occasions dating back to 2005. To summarize:

    Practice Monitoring

    a. Upon the ICRC's consideration of complaints made about Dr. Rubinoff, he has been required to have his practice monitored for a period of two (2) years on five (5) of these occasions. His practice was monitored from January 2005 to January 2007; from September 2010 to September 2012; from July 2012 to July 2014 (there being a three-month overlap with the September 2010 monitoring period); from December 2020 to December 2022; and from June 2021 to June 2023 (there being a seven-month overlap between the latter two periods).

    b. In sum, Dr. Rubinoff has been subject to practice monitoring for a total of 110 months since January 2005, or approximately 9.2 years, ending in June 2023.

    c. The extended time during which Dr. Rubinoff has been subject to practice monitoring is a serious and concerning aspect of Dr. Rubinoff's professional record with the College.

    Record-Keeping

    d. Dr. Rubinoff undertook to take a course on record-keeping in January 2005. In July 2012, the ICRC again expressed concern about Dr. Rubinoff's record-keeping. In July 2013, another panel of the ICRC issued a SCERP

requiring him to complete the College's course on record-keeping and in March 2017, it again expressed concern and provided advice to Dr. Rubinoff about his record-keeping. Lastly, in June 2021, the ICRC issued a caution and a SCERP requiring Dr. Rubinoff to take another course on dental record-keeping.

Informed Consent

e. In January 2005, Dr. Rubinoff provided a panel of the ICRC with an undertaking to take a course on informed consent. In November 2007, the ICRC cautioned Dr. Rubinoff about informed consent and his communications with a patient. Subsequently, in July 2013, the ICRC issued a SCERP requiring Dr. Rubinoff to complete the College's course on informed consent. In April 2016, the ICRC expressed concerns about Dr. Rubinoff having undertaken procedures with a patient in the absence of informed consent. Then, in November 2016, a different panel of the ICRC provided advice and direction to Dr. Rubinoff about obtaining meaningful informed consent from patients. Most recently, in June 2021, the ICRC issued a caution and a SCERP requiring Dr. Rubinoff to take another course on informed consent.

Compliance with the College's Sedation Guidelines

f. In December 2006, while his practice was being monitored, Dr. Rubinoff was cautioned by the ICRC to acquaint himself with the College's sedation guidelines and ensure that only appropriately trained staff were permitted to administer sedation and monitor patients.

g. Issues regarding Dr. Rubinoff's sedation practices were again considered by the ICRC in July 2012. The panel noted that Dr. Rubinoff had previously been cautioned to follow the College's sedation guidelines and accepted his undertaking to complete a one-on-one course in sedation protocols.

h. In March 2017, the ICRC considered concerns about Dr. Rubinoff's compliance with sedation guidelines. There were also concerns about Dr. Rubinoff's staff's practices in creating clear and precise records about sedation practices that complied with RCDSO sedation guidelines. These

concerns arose from an inspection of Dr. Rubinoff's office that was carried out in response to his application for a sedation facility permit.

Skills Upgrading

i. Since 2005, the ICRC has, on multiple occasions, required Dr. Rubinoff, to complete skills-upgrading courses. More specifically:

   i. **Endodontic therapy**: in January 2005, a panel of the ICRC accepted Dr. Rubinoff's undertaking to take a course in endodontic therapy and to cease endodontic practice until he had successfully completed the course;

   ii. **Restorative dentistry**: in September 2010 and again in July 2013, panels of the ICRC accepted Dr. Rubinoff's undertaking to complete a course in restorative dentistry;

   iii. **Sedation protocols**: in July 2012, a panel of the ICRC accepted Dr. Rubinoff's undertaking to complete a hands-on course in sedation protocols;

   iv. **Orthodontics**: in April 2016, a panel of the ICRC issued a SCERP requiring Dr. Rubinoff to complete a course in orthodontics; and

   v. **Implant Dentistry**: in December 2020, a panel of the ICRC expressed concern about multiple occasions on which Dr. Rubinoff failed to properly assess a case at the outset and failed to refer to specialists as appropriate. The panel also expressed concern about Dr. Rubinoff's tendency to overestimate his clinical abilities, and to take on cases without a thorough and adequate assessment and to mismanage complications. On this occasion, the ICRC issued a SCERP.

[36] It is notable that in the context of a complaint considered on July 10, 2013, the ICRC panel expressed "very serious concerns about Dr. Rubinoff's conduct with respect to the treatment provided…"[2] The panel referred to a number of prior ICRC decisions in which Dr.

[2] Brief provided entitled Rubinoff Past Decisions October 1, 2024, at p. 69 of 149

Rubinoff had been required to/undertook to take courses in recordkeeping and informed consent. He was cautioned about his need to communicate clearly and effectively with patients.[3]

[37] The ICRC panel expressed its concern that:

> "[D]espite the completion of a course and monitoring in 2004, and the issuance of cautions in 2007 and 2010, the [Registrant] has again failed to maintain the standards of the profession in these areas of practice. The panel [expressed concern] that *the [Registrant] has not maintained the* ***application*** *of the lessons learned in his previous course and cautions*."[4] [Emphasis added]

[38] The ICRC also noted that:

> [D]during its discussions, the panel *considered a referral of specified allegations for a hearing before a Discipline Committee*, given the extent of its concerns and the number of previous attempts at remediation on these same issues (recordkeeping, informed consent, billing issues). However, ***the panel has decided to provide the [Registrant] with one last opportunity at remediation***…"[5] [Emphasis added]

[39] That decision was delivered in 2013, being more than ten (10) years ago. In the interval, Dr. Rubinoff has appeared before panels of the ICRC on six (6) further occasions.

[40] Notwithstanding his extensive history with the ICRC, and the "last chance" warning he received in 2013, the present proceeding is the first time that Dr. Rubinoff has appeared before a panel of the Discipline Committee. The Panel recognizes that the ICRC matters cannot be considered for the substance of the complaints, which were not the subject of a hearing, and the ICRC is not a fact-finding body. However, the Registrant's history with the ICRC is relevant in considering the JSPC and appropriate terms of a penalty order to achieve remediation.

[41] Despite his extensive history before the ICRC, the many remediation courses he has completed, and the many years of having his practice monitored, Dr. Rubinoff has struggled to maintain his practice at or above the standard of care. He has, in fact, had many opportunities to remediate. As the ICRC panel noted in 2013, he has had many chances. Perhaps Dr. Rubinoff has had too many chances. It is for this reason, and against the backdrop of the Registrant's ICRC history, that the Panel agrees with the JSPC that a period of suspension, coupled with additional remediation requirements and practice monitoring, is appropriate in the circumstances of this case.

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[3] Ibid at p 70 of 149
[4] Ibid at p 71 of 149
[5] Ibid

[42] The period of three (3) months' suspension is appropriate and reasonable in the circumstances of this case, particularly in light of Dr. Rubinoff's extensive history before the ICRC. The suspension will have a specific deterrent effect for Dr. Rubinoff. It will also have a more general deterrent effect in that it will send a message to members of the profession and to the public that acts of professional misconduct will be taken very seriously by the Discipline Committee of the RCDSO. It will provide assurance to the public that the RCDSO is acting in its interest and doing its utmost to ensure its protection.

[43] The Panel has also ordered that Dr. Rubinoff complete a series of courses that the Panel hopes will support him in his rehabilitative efforts. These include courses on recordkeeping, informed consent, and a one-on-one instruction on ethics. He is also required to undergo compliance monitoring, practice mentoring for a period of six (6) months, and practice monitoring for a further period of thirty-six (36) months. The Panel's expectation is that the combination of these remediation measures will support and reinforce Dr. Rubinoff's rehabilitative efforts.

[44] With the imposition of the measures in the Panel's order, and the delivery of these Reasons, it is the Panel's intent to send a clear, unequivocal message to Dr. Rubinoff that his conduct has fallen below the standard expected of dentists in Ontario consistently over time; that any future appearances by him before the Discipline Committee may well result in the imposition of more severe penalties.

[45] It is also the Panel's intent to send a clear message to the profession that responding to complaints at the ICRC should be taken very seriously. Having a record of matters before the ICRC will be relevant to the issue of penalty should a related matter be referred to the Discipline Committee.

[46] With respect to the issue of costs, the Panel found that the amount of $7,500 as agreed by the parties in the JSPC was reasonable in the circumstances. There was no reason to depart from that agreement.

[47] For these reasons, the Panel accepted the JSPC and ordered that its terms and conditions be imposed.

The Reprimand

[48] At the conclusion of the discipline hearing, the Panel administered the reprimand to the Registrant. A copy of the reprimand is attached as Appendix "A" to these Reasons.

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

December 5, 2024

Date

APPENDIX "A"

RCDSO v. Dr. J. Corey Rubinoff

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

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

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

The panel has found that you have engaged in professional misconduct. The misconduct related to your treatment of Patient A. You have admitted, and the Panel found, that you performed complex and complicated oral surgery on this patient without having first received meaningful and informed consent from him. More specifically, when Patient A attended at your office for treatment, you made significant changes to a treatment plan that had been carefully and thoughtfully developed by yourself in collaboration with Patient A and Patient A's referring dentist, Dr. Nixon. The original treatment plan called for the extraction of four teeth whereas you extracted eight teeth on November 21, 2018. In the circumstances as described, you admitted, and the Panel found, that Patient A did not have an adequate opportunity to consider the proposed alteration to the treatment plan which represented a significant change to an already-complex plan, nor did he have an opportunity to consult with Dr. Nixon before proceeding.

We have found that your failure to obtain meaningful and informed consent for this therapeutic treatment constitutes professional misconduct.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged caused harm to your patient. The misconduct is considered very serious and might have been avoided had you taken steps to ensure that your patient was fully informed and that he had a meaningful opportunity to both consider the changes proposed by you and to consult with his referring dentist, Dr. Nixon.

While we acknowledge that this is your first appearance before a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario, we have also been made aware that you have a lengthy history with the Inquiries, Complaints and Reports Committee dating back to 2004. You have at times undertaken and at other times been required to take courses on informed consent, record keeping and other aspects of dentistry. You have been required on at least five occasions to submit to a two-year program of practice monitoring. That would be a ten-year period of practice monitoring thus far.

Your appearance here before the Discipline Committee represents an escalation for you and for the College. It is for this reason that we have ordered a suspension of three months and extensive practice mentoring and monitoring. The goal of these measures is to both impress upon you that the College takes your misconduct very seriously, and to aid you in your rehabilitation. The penalty is a fair one in light of the circumstances. Should you appear before a panel of this Committee in the future, you may expect a more severe penalty.