DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Weiss, 2026 ONRCDSO 13

Date: 2026-09-04

File No.: 24-0444, 25-0090

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Dr. Solomon Weiss
Registration No: 11087

FINDING AND PENALTY REASONS

RESTRICTION ON PUBLICATION

In the matter of the Royal College of Dental Surgeons of Ontario and Dr. Weiss 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 Notice of Hearing and/or the Agreed Statement of Facts in this matter.

PANEL MEMBERS:
Judy Welikovitch, Public Member (Chair)
Noha Gomaa, Professional Member
Luisa Ritacca, Subject Matter Expert

APPEARANCES:
Ahmad Mozaffari, for the College
Symon Zucker, for Dr. Solomon Weiss

Heard: June 23, 2026, by video conference

DECISION AND REASONS

[1] This matter came on for a hearing before a Panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario (the **"College**") on June 23, 2026. The hearing was held by way of videoconference.

[2] The matter concerned two (2) Notices of Hearing containing allegations of professional misconduct by Dr. Solomon Weiss ("Dr. **Weiss**" or the "**Registrant**"). The matters were heard

concurrently, on the consent of the parties, pursuant to Section 9.1(1)(a) of the Ontario *Statutory Powers Procedures Act.*[1]

[3] Dr. Weiss admitted to the acts of professional misconduct alleged by the College. The hearing proceeded by way of an agreed statement of facts. The Panel of the Discipline Committee (the "**Panel**") made findings of professional misconduct and imposed a penalty in accordance with the parties' Joint Submission on Order ("**JSO**"; Exhibit 4).

[4] These are the Panel's reasons for decision.

THE ALLEGATIONS

[5] The allegations were set forth in two Notices of Hearing, namely No. 24-0444 dated 30 July 2024 (Exhibit 1) and No.25-0090 dated 5 February 2025 (Exhibit 2).

[6] With respect to Notice of Hearing 24-0444, the College made five (5) allegations of professional misconduct against Dr. Weiss pursuant to section 51(1)(c) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991* (the "**Code**").[2] The allegations and related particulars are as follows:

1. Dr. Weiss committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code in that, during the years 2020 and/or 2021, he contravened a standard of practice or failed to maintain the standards of practice of the profession in relation to Patient 1 (the "**Patient**"), contrary to paragraph 1 of Section 2 of Ontario Regulation 853/93 under the Dentistry Act, 1991, as amended ("**Professional Misconduct Regulation**").

   Particulars:

   - he did not diagnose the Patient and created a treatment plan that was minimal and inadequate to the complexity of the Patient's case. He did not provide the Patient with a prognosis and did not conduct or record appropriate diagnostic testing to allow for an adequate case work-up.
   - He did not adequately conduct diagnostic testing or diagnose the Patient to support recommendations for root canal treatment.
   - His communications with other professionals regarding root canal treatment are not adequately documented in the Patient record.
   - He failed to arrive at a diagnosis for the Patient's complaint of pain in tooth 23 at the time of the Patient's initial consult and did not refer the Patient for root canal treatment on the tooth until much later.
   - His informed consent practices did not meet the standard of practice of the profession:
     - He did not inform the Patient about the treatment plan or the risks, benefits, and alternatives of the proposed treatment before starting the treatment or when the Patient's treatment plan was changed.

[1] SO 1990, C. S.22
[2] SO 1991, c. 18

- There was no indication that he asked if the Patient had any questions or provided them with an opportunity to ask questions about the proposed treatment.
- He did not discuss with the Patient the role that the third party, VH would play in the treatment or whether the Patient consented to his sharing the Patient's records or financial records with the third party.
- None of his informed consent discussions with the Patient were documented in the Patient's chart.

2. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code in that, during the years 2020 and/or 2021, he treated or attempted to treat a disease, disorder or dysfunction of the oral-facial complex that he knew or ought to have known was beyond his expertise or competence in relation to Patient 1, contrary to paragraph 5 of Section 2 of the Professional Misconduct Regulation.

   Particulars:

   - He did not understand the complexity of the Patient's case or consider the complexity of the Patient's case when he decided to start the treatment.
   - He failed to perform an adequate work-up or create a staged treatment plan that was appropriate to the complexity of the case.
   - He failed to offer or recommend that the Patient consult a prosthodontist to consider alternative treatment options.

3. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code in that, during the years 2020 and/or 2021, he treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent in relation to Patient 1, contrary to paragraph 7 of Section 2 of the Professional Misconduct Regulation.

   Particulars:

   - He did not inform the Patient about the treatment plan or the risks, benefits, and alternatives of the proposed treatment before starting the treatment or when the Patient's treatment plan was changed.
   - He did not ask if the Patient had any questions or provide them with an opportunity to ask questions about the proposed treatment.
   - He did not discuss with the Patient the role that the third party, VZ would play in the treatment or whether the Patient consented to his sharing the Patient's records or financial records with the third party.

4. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code in that, during the years 2020 and/or 2021, he failed to keep records as required by the regulations in relation to Patient 1, contrary to paragraph 25 of Section 2 of the Professional Misconduct Regulation.

   Particulars:

   - His dental records for the Patient did not meet the standards of practice of the profession, and lacked:
     - A comprehensive examination and clinical findings to support a diagnosis;

- A diagnosis;
- A problem list;
- A prognosis;
- Advantages and disadvantage of the treatment options;
- A discussion of the staging of treatment;
- Any discussion with the Patient about recommendations for hygiene treatment;
- Records of the financial arrangement between he and a third party for the treatment and of his communications with the third party about the costs of treatment; or
- Accurate and complete financial records.

5. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code in that, during the years 2020 and/or 2021, he engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical in relation to the Patient, contrary to paragraph 59 of Section 2 of the Professional Misconduct Regulation.

   Particulars:

   - He spoke to the Patient in an argumentative, inappropriate and unprofessional tone and interrupted the Patient when they were speaking;
   - He made inappropriate comments to the Patient, including saying that the Patient was "playing games" and saying "informed you about what" when the Patient raised concerns about his informed consent practices.

[7] With respect to Notice of Hearing 25-0090, the College made four (4) allegations of professional misconduct against Dr. Weiss pursuant to section 51(1)(c) of the Code. The allegations and related particulars are as follows:

1. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the years 2019 to 2022, he contravened a standard of practice or failed to maintain the standards of practice of the profession, in relation to the care he provided to Patient 2 and/or to Patient 3, contrary to paragraph 1 of Section 2 of Ontario Regulation 853/93 under the *Dentistry Act, 1991*, as amended ("*Professional Misconduct Regulation*").

   Particulars:

   With respect to Patient 2:

   - He failed to maintain the standard of the profession with respect to his diagnosis, work-up, treatment planning, and management of the patient's prosthodontic treatment.
     - He did not complete appropriate clinical investigations into Patient 2's pre-existing dental condition, including her periodontal health, post-accident temporomandibular jaw disorder and recurrent caries, before proceeding with implant-supported crowns on teeth 11 (upper right central incisor) and 22 (upper left lateral incisor) and a crown on tooth 21 (upper left central incisor).

    - He took insufficient photographs and he did not make appropriate models and/or diagnostic wax-ups.
    - He did not evaluate Patient 2's occlusion and habits, and he did not consider the functional aspects of his treatment.
    - He did not appropriately investigate the reason(s) for Patient 2's repeated broken temporary crowns.
- He failed to maintain the standard of the profession in his informed consent practice.
    - He did not appropriately review the risks of treatment and Patient 2's particular risks given her individual circumstances, including poor periodontal health, heavy occlusion, poor oral hygiene and smoking.
    - He did not appropriately review Patient 2's aesthetic expectations and her understanding about the importance of regular dental follow-up.
- He took excessive time to complete the prosthodontic treatment for Patient 2.
- He failed to appropriately refer Patient 2 to a specialist.
- He failed to maintain the standard of the profession in his dental recordkeeping practice.
    - He failed to document his clinical findings, interpretations of radiographs and diagnoses.
    - He failed to adequately document his informed consent and other treatment discussions with Patient 2.
    - He failed to document adequate instructions to the laboratory for the fabrication of Patient 2's crowns.
    - His clinical notes are poorly organized, incomplete and lack sufficient detail.

With respect to Patient 3:

- He failed to maintain the standard of the profession with respect to his diagnosis, work-up, treatment planning, and management of the patient's prosthodontic treatment.
    - He did not complete appropriate clinical investigations into Patient 3's pre-existing dental condition, including his periodontal health and occlusion, before recommending and proceeding with all on 4 dentures.
    - He did not adequately explore Patient 3's pre-treatment concerns and expectations.
    - He did not consider alternate treatment options that could have saved some or all of Patient 3's natural teeth.
    - He embarked on overly aggressive treatment for a relatively young patient. He did not educate and encourage Patient 3 to improve his oral hygiene and periodontal health so he might keep some or all of his teeth.
    - He did not evaluate Patient 3's occlusion and habits, and he did not consider the functional aspects of his treatment. He prioritized the patient's aesthetic concerns over functional concerns.
- He failed to maintain the standard of the profession in his informed consent practice.
    - He only gave Patient 3 the option of full mouth clearance with implant-supported dentures. He did not offer any alternate treatment proposals, including an option to preserve some or all of his teeth.

    - He did not appropriately review the risks of treatment and Patient 3's particular risks given his individual circumstances, including bone loss, poor periodontal health, smoking and poor oral hygiene.
    - He did not appropriately review Patient 3's aesthetic expectations and his understanding about the importance of regular dental follow-up.
- He took excessive time to complete the prosthodontic treatment for Patient 3.
- He failed to appropriately refer Patient 3 to a specialist.
- He failed to maintain the standard of the profession in his dental recordkeeping practice.
    - He failed to document his clinical findings, interpretations of radiographs and diagnoses.
    - He failed to adequately document his informed consent and other treatment discussions with Patient 3.
    - He failed to document adequate instructions to the laboratory for the fabrication of Patient 3's dentures.
    - His clinical notes are poorly organized, incomplete and lack sufficient detail.

2. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the years 2019 and 2021, he treated or attempted to treat Patient 3 for a disease, disorder or dysfunction of the oral-facial complex that he knew or ought to have known was beyond his expertise or competence, contrary to paragraph 5 of Section 2 of the *Professional Misconduct Regulation*.

   Particulars:

   - He failed to recognize that the complexity of Patient 3's case, including occlusal, functional and aesthetic considerations, was beyond his expertise or competence.
   - He failed to appropriately refer the patient to a specialist.

3. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the years 2019 to 2022, he treated Patient 2 and/or Patient 3 for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent, contrary to paragraph 7 of Section 2 of the *Professional Misconduct Regulation*.

   Particulars:

   With respect to Patient 2:

   - He failed to adequately discuss with Patient 2 the available treatment options and their respective risks and benefits.
       - He did not appropriately review the risks of treatment and Patient 2's particular risks given her individual circumstances, including poor periodontal health, heavy occlusion, poor oral hygiene and smoking.
       - He did not appropriately review Patient 2's aesthetic expectations and her understanding about the importance of regular dental follow-up.

With respect to Patient 3:

- He failed to adequately discuss with Patient 3 the available treatment options and their respective risks and benefits.
    - He only gave Patient 3 the option of full mouth clearance with implant-supported dentures. He did not offer any alternate treatment proposals, including an option to preserve some or all of his teeth.
    - He did not appropriately review the risks of treatment and Patient 3's particular risks given his individual circumstances, including bone loss, poor periodontal health, smoking and poor oral hygiene.
    - He did not appropriately review Patient 3's aesthetic expectations and his understanding about the importance of regular dental follow-up.

4. He committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code* in that, during the years 2019 to 2022, he failed to keep records as required by the regulations, in relation to Patient 2 and/or Patient 3, contrary to paragraph 25 of Section 2 of the *Professional Misconduct Regulation* and section 38 of Regulation 547, R.R.O. 1990, under the *Drug and Pharmacies Regulation Act*, as amended.

    Particulars:

    - He failed to document his clinical findings, interpretations of radiographs and diagnoses.
    - He failed to adequately document his informed consent and other treatment discussions with the patients.
    - He failed to document adequate instructions to the laboratory for the fabrication of Patient 2's crowns and/or Patient 3's dentures.
    - His clinical notes are poorly organized, incomplete and lack sufficient detail.

THE REGISTRANT'S PLEA

[8] The Registrant admitted to each of the allegations in the notices of hearing. The Chair conducted an oral plea inquiry to confirm that the Registrant's admissions of professional misconduct were voluntary, informed and unequivocal. The Agreed Statement of Facts (the "**ASF**"; Exhibit 3) entered into evidence and signed by the parties also confirmed Dr. Weiss' understanding of the nature of the allegations made against him and the consequences of admitting to the alleged acts of professional misconduct, and that he voluntarily decided to admit to the allegations against him.

THE EVIDENCE

[9] As noted, the parties provided the Panel with an ASF. The relevant facts set out in the ASF are as follows (attachments referred to in the ASF have been omitted):

Background

1. At the material times, Dr. Solomon David Weiss (the "**Registrant**"), was a duly registered member of the Royal College of Dental Surgeons of Ontario (the "**College**") practising at The

Art of Dentistry located at 2-25 Bellair Street in Toronto, Ontario (the "**Clinic**"). A copy of the Registrant's profile from the Dentist Register is attached hereto as "**Tab 1**".

NOTICE OF HEARING 24-0444

Patient 1

2. In February 2020, Patient 1 sought orthodontic treatment from the Registrant at the Clinic based on a recommendation from Patient 1's friend (the "**Third Party**").

3. Patient 1 received treatment from the Registrant for a full mouth reconstruction. Patient 1 attended appointments with the Registrant from February 14, 2020 to May 13, 2021.

4. Between March 4, 2020 and May 13, 2021, Patient 1 attended the Registrant's office over a dozen times for treatment. During this time period, the Registrant shaved teeth, placed temporaries, extracted teeth, installed crowns, inserted implants, performed root canals and inserted dentures in Patient 1's mouth.

5. At various points over the course of receiving treatment from the Registrant, Patient 1 complained of severe sensitivity, extreme discomfort, pain and bleeding. Patient 1 also developed an infection in her mouth resulting from the treatment she received from the Registrant. Towards the end of her treatment, the Registrant prescribed steroids and Toradol to manage Patient 1's pain.

Failure to Obtain Informed Consent

6. The Registrant failed to obtain informed consent to treatment from Patient 1 prior to commencing treatment. The Registrant did not create, provide to or discuss with Patient 1 an appropriate treatment plan, especially considering the complexity of Patient 1's case.

7. The Registrant did not discuss the risks, benefits and alternatives of the proposed treatment, either before starting treatment or when Patient 1's treatment plan was changed.

8. The Registrant did not ask Patient 1 if they had any questions about their treatment and did not provide Patient 1 with an opportunity to ask questions about the proposed treatment prior to commencing treatment.

9. The Registrant shared information, including the Patient's medical and financial records, with the Third Party without Patient 1's consent and without discussing the role that the Third Party would play in Patient 1's treatment.

10. The Registrant failed to document any discussions he had with Patient 1 regarding the proposed treatment in Patient 1's chart.

11. The Registrant acknowledges that his failure to obtain and document informed consent to the treatment from Patient 1 also constitutes a failure to maintain the standards of practice of the profession.

Failure to Maintain the Standards of Practice of the Profession

12. In addition to the conduct described in paragraphs 4 to 11 above, the Registrant agrees that he failed to maintain the standards of the practice of the profession in the following ways:

    a. The Registrant failed to properly diagnose Patient 1. The Registrant did not provide Patient 1 with a prognosis, and did not conduct or record appropriate diagnostic testing to allow for an adequate case work-up;

    b. The Registrant did not conduct adequate diagnostic testing or diagnose Patient 1 to support recommendations for root canal treatment;

    c. The Registrant's communications with other professionals regarding root canal treatment were not adequately documented in Patient 1's record;

    d. The Registrant failed to diagnose the cause of pain in Patient 1's tooth 23 during their initial consultation and failed to refer Patient 1 for root canal treatment on tooth 23 within an adequate timeframe;

    e. The Registrant prepared a treatment plan, which included root canal treatments, for Patient 1 that was minimal, not suited to the complexity of their case, and that was inadequately supported by diagnostic testing or a diagnosis; and

    f. The Registrant did not maintain appropriate records about any diagnostic testing of Patient 1, or about any communications he had with other professionals about the treatment he recommended.

The Registrant provided treatment that was beyond his expertise or competence

13. The Registrant knew or ought to have known that Patient 1's case was complex. The Registrant did not understand or consider the complexity of Patient 1's case in his decision to initiate treatment.

14. The Registrant failed to prepare an adequate case work-up or create a staged treatment plan suitable for the complexity of Patient 1's case.

15. The Registrant did not offer to Patient 1, and did not refer Patient 1 to, a prosthodontist for consultation and to consider alternative treatment options.

Failure to Keep Records as Required

16. The Registrant's records about Patient 1 and their treatment were incomplete and did not include:

    a. A comprehensive examination and clinical findings to support a diagnosis;

    b. A medical history for Patient 1;

    c. A diagnosis, problem list or prognosis for Patient 1;

d. The development of a treatment plan, or the advantages and disadvantages of the treatment options;

e. A discussion of the staging of treatment;

f. Any discussion with Patient 1 about recommendations for hygiene treatment;

g. Records of the financial arrangement between the Registrant and the Third Party for the treatment and of his communications with the Third Party about the costs of treatment; or

h. Accurate and complete financial records.

Committing Conduct or Act that Would Reasonably Regarded as Disgraceful, Dishonourable, Unprofessional or Unethical

17. While treating Patient 1, the Registrant spoke in an argumentative, inappropriate, and unprofessional tone. The Registrant interrupted Patient 1 and made inappropriate comments during their appointments, like saying Patient 1 was “playing games", and, when Patient 1 raised concerns about informed consent, responding “informed you about what".

Expert Report

18. The College retained an expert, Dr. Peter McDermott, to review the Registrant’s treatment of Patient 1. Dr. McDermott opined that, in his treatment of Patient 1, the Registrant failed to meet the standards of practice of the profession and failed to maintain records as required.

19. In particular, Dr. McDermott opined that the Registrant’s consent, diagnosis, casework, treatment planning, and recordkeeping related to his treatment of Patient 1 all failed to meet the standards of the practice of the profession. Dr. McDermott further opined that Patient 1’s case presented sufficient complexity that was outside of the Registrant’s scope of practice as a general dentist, and that the Registrant should have provided Patient 1 with the opportunity to be referred to a prosthodontist for treatment.

NOTICE OF HEARING 25-0090

Patient 2 and Patient 3

20. In 2019, Patient 2 and her adult son, Patient 3, sought orthodontic treatment from the Registrant at the Clinic. Both Patients 2 and 3 received treatment from the Registrant for temporary and, later, permanent teeth. Patients 2 and 3 saw the Registrant for treatment until early 2022.

21. The Registrant failed to obtain informed consent from Patients 2 and 3 prior to commencing their treatments.

Failure to Obtain Informed Consent – Patient 2

22. Regarding Patient 2, the Registrant failed to create an appropriate treatment plan. The Registrant did not adequately discuss the available treatment options for Patient 2, and their

respective risks and benefits. In particular, the Registrant did not discuss the specific risks of treatment in light of Patient 2's individual circumstances, including poor periodontal health, heavy occlusion, poor oral hygiene and the fact that Patient 2 was a smoker.

23. In addition, the Registrant did not review Patient 2's aesthetic expectations with her or discuss the importance of regular dental follow up.

Failure to Obtain Informed Consent – Patient 3

24. Regarding Patient 3, the Registrant also failed to create an appropriate treatment plan and did not review a treatment plan with Patient 3. The Registrant did not adequately discuss the available treatment options for Patient 3, and their respective risks and benefits. In particular, the Registrant only gave Patient 3 the option of full mouth clearance with implant-supported dentures. The Registrant did not offer any alternate treatment proposals, including the option to preserve some or all of Patient 3's teeth.

25. The Registrant did not discuss with Patient 3 the specific risks of treatment in light of Patient 3's individual circumstances, including bone loss, poor periodontal health and oral hygiene and history of smoking.

26. In addition, the Registrant did not review Patient 3's aesthetic expectations with him. The Registrant also did not discuss the importance of regular dental follow up.

27. The Registrant agrees that his failure to obtain and document informed consent from Patients 2 and 3 also constitutes a failure to maintain the standards of the practice of the profession.

Failure to Maintain the Standards of Practice of the Profession – Patient 2

28. In addition to the conduct described in paragraphs 21 to 23 above the Registrant agrees that he failed to maintain the standards of the practice of the profession in the following ways:

    a. The Registrant did not complete appropriate clinical investigations into Patient 2's pre-existing dental conditions, including their periodontal health, post-accident temporomandibular jaw disorder and recurrent caries, before proceeding with implant-supported crowns on teeth 11 and 22, and a crown on tooth 22;

    b. The Registrant did not obtain sufficient pre-treatment photographs and did not prepare appropriate models or diagnostic wax-ups during implant treatment for Patient 2;

    c. The Registrant did not investigate the reason for Patient 2's repeated broken temporary crowns;

    d. The Registrant did not evaluate Patient 2's occlusion and habits, and did not consider the functional aspects of the treatment he recommended;

    e. The Registrant took excessive time to complete Patient 2's prosthodontic treatment and did not refer them to a specialist;

f. The Registrant failed to document his clinical findings, interpretations of radiographs and diagnoses in Patient 2's records, and failed to adequately document treatment discussions with Patient 2;

g. The Registrant failed to document adequate instructions to the laboratory for the fabrication of Patient 2's crowns; and

h. In general, the Registrant's clinical notes for Patient 2 were poorly organized, incomplete, and lacked sufficient detail.

Failure to Maintain the Standards of Practice of the Profession – Patient 3

29. In addition to the conduct described in paragraphs 24-27 above, the Registrant agrees that he failed to maintain the standards of the practice of the profession in the following ways:

a. The Registrant did not complete appropriate clinical investigations into Patient 3's pre-existing dental conditions, including Patient 3's periodontal health and occlusion, before recommending and proceeding with treatment and dentures;

b. The Registrant did not adequately explore Patient 3's pre-treatment concerns and expectations;

c. The Registrant proceeded with an overly aggressive treatment for a younger patient like Patient 3, without considering other alternative treatment options that could have saved some or all of Patient 3's natural teeth. The Registrant did not educate or encourage Patient 3 to improve their oral hygiene and periodontal health;

d. The Registrant did not evaluate Patient 3's occlusion and habits, and did not consider the functional aspects of his treatment. The Registrant prioritized Patient 3's aesthetic concerns over functional concerns;

e. The Registrant took excessive time to complete Patient 3's treatment and did not refer them to a specialist;

f. The Registrant failed to document his clinical findings, interpretations of radiographs and diagnoses in Patient 3's records. The Registrant also failed to document treatment discussions with Patient 3;

g. The Registrant failed to document adequate instructions to the laboratory for the fabrication of Patient 3's dentures; and

h. In general, the Registrant's clinical notes for Patient 3 were poorly organized, incomplete and lacked sufficient detail.

The Registrant provided treatment that was beyond his expertise or competence – Patient 3

30. The Registrant failed to recognize the complexity of Patient 3's case, including occlusal, functional and aesthetic considerations. The Registrant knew or ought to have known that Patient 3's case was beyond his expertise and competence.

31. The Registrant should have referred Patient 3 to a specialist for consultation and treatment.

Failure to Keep Records as Required – Patients 2 and 3

32. The Registrant's records for Patients 2 and 3 were incomplete and did not include the following:

    a. Clinical findings, interpretations of radiographs and diagnoses;

    b. Informed consent and other treatment discussions with Patients 2 and 3; and

    c. Adequate instructions to the laboratory for the fabrication of Patient 2's crowns and Patient 3's dentures.

33. In general, the Registrant's clinical notes for patients 2 and 3 were poorly organized, incomplete and lacked sufficient detail.

Expert Report

34. The College retained an expert, Dr. Phillip Stulginski, to review the Registrant's treatment of Patients 2 and 3.

35. Dr. Stulginski opined that, in his treatment of Patient 2, the Registrant failed to meet the standards of practice of the profession in relation to obtaining a diagnosis, workup, and treatment, and did not obtain informed consent or maintain dental records that met the standards of the practice of the profession.

36. Dr. Stulginski also opined that Patient 3's case was a complex implant restorative case that required treatment by a general dentist with "advanced prosthodontic training and extensive experience" or a "prosthodontist". Dr. Stulginski opined that Patient 3's case was beyond the scope of the average general dentist.

Guidelines

37. Between 2020 and 2022, the College's *Guidelines on Dental Recordkeeping* were in force. Enclosed hereto as **Tab "B"** are the versions that were in force over the material time.

Professional Misconduct Admitted

38. By this document, the Registrant admits to the truth of the facts referred to in paragraphs 1 to 36 above (the "**Agreed Facts**").

39. It is agreed that the Agreed Facts constitute professional misconduct pursuant to the following:

    a. Section 51(1)(c) of the Code, and as defined in the following paragraphs of section 2 of Ontario Regulation 853/93:

        i. Paragraph 1: Contravening a standard of practice or failing to maintain the standards of practice of the profession;

ii. Paragraph 5: Treating or attempting to treat a disease, disorder or dysfunction of the oral-facial complex that the member knows or ought to know is beyond his or her expertise or competence;

iii. Paragraph 7: Treating 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;

iv. Paragraph 25: Failing to keep records as required by the regulations; and

v. Paragraph 59: Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

DECISION

[10] Based on the evidence presented and the parties' submissions the Panel found that the College had proven the allegations of professional misconduct against Dr. Weiss on a balance of probabilities.

REASONS FOR DECISION

[11] The College bears the onus of proving the allegations against the Registrant on a balance of probabilities through clear, cogent and convincing evidence. The Registrant's admissions of professional misconduct are material but must be supported by evidence. The Panel found that the evidence in the ASF supports the allegations and Dr. Weiss' admissions and that it satisfies the College's burden of proof.

[12] The allegations concerning Patient 1 are found in Notice of Hearing 24-0444. The evidence established that Patient 1 received treatment from Dr. Weiss for a full mouth reconstruction.

[13] Patient 1 first saw Dr. Weiss on February 14, 2020. During the period March 4, 2020 to May 13, 2021, Patient 1 attended Dr. Weiss' office more than a dozen times. Over the course of the treatment period, Patient 1 complained of severe sensitivity, extreme discomfort, pain and bleeding. She also developed an infection in her mouth. To manage her pain, Dr. Weiss prescribed steroids and Toradol towards the end of her treatment period.

[14] The evidence, including Dr. Weiss' admissions and the evidence contained in the ASF, established that, over the course of the treatment period, Dr. Weiss did not create, provide or discuss an appropriate treatment plan with Patient 1, nor did he document any discussions he had with Patient 1 regarding the proposed treatment in her chart.

[15] The allegations relating to Patients 2 and 3 are found in Notice of Hearing No. 25-0090. The evidence established that during the years 2019 to 2022, Dr. Weiss did not appropriately review the risks of treatment with the patients, nor did he appropriately review their aesthetic expectations with them or their understanding about the importance of regular dental follow-up.

[16] The evidence thus established that, with respect to Patients 1, 2 and 3, Dr. Weiss failed to maintain the standard of the profession in his informed consent practice, contrary to section 2(1) of the Professional Misconduct Regulation.

[17] There was further significant evidence before the Panel that established that Dr. Weiss also failed to maintain the standards of practice of the profession in a number of different ways. With respect to Patient 1, the evidence was that Dr. Weiss did not diagnose his patient and that he created a treatment plan that was minimal and inadequate relative to the complexity of the patient's case; that he did not conduct adequate diagnostic testing or diagnose the patient to support a recommendation for a root canal treatment; and that he took too long to refer the patient for root canal therapy.

[18] With respect to Patient 2, the evidence was that Dr. Weiss did not complete appropriate clinical investigations of the patient, that he took insufficient photographs, that he did not make appropriate models or diagnostic wax-ups, and that he did not appropriately investigate the reasons for Patient 2's repeated broken temporary crowns.

[19] With respect to Patient 3, the evidence was that Dr. Weiss did not complete appropriate clinical investigations of the patient, that he embarked on an overly aggressive treatment for a relatively young patient, and that he prioritized the patient's aesthetic concerns over functional concerns.

[20] On the basis of this evidence, including Dr. Weiss' admissions and the evidence contained in the ASF, the Panel found that Dr. Weiss failed to maintain the standard of practice of the profession, contrary to section 2(1) of the Professional Misconduct Regulation.

[21] In addition, there was evidence that, with respect to Patients 2 and 3, Dr. Weiss failed to maintain the standard of the profession in his dental record-keeping practices as required by the College's *Guidelines on Dental Recordkeeping* (the "**Guidelines**") that were in force from 2020 to 2022, contrary to section 2(25) of the Professional Misconduct Regulation. The evidence was that Dr. Weiss failed to document his clinical findings, interpretations of radiographs and diagnoses; that he failed to adequately document informed consent and other treatment discussions with Patient 2; and that his clinical notes were poorly organized, incomplete and lacked sufficient detail.

[22] The College presented expert evidence from Dr. Phillip Stulginski regarding Dr. Weiss' treatment of Patients 2 and 3. Dr. Stulginski opined that in his treatment of Patient 2, Dr. Weiss failed to meet the standards of practice of the profession in relation to obtaining a diagnosis, workup and treatment, and he did not obtain informed consent or maintain dental records that met the standards of the practice of the profession.

[23] With respect to Patient 1, the evidence established that Dr. Weiss' dental records lacked a diagnosis, a problem list, a prognosis, advantages and disadvantages of treatment options, a discussion of staging the treatment, accurate and complete financial records, and records of financial arrangements between Dr. Weiss and a third party for payment for the treatment of the patient.

[24] The College presented expert evidence from Dr. Peter McDermott regarding Dr. Weiss' treatment of Patient 1. Dr. McDermott opined that Dr. Weiss' consent, diagnosis, casework,

treatment planning and recordkeeping in this case failed to meet the standards of practice of the profession.

[25] On the basis of the totality of the evidence, including the Registrant's admissions and the evidence contained in the ASF, the Panel found, on a balance of probabilities, that Dr. Weiss failed to maintain the standard of practice of the profession and that he failed to maintain dental records as required by the regulations and the Guidelines, contrary to sections 2(1) and 2(25) of the Professional Misconduct Regulation.

[26] In addition, the evidence established that Dr. Weiss treated patients for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without obtaining such consent, contrary to paragraph 7 of Section 2 of the Professional Misconduct Regulation.

[27] With respect to Patient 1, there was credible and reliable evidence that Dr. Weiss did not discuss the treatment plan or the risks, benefits and alternatives of the proposed treatment plan with the patient before starting the treatment plan or when the patient's treatment plan was changed. He did not provide Patient 1 with an opportunity to ask questions about the proposed treatment prior to commencing that treatment. Dr. Weiss also failed to document any discussions he had with Patient 1 regarding the proposed treatment plan in the patient's chart.

[28] With respect to Patients 2 and 3, there was credible and reliable evidence that Dr. Weiss failed to create an appropriate treatment plan or to discuss the available treatment options, and their risks and benefits.

[29] Specifically with respect to Patient 2, the evidence established that Dr. Weiss did not discuss the risks of treatment in light of the patient's individual circumstances, including poor periodontal health, heavy occlusion, poor oral hygiene and the fact that Patient 2 was a smoker.

[30] With respect to Patient 3, the evidence established that Dr. Weiss only gave the patient the option of full mouth clearance with implant-supported dentures; that he did not offer any alternative treatment proposal, including the option to preserve some or all of Patient 3's teeth.

[31] On the basis of the evidence before it, including the Registrant's admissions and the evidence contained in the ASF, the Panel found, on a balance of probabilities, that Dr. Weiss failed to maintain the standards of the profession, contrary to section 25(7) of the Professional Misconduct Regulation in that he did not obtain informed consent from his patients in circumstances where such consent is required by law.

[32] The College also alleged that with respect to both Patients 1 and 3, Dr. Weiss treated or attempted to treat a disease, disorder or dysfunction or the oral-facial complex that he knew or ought to have known was beyond his expertise or competence, contrary to section 2(5) of the Professional Misconduct Regulation.

[33] With respect to Patient 1, the evidence was that Dr. Weiss did neither understand nor consider the complexity of the patient's case in his decision to initiate treatment; that he failed to prepare an adequate case work-up or create a staged treatment plan suitable for the complexity of the case, or to refer the patient to a prosthodontist for consultation, and to consider alternative treatment options.

[34] With respect to Patient 3, the evidence established that Dr. Weiss failed to recognize the complexity of the patient's case, including occlusal, functional and aesthetic considerations; that Dr. Weiss should have referred Patient 3 to a specialist for consultation and treatment.

[35] Dr. Stulginkski's expert opinion was that with respect to Patient 3, the case involved a complex implant restoration that required treatment by a general dentist with "advanced prosthodontic training and extensive experience" or by a prosthodontist. Dr. Stulginski's opinion was that Patient 3's case was "beyond the scope of the average general dentist."

[36] On the basis of the evidence before it, including the Registrant's admissions and the evidence contained in the ASF, the Panel found, on a balance of probabilities, that Dr. Weiss treated a disease, disorder or dysfunction of the oral-facial complex that he knew or ought to have known was beyond his expertise or competence, contrary to section 2(5) of the Professional Misconduct Regulation.

[37] Lastly, the College alleged that with respect to Patient 1, during the years 2020 and/or 2021, Dr. Weiss engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by registrants of the profession as disgraceful, dishonourable, unprofessional or unethical, contrary to section 2(59) of the Professional Misconduct Regulation.

[38] Registrants of the College would expect that dentists comport themselves in a professional manner, meaning that they respond to challenges in the workplace in a measured and respectful way.

[39] The evidence established that while treating Patient 1, Dr. Weiss spoke in an argumentative, inappropriate and unprofessional tone. He interrupted the patient and made inappropriate comments during their appointments, like saying the patient was "playing games", and, when Patient 1 raised concerns about informed consent, Dr. Weiss responded "informed you about what."

[40] The Panel found, on a balance of probabilities, that Dr. Weiss' admissions of his own conduct as set forth in the ASF supported a finding that it was disgraceful, dishonourable, unprofessional or unethical. The admitted facts demonstrate a serious disregard for his obligations as a registrant of the College. Further, Dr. Weiss' conduct undermines the relationship of trust that exists between dentists and patients, the College and the public.

PENALTY SUBMISSIONS

[41] The parties presented the Panel with a Joint Submission on Order (Exhibit 4) asking the Panel to impose an order with the following terms and conditions:

1. Requiring the Registrant to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of the Order or on a date fixed by the Registrar;

2. Directing the Registrar to suspend the Registrant's certificate of registration for a period of five (5) months, commencing on a date and time to be set by the Discipline Committee. The suspension shall run without interruption;

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

    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;
        iv. faculty members at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;
        v. owners of a practice or office in which the Registrant works;
        vi. 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;
        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 and
        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 thinks 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:

Courses

a) At the Registrant's own expense, the Registrant must successfully complete the following courses approved by the College and provide written proof of completion within six months of this Order, or such further time as may be permitted by the College:

i. The PROBE ethics and professionalism course (must achieve an unconditional pass);
ii. A one-on-one course, pre-approved by the College, in prosthodontics, which must include the topics of diagnosis, treatment planning, management of dental pain, and referral protocols;
iii. A course on informed consent, pre-approved by the College;
iv. The College's Fundamentals of Dental Recordkeeping course; and
v. The College's Applied Dental Recordkeeping course.

Clinical Supervision

b) The Registrant shall retain, at his own expense, a qualified dentist, pre-approved by the College, to act as his Clinical Supervisor (the "Clinical Supervisor") related to diagnosis and treatment, informed consent and record-keeping.

c) The Registrant will ensure that his Clinical Supervisor provides the College with a signed copy of the Clinical Supervisor's Undertaking attached as Appendix "A" to this Order.

d) Following the completion of the suspension of the Registrant's certificate of registration as referred to in paragraph 2 above, and as soon as the Registrant has been notified in writing that the Clinical Supervisor is approved, the Registrant will practise under Clinical Supervision at Level 2 as specified in the Clinical Supervision Framework attached as Appendix "B" to this Order.

e) The level of Clinical Supervision will not be reduced, and the Clinical Supervision will not end without the recommendation of the Clinical Supervisor and the College's prior approval in writing. If the College approves a reduction in the level of supervision, the Registrant will continue to practise under the Clinical Supervision at the prescribed level as specified in the Clinical Supervision Framework.

f) The Registrant shall abide by all recommendations of the Clinical Supervisor, including

recommendations for changes to his practice and taking any course or reviewing any resources recommended by the Clinical Supervisor.

g) The Registrant shall ensure that the Clinical Supervisor completes all the requirements of the Clinical Supervision set out below, including providing required reports to the College, as outlined in this Order, in a timely manner.

h) During Level 2 Clinical Supervision, the Clinical Supervisor will:

    i. be accessible to the Registrant by telephone or other electronic means, and/or available at scheduled times to discuss or observe the Registrant's diagnosis and treatment, informed consent and record keeping practices;
    ii. directly observe the Registrant's diagnosis and treatment, informed consent and record-keeping practices in-person at least once every month;
    iii. review at least 15 of the Registrant's chart entries for diagnosis and treatment, informed consent and record keeping each month and discuss with the Registrant any recommendations with respect to the Registrant's diagnosis and treatment, informed consent and record keeping practices. If fewer than 15 chart entries are available for any given month, the Clinical Supervisor will review all of the chart entries for diagnosis and treatment, informed consent and record keeping for that month. If the Registrant does not provide any diagnosis and treatment, informed consent and record keeping in a given month, no chart review is required;
    iv. provide a report to the College every month in the format specified by the College; and
    v. prior to recommending that the Registrant progress to Level 1 Clinical Supervision, the Clinical Supervisor shall:
        1. conduct chart reviews for at least 15 patient visits over at least one month; and
        2. confirm that both the Clinical Supervisor and the Registrant are confident that the Registrant can engage in diagnosis and treatment, informed consent and record keeping autonomously without regular input from the Clinical Supervisor.

i) During Level 1 Clinical Supervision, the Clinical Supervisor will:

    i. Be available to the Registrant at scheduled times, in-person or electronically, to discuss the Registrant's diagnosis and treatment, informed consent and record keeping practices;
    ii. review at least 15 of the Registrant's chart entries for diagnosis and treatment, informed consent and record keeping each month and discuss with the Registrant any recommendations with respect to the Registrant's diagnosis and treatment, informed consent and record keeping practices. If fewer than 15 chart entries are available for any given month, the Clinical Supervisor will review all of the chart entries for diagnosis and treatment, informed consent and record keeping for that month. If the Registrant does not provide any diagnosis and treatment, informed consent and record keeping in a given month, no chart review is required.

iii. Provide a report to the College every three months in the format specified by the College; and
iv. Prior to recommending that the Registrant practise without Clinical Supervision:
    1. conduct chart reviews for at least 15 patient visits over at least a three-month period; and
    2. confirm that both the Clinical Supervisor and the Registrant are confident that he can engage in diagnosis and treatment, informed consent and record keeping autonomously without a Clinical Supervisor.

j) At any time during Clinical Supervision, the Clinical Supervisor will report to the College immediately if:

i. the Clinical Supervisor believes that the Registrant's conduct or treatment is likely to expose his patients to harm or injury;
ii. the Registrant has breached the terms of this Order, or any terms, conditions or limitations placed on the Registrant's certificate of registration;
iii. the Clinical Supervisor believes that the Registrant has engaged in professional misconduct;
iv. any patient or staff member expresses concerns to the Clinical Supervisor about improper care or conduct by the Registrant;
v. a breakdown or conflict of interest has occurred in the relationship between the Registrant and the Clinical Supervisor; or
vi. the Clinical Supervisor no longer wishes or is no longer able to act as the Registrant's Clinical Supervisor.

k) If the Clinical Supervisor is no longer able to act as the Registrant's Clinical Supervisor, the Registrant shall notify the College in writing immediately and will cease practising until he is able to retain a new Clinical Supervisor, approved by the College, to continue the Clinical Supervision.

Practice Monitoring

l) The Registrant will submit to Practice Monitoring for 24 months after completing Clinical Supervision.

m) Practice Monitoring may be conducted by way of unannounced visits, which may be conducted virtually or in-person at the discretion of the College.

n) The Registrant shall pay the monitoring fee of $1,000 to the College within two weeks of the invoice date for each monitoring visit.

Compliance Monitoring

o) The Registrant will cooperate with College inspections of his practice locations, whether announced or unannounced, for the purpose of monitoring his compliance with this Order.

p) The Registrant will pay the monitoring fee of $1,000 per visit to the College within two

weeks of the invoice date for each monitoring visit.

[42] The parties also agreed that Dr. Weiss would pay costs to the College in the amount of ten thousand dollars ($10,000) in respect of this discipline hearing and that he would do so within three (3) months of the date of this Order.

[43] While the parties agreed on most of the terms of the Order, including the length of the Registrant's suspension, they did not agree on the date on which Dr. Weiss' suspension was to commence.

[44] College counsel made submissions regarding aggravating and mitigating factors present in this case. In terms of aggravating factors, the College highlighted that Dr. Weiss' conduct was serious, and that it occurred from 2019 to 2022 across multiple patients. The professional misconduct was therefore not the result of a momentary lapse in judgment. Further, Dr. Weiss' care was problematic. In particular, Patient 1 experienced severe pain, bleeding and an infection related to Dr. Weiss' treatment, and the impact on that patient was significant. Of further concern was that Dr. Weiss' recordkeeping was highly deficient as were his informed consent practices.

[45] In terms of mitigating factors, the College pointed to Dr. Weiss' cooperation with the investigation that led to the referral to the Discipline Committee, that he took responsibility for his conduct and that he had no prior discipline history (although he did have a history with the Inquiries, Complaints and Reports Committee).

[46] The College made submissions on the goal of penalties, including specific and general deterrence, remediation and public protection. With respect to the length of the suspension, the College pointed the Panel to a number of similar cases which it cited as evidence of the proportionality of the suspension sought in Dr. Weiss' case.

[47] With respect to the Registrant's request for a delay in the commencement of the suspension being requested, the College asserted that there was no basis on which to grant a delay. He submitted that since the pre-hearing conference had taken place in late 2025, that the Registrant was aware that he would be the subject of a suspension and that he should have organized his affairs accordingly; that he had known for a number of months that he would need to obtain the short-term services of an accredited dentist to continue to run his office and provide care to his patients. He said "if no one is available, that's part of the suspension." The College further submitted that the findings in this case are serious and that delaying the commencement of the suspension would prejudice the public.

[48] Counsel for Dr. Weiss also made submissions on the issue of penalty. He, too, pointed to the degree of cooperation between the parties throughout the investigation. He submitted that this was a very organized plea.

[49] In terms of mitigating factors, the Registrant noted that he had been in practice for forty-five (45) years with no discipline history.

[50] With respect to the commencement of the suspension, the Registrant submitted that August 15, 2026 was a reasonable date; that this was the date Dr. Weiss was working towards in terms of having a dentist in place at his practice. He asserted that there was no risk to the public

in terms of delaying commencement of the suspension and that it would be unfortunate to close down Dr. Weiss' practice for a month-and-a-half.

PENALTY DECISION

[51] The Panel accepted the JSO and made an order in accordance with its terms and conditions as set forth above.

[52] With respect to the issue of the commencement date of the suspension, the Panel found that there was no basis upon which to grant the request for delay and that the suspension would begin on the day following the making of the order. The Panel was not apprised of any extenuating circumstances that would support a delay. The Registrant had agreed to the suspension and its length in the Joint Submission on Order. He had had months to make any preparations for his suspension and there was nothing extraordinary about his circumstances relative to other registrants who are being suspended.

REASONS FOR PENALTY DECISION

[53] Once the Discipline Committee makes findings of professional misconduct, it is incumbent upon it to impose an order that is appropriate in the circumstances. 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."[3]

[54] The Panel considered the terms of the JSO in the context of the basic principles relating to the imposition of penalties. Those principles include that: (a) the goal of a penalty is to protect the public from dentists who have committed professional misconduct and to maintain public confidence in the profession and in its ability to self-regulate; (b) a penalty must serve as a measure of general deterrence, in that it sends a message to all registrants of the dental profession that this type of conduct will not and cannot be tolerated; (c) it must also serve as a measure of specific deterrence with respect to the dentist concerned; (d) it should also provide for remediation or rehabilitation of the dentist concerned, where possible and appropriate; and lastly, (e) the penalty must be proportionate to penalties ordered in similar circumstances.

[55] The Panel must consider both mitigating and aggravating factors when assessing the appropriateness of the penalty in the circumstances.

[56] Put simply, in this case, the order jointly proposed by the parties comprises a reprimand, a five (5) month suspension of Dr. Weiss' certificate of registration, cooperation with any office monitoring which the Registrar thinks is needed to ensure that the Registrant has complied with any suspension conditions, completion of courses in ethics and professionalism, prosthodontics, and informed consent. He must also complete the College's Fundamentals of Dental

[3] *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

Recordkeeping and Applied Dental Recordkeeping courses. The Registrant will also be subject to clinical supervision, practice monitoring and compliance monitoring.

[57] The Panel was satisfied that these components serve the objectives of penalty. The reprimand and suspension achieve both specific and general deterrence. The courses that Dr. Weiss must take, in addition to the requirements of clinical supervision and practice monitoring all provide remediation. Together, the terms protect the public and maintain confidence in the College's ability to regulate the profession.

[58] The penalty as a whole is proportionate to the severity of Dr. Weiss' misconduct and circumstances. It reflects the relevant mitigating and aggravating factors. The most important mitigating factor is that Dr. Weiss took responsibility for his actions by admitting to misconduct allegations at an early stage and working with the College to reach an agreed statement of facts and joint submission on order. The number of patients involved and the length of time over which the misconduct persisted are relevant aggravating factors. The terms and conditions requiring Dr. Weiss to complete five (5) different remedial courses and his agreement to undertake clinical supervision and practice monitoring are appropriate to the circumstances of this case. It is expected that Dr. Weiss' remediation efforts will improve his practice and thereby protect the public.

[59] The Panel was also satisfied that the penalty falls within a reasonable range having regard to prior cases involving similar types of misconduct. College counsel brought several cases to the Panel's attention, some with shorter periods of suspension and some with longer periods. In particular, College counsel referred the Panel to the following cases:

(a) *Royal College of Dental Surgeons v Segura*, (2023 ONRCDSO 7), in which the panel expressed concern given the seriousness of its findings, and the repetitive nature of the clinical, recordkeeping and informed consent issues. The panel there accepted the joint submission that an eight (8)-month suspension was appropriate, in addition to other requirements including a reprimand, having a practice mentor, and continued practice monitoring for twenty-four (24) months to provide necessary supports and guidance; and

(b) *Royal College of Dental Surgeons v Tsang* (2019 ONRCDSO 9), a case involving similar issues to those in the Weiss case, including failing to keep records according to College standards and disclosure of information to a third party. Dr. Tsang, however, also breached a requirement of an ICR Committee panel relating to mentorship for multi-implant cases. In this instance, the discipline committee ordered a six (6)-month suspension in addition to requirements to take courses in recordkeeping, informed consent, and the ProBE Programe on Professionalism. The panel there also imposed requirements of Practice Mentorship and Practice Monitoring. [See also *RCDSO v Kliman*, 2026 ONRCDSO 5; *RCDSO v Estrabillo*, 2021 CanLii 154975; and *CPSO v Alexander*, 2022 O3NPSDT 71 (CanLii)]

[60] Having regard to the similarities and differences between this case and the cases cited by the College, the Panel accepted that the terms and conditions of the JSO are within the appropriate range for the type of misconduct involved in Dr. Weiss' case.

[61] Lastly, the Panel accepted the parties' agreement on costs. An order for costs in the amount of $10,000 is similar to the costs ordered in other uncontested matters that come before this Committee.

THE REPRIMAND

[62] At the conclusion of the hearing, Dr. Weiss confirmed through his counsel that he would not waive his right to appeal and that he wished to receive the reprimand at a later date. Accordingly, the Hearings Administrator has been asked to schedule the reading of the reprimand at a date to be set once the appeal period has expired or any appeal has been dealt with.

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

September 4, 2026

Judy Welikovitch, Chair, Discipline Committee Panel — Date