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

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

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

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Harpaul Anand
Ms. Susan Davis
Ms. Margaret Dunn
Mr. Manohar Kanagamany

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
- and -	)	Surgeons of Ontario
	)	
	)	Ms. Megan Shortreed for the Royal College of Dental Surgeons of Ontario
	)	
DR. OLEH VOLODYMYR KOROL	)	Mr. Neil Abramson
	)	For Dr. Oleh Volodymyr Korol

Hearing held on June 6, 2017.

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto June 6, 2017.

PUBLICATION BAN

The Panel made an order banning the publication or broadcasting of the names of any patient referred to in the hearing, including in the Notice of Hearing and/or the Agreed Statement of Facts and/or any of the exhibits, as well as an order banning the publication or broadcasting of any information that would identify the patient.

THE ALLEGATIONS

The allegations against Dr. Oleh Volodymyr Korol (the "Member") were contained in the Notices of Hearing dated November 1, 2016. The allegations against the Member were 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 2013, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely Ms. LK contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - You failed to meet the standards expected of a registered specialist in oral and maxillofacial surgery.
   - On or about January 9, 2013, you did not manage the patient's symptoms appropriately.
     - The dental hygienist who was present at this appointment noted a diagnosis of "adenoma virus" in her records of the appointment. Accordingly, it was unnecessary to prescribe a steroid ointment.
     - In the event that you suspected her symptoms resulted from Invisalign trays, you failed to note any concerns

with the trays in your records.

- In the event that you suspected her symptoms resulted from the Invisalign trays, you failed to eliminate the etiologic agent, recommend improving oral hygiene, or establish an appropriate follow-up plan.

- You did not follow the patient's case until her symptoms had resolved or until a definitive diagnosis had been made.
  - You did not arrange for an initial follow-up appointment 7-14 days after your first examination of the patient.
  - Every examination of the patient by you was initiated by her general dentist or a hygienist.
  - When normal healing or resolution of the symptoms did not occur, you did not perform a biopsy within 4-8 weeks of your initial consultation with the patient.
  - You failed to take action based on the patient's on-going clinical presentation.
  - You did not consider factors specific to this case that indicated the need for active follow-up with the patient.
    - Palatal ulceration is not commonly associated with overextended Invisalign trays. Irritation from the Invisalign trays was not identified by the patient's general dentist or two hygienists who saw her during the same period as you, and the lesion did not resolve when the Invisalign trays were changed or left out.
    - A non-healing solitary ulcer in the palatal area is most likely malignant. Most of the conditions associated with solitary ulcers in the anterior palate are malignant.
    - The centre of the ulcer was remote from the gingival margin.
    - It was documented by the patient's general dentist on or about January 23, 2013, that the lesion looked "ulcerated in the centre and suspicious." This remark is consistent with all of the photographs taken of the lesion.
  - A photograph of the patient's palate on or about May 8, 2013, indicated that there was a longstanding, eroded or ulcerated lesion present with inflamed margins that extended away from the gingival sulcus, but you made no diagnosis and did not take any steps to address it.

- Your differential diagnosis on or about July 3, 2013, was inappropriate.

- Minor and major aphthous ulcers do not occur in the mucosa of the anterior palate and their duration ranges from one to six weeks including both minor and major variants.
- Herpetiform aphthous ulcers can be found on keratinized mucosal surfaces but last 7-10 days.
- Bechet's Disease (or Syndrome) is uncommon and the oral mucosal lesions are usually found on the soft palate and oropharynx and are similar in duration and frequency to aphthous ulcers.
- Ulcers associated with the Herpes Simplex Virus resolve within 7-10 days.
- Vesicle clusters associated with the varicella-zoster viral infection resolve within 7-10 days.
- Necrotizing Sialometaplasia must be confirmed with a biopsy.

- You did not develop a treatment plan with respect to the patient's lesion.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the Regulated Health Professions Act, 1991, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2013, you failed to keep records as required by the Regulations relative to one of your patients, namely Ms. LK, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended

   Particulars:

   - You failed to record the relevant history of the lesion, updates to the patient's medical history, clinical and radiographic findings, a differential diagnosis prior to that dated on or about July 3, 2013, recommendations for arriving at a definitive diagnosis, or a relevant follow-up plan.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct. He also made admissions in writing in the Agreed Statement of Facts, which was signed by the Member.

The Panel conducted a plea inquiry at the hearing, and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

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

Background

1. Dr. Oleh Korol has been registered with the College in the general class since October 7, 1971. He has also been registered as an Oral and Maxillofacial Surgeon since June 19, 1978. At all relevant times, he worked out of 4 different practice locations, including the office of Dr. Arun Narang & Associates in Mississauga.

The Notice of Hearing

2. Dr. Korol was served with a Notice of Hearing dated November 1, 2016. These allegations arose following a complaint by L.K., a patient, and a resulting investigation under s. 75(1)(c) of the Code.

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

Facts and Admissions

i. Failure to meet the standards of practice

4. Dr. Korol admits that he failed to meet the standards of practice expected of a registered specialist in oral and maxillofacial surgery in respect of his treatment and diagnosis of the patient's cancerous lesion.

5. L.K. complained to the dental hygienist on January 4, 2013 about pressure behind her front teeth and her right upper jaw associated with a sore/ulcer. The hygienist advised that L.K.'s invisilign trays were not touching the gum area and that the problem did not relate to the trays. She referred L.K. to Dr. Korol, an oral surgeon who worked in the office once a week.

6. Dr. Korol first saw patient L.K. on January 9, 2013. Her chart noted a possible diagnosis of "adenoma virus". Dr. Korol prescribed a topical steroid ointment. He did not make

or record a definitive diagnosis, formulate a treatment plan, or initiate follow up appointments to monitor the patient's condition.

7. Dr. Korol did not arrange for an initial follow-up appointment within 7 to 14 days of his first examination. When normal healing or resolution of the symptoms did not occur, a biopsy should have been performed within a reasonable time of his initial consultation.

8. On the January 9, 2013 visit, L.K. advised Dr. Korol that she was leaving for Australia on February 2, 3013 for 4 weeks, and he advised this would not be an issue.

9. The patient's general dentist documented on January 23, 2013 that the lesion looked "ulcerated in the centre and suspicious".

10. At the patient's or hygienist's request, Dr. Korol saw L.K. again on January 30, 2013 and May 8, 2013. The lesion remained. A photograph of the patient's palate taken on May 8, 2013 indicated a longstanding, eroded or ulcerated lesion with inflamed margins that extended away from the gingival sulcus. Dr. Korol did not schedule further follow-up or incisional biopsy at these appointments.

11. Dr. Korol failed to make a diagnosis or take any steps concerning the patient's on-going clinical presentation. To the extent he suspected the symptoms resulted from the invisalign trays, he failed to eliminate the etiologic agent (i.e. any overextended invisalign tray), recommend improving oral hygiene, or establish an appropriate follow up plan. He failed to recognize the need to follow up on L.K.'s signs and symptoms or to take appropriate steps to follow up, including formulating a treatment plan, providing instructions for other care providers in the office, or making a referral to an external practitioner or for a biopsy.

12. The following factors, individually or in the aggregate, indicated the need for follow-up:

    a. Palatal ulceration is not commonly associated with overextended invisalign trays;

    b. While the trays were adjusted, irritation from invisalign trays was not recorded by Dr. Korol, the patient's general dentist or two hygienists who saw her regularly during the period;

    c. Very few conditions are associated with solitary

ulcers in the anterior palate and most of these are malignant; and

d. The centre of the ulcer was remote from the gingival margin.

13. Dr. Korol saw L.K. again on July 3, 2013, and asked for an x-ray of the area with the lesion. He made a differential diagnosis of common aphthous ulcer or canker sores, viral ulceration, Bechet's Disease, Herpes, or necrotizing sealometaplasia. He determined that if the lesion did not improve shortly, he would proceed with a biopsy.

14. Each of the possible diagnoses in Dr. Korol's differential diagnosis was inappropriate because, certainly by July 3rd, they either would have resolved or presented differently.

15. On July 18, 2013, Dr. Korol completed a biopsy. L.K. was diagnosed with oral cancer by a pathologist on July 23, 2013.

16. L.K. passed away from squamous cell carcinoma on February 9, 2015. The delay in Dr. Korol arriving at a diagnosis likely did not influence L.K.'s prognosis and eventual outcome.

17. By failing to provide proper treatment and diagnosis of L.K.'s lesion, Dr. Korol admits that his conduct contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 in the Notice of Hearing.

ii. Failure to keep records as required

18. Dr. Korol admits that he failed to keep records as required in relation to L.K. In particular, he failed to record the relevant history of the lesion, updates to the patient's medical history, clinical and radiographic findings, a differential diagnosis prior to July 3, 2013, recommendations for arriving at a definitive diagnosis, or a relevant follow-up plan.

19. Dr. Korol acknowledges that with respect to patient L.K., his recordkeeping was not in accordance with the regulations, or the standards of practice of the profession. Dr. Korol acknowledges that he breached his professional, ethical and legal responsibilities that required him to maintain a complete record documenting all aspects of each patient's dental care, per the College's Dental Recordkeeping Guideline, and s. 38 of Regulation 547.

20. Therefore, Dr. Korol admits that he failed to keep records as

required by the Regulations, contrary to paragraph 25 of section 2 of the Dentistry Act Regulation, as set out in Allegation 2 in the Notice of Hearing.

Summary

21. Dr. Korol admits that the acts described above constitute professional misconduct and he now accepts responsibility for his actions and the resulting consequences.

22. Dr. Korol has voluntarily taken the College's Recordkeeping course (October 2016), a course in Oral Pathology at the University of Western Ontario (October 2016), and a custom course with Dr. David Eller, an oral and maxillofacial surgeon.

23. Dr. Korol has had the opportunity to take independent legal advice with respect to his admissions.

DECISION

Having considered the evidence and submissions of the parties, the Panel found that the Member committed professional misconduct as alleged in the Notice of Hearing.

REASONS FOR DECISION

The Member pled guilty to both allegations as set out in the Notice of Hearing and did not dispute the facts presented in the Agreed Statement of Facts.

The Panel was satisfied that the facts established that Dr. Korol did not meet the standards of practice expected of a registered specialist in oral and maxillofacial surgery in respect to his treatment and diagnosis of the patient's cancerous lesion.

Further, the panel was satisfied that Dr. Koral failed to keep records as required by the Regulations in relation to his patient. Dr. Koral admitted to same in the Agreed Statement of Facts.

PENALTY SUBMISSIONS

The parties presented the Panel with a joint submission with respect to penalty and costs, which requested that the Panel make an order as follows.

> The Royal College of Dental Surgeons of Ontario ("College") and Dr. Oleh Korol ("the Member") jointly submit that this panel of the Discipline Committee impose the following penalty on the Member as a result of the panel's finding that the Member is guilty of professional misconduct, namely, that it make an order:
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> 1. Requiring the Member appear before the Panel of the Discipline Committee to be reprimanded, within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;
>
> 2. Directing the Registrar to suspend the Member's certificate of registration for a period of one (1) month, to run consecutively, such suspension to commence within thirty (30) days of the date this Order becomes final;
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> 3. Directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served, namely:
>
> a. while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office(s) when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;
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> b. upon commencement of the suspension, the Member shall advise the principal dentist in the office(s) that the Member engages in practice with of the fact that the Member's certificate of registration is under suspension;
>
> c. during the suspension, the Member shall not do anything that would suggest to another health professional, staff member or patients that the Member is entitled to engage in the practice of dentistry and will not communicate with any health professional, staff member or patient about the practice of dentistry during the suspension;
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> d. the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in that connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and
>
> e. the Conditions imposed in subparagraphs 3(a)-(d) above shall be removed at the end of the period the Member's certificate of registration is suspended;

4. Directing the Registrar to also impose the following terms, conditions and limitations on the Member's Certificate of Registration, namely:

a. the Member's practice shall be monitored by the College, including monitoring his recordkeeping and oral diagnosis practices, by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the end of the period the Member's certificate of registration is suspended, and ending twenty-four (24) months thereafter, or such earlier time as a panel of the ICRC is satisfied that monitoring is no longer necessary and has advised the Member of this in writing;

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

c. the representative or representatives of the College shall report the results of those inspections to the ICRC and the ICRC may, if deemed warranted, take such action as it considers appropriate; and

5. Requiring the Member to pay costs to the College in the amount of $3000 in respect of this discipline hearing, such costs to be paid within thirty (30) days of this Order becoming final or on a date to be fixed by the Registrar.

The College and the Member further submit that pursuant to the Regulated Health Professions Act, 1991, the results of these proceedings must be recorded on the Register of the College and publication of the Decision of the panel will therefore occur with the name and address of the Member included.

Both parties submitted that the proposed penalty should be accepted by the Panel. [.] The parties submitted that the joint proposal meets the goal of public protection, deterrence and rehabilitation. The suspension and reprimand sends a message to the member specifically and the membership at large that this conduct warrants sanction. The office inspections will promote public safety and will minimize any risk that this could happen again in future.

PENALTY DECISION

The Panel ordered:

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

2. That the Registrar be directed to suspend the Member's certificate of registration for a period of one (1) month, to run consecutively, such suspension to commence within thirty (30) days of the date this Order becomes final;

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

a. while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office(s) when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;

b. upon commencement of the suspension, the Member shall advise the principal dentist in the office(s) that the Member engages in practice with of the fact that the Member's certificate of registration is under suspension;

c. during the suspension, the Member shall not do anything that would suggest to another health professional, staff member or patients that the Member is entitled to engage in the practice of dentistry and will not communicate with any health professional, staff member or patient about the practice of dentistry during the suspension;

d. the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in that connection, the Member shall provide access to any records associated with the

practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

e. the Conditions imposed in subparagraphs 3(a)-(d) above shall be removed at the end of the period the Member's certificate of registration is suspended;

4. That the Registrar be directed to also impose the following terms, conditions and limitations on the Member's Certificate of Registration, namely:

a. the Member's practice shall be monitored by the College, including monitoring his recordkeeping and oral diagnosis practices, by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the end of the period the Member's certificate of registration is suspended, and ending twenty-four (24) months thereafter, or such earlier time as a panel of the ICRC is satisfied that monitoring is no longer necessary and has advised the Member of this in writing;

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

c. the representative or representatives of the College shall report the results of those inspections to the ICRC and the ICRC may, if deemed warranted, take such action as it considers appropriate; and

5. That the Member be required to pay costs to the College in the amount of $3000 in respect of this discipline hearing, such costs to be paid within thirty (30) days of this Order becoming final or on a date to be fixed by the Registrar.

REASONS FOR PENALTY DECISION

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

The Panel was satisfied that the reprimand and the one (1) month suspension send a message to both the Member and the membership at large. These portions of the penalty act as both specific and general deterrents.

The Panel agrees with the parties' submissions insofar as the required office inspection will ensure ongoing public safety and will greatly minimize the risk of this ever happening again with Dr. Korol's practice.

In considering the appropriateness of the proposed penalty, the Panel also considered the fact that the Member has already voluntarily taken College approved courses in Record Keeping, Pathology and a custom course with Dr. David Eller, an oral and maxillofacial surgeon. These actions will certainly help to remediate the Member and protect the public.

The Panel found that the Penalty was within the appropriate range of proposed penalties and will adequately serve to protect the public. In reaching this decision, the Panel was mindful of the seriousness of the misconduct in this case and of the mitigating factors including that the Member has not appeared before a Discipline Panel before and has been co-operative throughout the investigation. He pled guilty which prevented a more drawn out hearing and he voluntarily took courses to correct his deficiencies.

The Panel was satisfied that all the objectives of penalty have been met and

the public will be adequately protected.

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

R Hunter — June 19, 2017

Chairperson — Date

TEXT OF PUBLIC REPRIMAND

Delivered June 6, 2017

in the case of the

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

and

DR. OLEH VOLODYMYR KOROL

Dr. Korol, the Discipline Panel has found you guilty of two allegations of professional misconduct. As part of its Penalty Order, this Panel has ordered you to attend before us to be given an oral reprimand

Dr. Korol, you have breached the standards of the profession expected of a registered specialist and you failed to keep records as required. This conduct is of concern to this Panel. The patient in this case entrusted her well-being to you and you failed to diagnose a serious condition that your peers would be expected to make.

The Panel appreciates your co-operation. We also recognize your commitment to rehabilitation by taking two courses and a custom mentoring program with Dr. Eller.

The Panel sincerely hopes that you have learned from this process and expects that you will not appear before a Discipline Panel again.

This is not an official transcript