H150015 and H170014

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. RONALD JOSEPH MCCLURE**, of the City of Niagara Falls, 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
Susan Davis
Dr. Elliot Gnidec

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Andrea Gonsalves
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Mr. Nick Coleman
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. RONALD JOSEPH MCCLURE	)	Mr. Matthew Wilton
	)	For Dr. Ronald Joseph McClure

Hearing held May 15, 2018

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 on May 15, 2018.

PUBLICATION BAN

On the request of the College and on the consent of the Member, the Panel made an order that no person shall publish, broadcast or in any manner disclose any facts or information concerning the personal health information of the Member or his patients referred to orally in evidence or in submission, or in the exhibits filed at the hearing. Further, the Panel ordered that there shall be no public release of any documentary evidence filed at the hearing that contain or identifies the Member's personal health information.

THE ALLEGATIONS

The allegations against Dr. Ronald McClure (the "Member") were contained in two Notices of Hearing. The first Notice of Hearing (H150015), dated November 2, 2015, contains the following allegations against the Member.

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 to 2014, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to your patients, [EH] and [JB], contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about September 22, 2011, you performed inadequate root canal therapy on tooth 16, for your patient, [EH], in that only one canal was partially obturated.
   - On or about April 14, 2010, you performed inadequate root canal therapy on tooth 36 for your patient, [JB], in that only a single canal was obturated.
   - On or about November 9, 2010, you performed inadequate root canal therapy on tooth 37, for your patient, [JB], in that the canals were not obturated.
   - On or about April 28, 2010, November 25, 2010, September 8, 2011 and/or December 17, 2013, you performed inadequate restorative treatment for your

patient, [JB], in that you failed to remove all decay from tooth 36.

- On or about April 5, 2014, you performed inadequate restorative treatment for your patient, [JB], in that you failed to remove all decay from tooth 16.
- On or about February 3, 2014, you performed inadequate restorative treatment for your patient, [JB], in that you failed to remove all decay from tooth 46.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010, 2011, 2014 and 2015, you failed to keep records as required by the regulations in regards to your patients, [EH] and [JB], contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - You were unable to produce your records for patient [EH] despite being given several months to provide them and a personal attendance at your office by a College investigator, following which you indicated that you searched but were not able to locate them.
   - On or about April 14, 2010, you incorrectly charted the number of canals treated in tooth 36, for your patient [JB].
   - On or about November 9, 2010, you incorrectly charted the root canal therapy attempted and/or performed on tooth 37, for your patient [JB].

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 and 2011, you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement in regards to your patients [EH] and [JB], contrary to paragraph 28 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about September 22, 2011, you issued a claim for root canal therapy (three canals) on tooth 16, for your patient, [EH] despite the fact that only one canal was partially treated.
   - On or about April 14, 2010, you issued a claim for root canal therapy (three canals) on tooth 36, for your patient,

[JB] despite the fact that only one canal was partially treated.

- On November 9, 2010, you issued a claim for root canal therapy (three canals) on tooth 37, for your patient, [JB] despite the fact that no canals were obturated.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 and 2011, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading in regards to your patients [EH] and [JB], contrary to paragraph 33 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about September 22, 2011, you charged a fee for root canal therapy (three canals) on tooth 16, for your patient [EH] despite the fact that only one canal was partially obturated.
   - On or about April 14, 2010, you charged a fee for root canal therapy (three canals) on tooth 36, for your patient [JB] despite the fact that only one canal was obturated.
   - On or about November 9, 2010, you charged a fee for root canal therapy (three canals) on tooth 37, for your patient [JB] despite the fact that no canals were obturated.

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 and 2011, you charged a fee that was excessive or unreasonable in relation to the service performed in regards to your patients [EH] and [JB], contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about September 22, 2011, you charged a fee for root canal therapy (three canals) on tooth 16, for your patient [EH] despite the fact that only one canal was partially obturated.
   - On or about April 14, 2010, you charged a fee for root canal therapy (three canals) on tooth 36, for your patient [JB] despite the fact that only one canal was obturated.
   - On or about November 9, 2010, you charged a fee for root canal therapy (three canals) on tooth 37, for your

patient [JB] despite the fact that no canals were obturated.

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2014 and 2015, you failed to reply appropriately or within a reasonable period of time to a written enquiry made by the College in regards to your patients [EH] and [JB], contrary to paragraph 58 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Despite several requests from the College from the time period of about July 2014 to December 2014, you failed to respond to the College's request for your patient records for [JB] and/or you failed to provide to the College your patient records for [JB].
   - Despite requests beginning in or about July 2014, you failed to respond to the College's request for your patient records for [EH] and/or failed to provide to the College your patient records for [EH] and eventually indicated that you had lost these records.

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the years 2010 to 2015, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to your patients, [EH] and [JB], contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - On or about September 22, 2011, you failed to inform your patient, [EH], that root canal treatment on tooth 16 was incomplete.
   - On or about April 14, 2010, you failed to inform your patient, [JB], that root canal treatment on tooth 36 was incomplete.
   - On or about November 9, 2010, you failed to inform your patient, [JB], that root canal treatment on tooth 37 was not done.

The second Notice of Hearing (H170014), dated August 17, 2017, contains the following allegations against the Member.

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 years 2013-2016, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one or more of the following patients, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   [LB]
   [BC]
   [KC]
   [JH]
   [SN]
   [CN]
   [SN2]
   [VP]
   [MT]
   [KD]
   [TE]
   [DS]
   [CS]
   [BS]

   Particulars:

   - You performed inadequate examinations for 4 patients, omitting steps or information related to the chief complaint, area of concern, history of the chief complaint, the patient's signs or symptoms, your findings and/or diagnoses, and/or your treatment plan.

Patients	
[LB]	2015
[BC]	2015
[KC]	2015
[JH]	2015

   - You did not take adequate or appropriate steps to diagnose and treatment plan for 14 patients with respect to crowns and bridges, implant-supported crowns, post and cores, root canal therapy, extractions, dentures, and/or restorations. You failed

to take appropriate radiographs and/or failed to perform appropriate clinical testing to plan and provide treatment.

Patients	
[BC]	2015
[KC]	2015-2016
[SN]	2015-2016
[CN]	2015-2016
[SN2]	2015
[VP]	2015
[MT]	2015-2016
[KD]	2015
[LB]	2015-2016
[TE]	2015-2016
[JH]	2015
[DS]	2015-2016
[CS]	2015-2016
[BS]	2015

- You failed to diagnose caries that were apparent on the radiographs contained in the patient records for 4 patients.

Patients	
[LB]	2014-2015
[TE]	2014
[DS]	2014-2015
[CS]	2015

- You performed repeated restorations on the same teeth within short time periods for 3 patients, which should not be required.

Patients	
[SN]	2015-2016
[CN]	2015-2016
[DS]	2015-2016

- You issued prescriptions for antibiotics to [CN] without justification on five occasions in or about 2015.

- You failed to take intra-operative and post-operative radiographs when performing endodontic treatment for 3 patients.

Patients	
[CN]	2015
[SN2]	2015
[VP]	2015

- You re-cemented crowns without justification for 3 patients.

Patients	
[KC]	2013
[CN]	2014
[SN2]	2015

- In or about 2015, you performed unnecessary extractions. [KD]'s teeth 33 (lower left cuspid), 34 (lower left 1st bicuspid), 43 (lower right cuspid), and 45 (lower right 2nd bicuspid) could have been saved, but you provided no justification for extracting them in your patient record. A patient's desire for a complete denture is insufficient justification for extraction absent discussions about the options available to the patient and their risks and benefits.

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 years 2015-2016, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one or more of the following patients, contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

[KC]
[CN]
[SN2]
[SN]
[VP]
[MT]
[BC]
[KD]
[DS]
[BS]

Particulars:

- You did not appear to have obtained informed consent for crown and bridge treatment, implant-supported crowns, endodontic treatment, and/or extractions for 10 patients, as the patient charts do not include notes regarding informed consent, reasons for treatment, options, and possible complications.

Patients	
[KC]	2015
[CN]	2015-2016
[SN2]	2015
[SN]	2015
[VP]	2015
[MT]	2015-2016
[BC]	2015
[KD]	2015
[DS]	2015
[BS]	2015

3. 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 years 2015-2016, you failed to keep records as required by the Regulations relative to one or more of the following patients, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended

[BC]
[KC]
[TE]
[JH]
[SN]
[CN]
[SN2]
[VP]
[DS]
[CS]
[BS]
[LB]
[KD]

[MT]

Particulars:

- You failed to document the details of treatment provided, including the use of local anaesthetic, information required about examinations performed, and materials and methods used for various treatments for 14 patients.

Patients	
[BC]	2015-2016
[KC]	2015
[TE]	2015-2016
[JH]	2015
[SN]	2015-2016
[CN]	2015-2016
[SN2]	2015
[VP]	2015
[DS]	2015-2016
[CS]	2015-2015
[BS]	2015
[LB]	2015-2016
[KD]	2015-2016
[MT]	2015-2016

- You erred in documenting which teeth were treated for 3 patients.

Patients	
[LB]	2015
[CS]	2015
[MT]	2016

- You failed to provide and/or retain laboratory invoices for 2 patients.

Patients	
[SN2]	2015
[MT]	2015

4. 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 2015-2016, you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to one or more of the following patients, contrary to paragraph 28 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

[BC]
[KC]
[KD]
[VP]
[BS]
[SN]
[CN]

Particulars:

- You issued claims for complicated extractions without justification for 5 patients.

Patients	
[BC]	2015
[KC]	2015
[KD]	2015
[VP]	2015
[BS]	2015

- You issued claims for laboratory fees without corresponding invoices for 5 patients.

Patients	
[KC]	2016
[KD]	2015
[SN]	2015
[CN]	2015-2016
[BS]	2015

5. 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 years 2015-2016 , you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to one or more of the following patients, contrary to

paragraph 33 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

[BC]
[KC]
[KD]
[VP]
[BS]
[SN]
[CN]

Particulars:

- You charged a fee for complicated extractions without justification for 5 patients.

[BC]	2015
[KC]	2015
[KD]	2015
[VP]	2015
[BS]	2015

- You charged a fee for laboratory fees without corresponding invoices for 5 patients.

[KC]	2016
[KD]	2015
[SN]	2015
[CN]	2015-2016
[BS]	2015

6. 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 years 2015-2016, you accepted an amount in full payment of an account or charge that was less than the full amount of the account or charge submitted by you to a third party payer without making reasonable efforts to collect the balance from the patient or to obtain the written consent of the third party payer relative to one of your patients, namely [LB], contrary to paragraph 34 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:
In or about 2015 and/or 2016, you wrote off co-payments or deductibles for [LB] without making efforts to collect them.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct. He also made admissions in writing in an 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.

Allegations of Professional Misconduct

1. Allegations of professional misconduct against Dr. Ronald Joseph McClure are set out in the Notices of Hearing, dated November 2, 2015 and August 17, 2017 (Exhibits 1 and 2, respectively).

Background

2. Dr. McClure has been registered as a general dentist with the Royal College of Dental Surgeons of Ontario ("the College") since April 1983. He received his dental education at the University of Toronto. Dr. McClure's primary place of practice is located on Montrose Road in Niagara Falls, Ontario.

3. Dr. McClure has no prior record of discipline at the College.

Complaint to the College

4. The College received a complaint regarding Dr. McClure on June 18, 2014. The subject matter of the complaint was incomplete root canal therapies performed for the complainant, [EH], and her mother, [JB], and false insurance claims submitted by Dr. McClure with respect to those therapies.

Complaint Investigation

5. The College notified Dr. McClure regarding the complaint on July 10, 2014. Initially, Dr. McClure was asked to respond to the complaint regarding [EH] only ([JB]'s consent was still being sought by the College). Dr. McClure was asked to deliver to the College all original records for [EH], and his response to the complaint, by August 14, 2014.

6. The College also obtained the patient records for [EH] and [JB] from the dentist who had treated them after Dr. McClure. Copies of those records were also provided to Dr. McClure in August 2014.

7. After obtaining [JB]'s consent, the College asked Dr. McClure on October 3, 2014 to produce the original patient records for both [EH] and [JB] by October 17, 2014.

8. Dr. McClure did not provide the patient records for [EH] or [JB] as the College had requested. Accordingly, in November 2014, the Registrar appointed an investigator to inquire into Dr. McClure's conduct with respect to those records.

9. On December 12, 2014, the College investigator attended at Dr. McClure's practice and asked him to produce the patient records for [EH] and [JB]. Dr. McClure provided the patient records for [JB] at that time but not for [EH].

10. The College investigator followed-up with telephone calls to Dr. McClure on December 17, 2014 and December 22, 2014. During these telephone calls, Dr. McClure explained that he could not locate [EH]'s patient records.

11. The College investigator followed-up with correspondence to Dr. McClure on January 6, 2015 asking him to produce the original patient records for [EH] no later than January 12, 2015. Dr. McClure called the College on January 13, 2015 to advise that he still had not been able to locate [EH]'s patient records, but that he would continue to search for them.

12. The College investigator completed his Report of Section 75(1)(c) Investigation on January 21, 2015 ("First Report") regarding the College's attempts to obtain the patient records. The First Report was forwarded to the ICRC on that same date.

13. A copy of the First Report was provided to Dr. McClure with correspondence dated January 23, 2015. He was advised that, if he wished to reply to the First Report, he should do so by February 27, 2015. Dr. McClure did not reply to the First Report, nor did he provide the patient records for [EH] to the College.

ICRC Review

14. A panel of the ICRC met to review the complaint against Dr. McClure and the First Report on August 6, 2015. The ICRC identified specific concerns regarding Dr. McClure's conduct including:

    (a) performed inadequate root canal therapies for [EH] and [JB] in 2010-2011;

    (b) performed inadequate restorative treatments for [EH] and [JB] on numerous occasions between 2010 and 2014;

    (c) failed to keep records as required when he failed to record accurately the number of canals treated for root canal therapies for [JB] on two occasions in 2010;

    (d) failed to make and retain proper records for [EH], including by maintaining those records in a manner that would permit access, as required;

    (e) issued false reports and accounts, and charged fees that were excessive, with respect to root canal therapies claimed for [EH] and [JB] in 2010-2011 that he had not actually performed; and

    (f) failed to respond appropriately to written enquiries from the College to produce the patient records for [JB] and [EH].

15. The specific concerns of the ICRC are replicated in the particulars to the allegations of professional misconduct in the Notice of Hearing dated November 2, 2015 (Exhibit 1).

16. On August 19, 2015, the College notified Dr. McClure that the ICRC had formed an intention to refer specified allegations of professional misconduct against him to the Discipline Committee. The specific concerns of the ICRC

were listed in that correspondence. Dr. McClure was advised that he could attend the next meeting of the ICRC, on September 30, 2015, to make any submissions, if he wished.

17. Dr. McClure attended the meeting with the ICRC on September 30, 2015. During the meeting, Dr. McClure did not attempt to explain his conduct in relation to [EH] or [JB], or his failure to produce the patient records as requested by the College. Dr. McClure stated that he was willing to do whatever the College recommended to remediate the situation.

18. The ICRC decided at the meeting on September 30, 2015 to refer allegations of professional misconduct against Dr. McClure. As noted above, the allegations of professional misconduct against Dr. McClure referred by the ICRC to the Discipline Committee on September 30, 2015 are set out in the Notice of Hearing dated November 2, 2015 (Exhibit 1).

Registrar's Investigation

19. On December 18, 2015, the ICRC expressed concerns to the Registrar that the problems in Dr. McClure's practice may extend beyond the parameters of [EH]'s complaint.

20. On January 5, 2016, the Registrar appointed an investigator under the Health Professions Procedural Code, section 75(1)(a), to inquire into and examine the the billing practices, informed consent protocols, recordkeeping, and standards of practice of Dr. McClure. The appointment was approved by the ICRC.

21. The College investigator attended at Dr. McClure's practice to obtain records for review on February 4, 2016. During that attendance, the College investigator also located the patient records for [EH]. In total, the College investigator reviewed dental records for 16 of Dr. McClure's patients.

22. The College investigator completed her Report of Section 75(1)(a) Investigation on March 7, 2017 ("Second Report"). The Second Report was forwarded to the ICRC on that same date.

23. The College's investigation confirmed that:

(a) patients of Dr. McClure complained to staff that filings dislodged, filings had to be redone, or teeth had to be extracted because filings dislodged;

(b) patients of Dr. McClure complained to staff that crowns were not inserted in a timely fashion or that they experienced pain after the crowns were inserted; and

(c) there were numerous deficiencies in Dr. McClure's dental treatment, consent, recordkeeping, and billing practices.

24. A copy of the Second Report was provided to counsel for Dr. McClure for his review and comment on March 7, 2017.

25. On May 12, 2017, through his counsel, Dr. McClure provided his response to the Second Report. In his response, Dr. McClure provided additional information and context with respect to a number of the concerns the College had identified based on the patient charts it had reviewed, including information regarding his patient examinations and procedures related to crown and bridge treatments, implant-supported crowns, post and core, endodontic treatment, extractions, dentures, and restorative treatment. In addition, Dr. McClure commented that he only documented treatment to which his patients had consented. Finally, Dr. McClure provided additional detail as to his office's processes, including with respect to the filing of laboratory slips.

ICRC Review

26. A panel of the ICRC met on June 19, 2017 to consider the Second Report and Dr. McClure's response. The ICRC identified specific concerns regarding Dr. McClure's conduct which are replicated in the particulars to the allegations of professional misconduct set out in the Notice of Hearing dated August 17, 2017 (Exhibit 2).

27. On June 20, 2017, the College notified Dr. McClure that the ICRC had formed both the intention to refer specified allegations of professional misconduct to the Discipline Committee and to make an interim order regarding a term, condition or limitation to be imposed on Dr. McClure's certificate of registration. The specific concerns of the ICRC were listed in that correspondence. Dr. McClure was advised that he could make further submissions in writing by July 5,

2017, or in person at the next meeting of the panel on July 10, 2017.

28. Counsel for Dr. McClure requested production from the College of x-rays for some of Dr. McClure's patients whose records were under review. He also requested an extension of the deadline for making further submissions regarding the interim order. The College provided the x-rays to counsel as requested and extended the deadline for submissions regarding the interim order to July 14, 2017.

29. Counsel provided Dr. McClure's response to the panel's intention to make an interim order on July 14, 2017. Through his counsel, Dr. McClure urged the ICRC not to make any interim order noting that there was no evidence that the patients had suffered any harm or adverse outcome because of the alleged deficiencies in any of Dr. McClure's endodontic or extraction procedures.

30. At its meeting on July 17, 2017, the panel of the ICRC issued an interim order directing the Registrar to impose a term, condition or limitation on Dr. McClure's certificate of registration. The interim order of the ICRC was as follows:

> Before proceeding with any endodontic treatment or extractions, Dr. McClure must have his diagnosis and treatment plan(s), including relevant radiographs, reviewed and approved by a mentor. The mentor must be approved in advance by the College.

31. Counsel for Dr. McClure was notified regarding the interim order on July 18, 2017. He was also notified that the ICRC would meet on August 15, 2017 to discuss the intention to refer specified allegations of professional misconduct against Dr. McClure to the Discipline Committee. Counsel was advised that any further written submissions would be due on August 8, 2017 and that counsel and Dr. McClure could also attend to make submissions in person at the meeting on August 15, 2017.

32. The ICRC met on August 15, 2017 to review the Second Report, Dr. McClure's submissions, and the relevant patient records. Dr. McClure did not attend the meeting of the ICRC to make any further submissions, nor did his counsel.

33. The ICRC decided to refer specified allegations of professional misconduct against Dr. McClure to the Discipline Committee. As noted above, the allegations of professional misconduct against Dr. McClure referred by the ICRC to the Discipline Committee on August 15, 2017 are set out in the Notice of Hearing, dated August 17, 2017 (Exhibit 2).

Recordkeeping Regulations

34. Regulation 547, section 38 requires a dentist to make and keep clinical and financial records regarding his or her patients in a systematic manner, to be retained for not less than 10 years after the date of the last entry. The record for each patient must include at least the patient's history, the examination procedures used, the clinical findings obtained, the treatment prescribed and provided, and the dentist's fees and charges.

Admissions of Professional Misconduct

35. Dr. McClure admits that he committed the acts of professional misconduct during the years 2010 to 2014, as alleged in paragraphs 1, 2, 3, 4, 5, 6, and 7 of the Notice of Hearing dated November 2, 2015 (Exhibit 1).

36. In particular, Dr. McClure admits that, as described in the particulars to those allegations, he:

- contravened a standard of practice or failed to maintain the standards of practice of the profession;
- failed to keep records as required by the regulations;
- signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement;
- submitted an account or charge for dental services that he knew or ought to have known was false or misleading;
- charged a fee that was excessive or unreasonable in relation to the service provided; and
- engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably

be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

37. Dr. McClure also admits that he committed the acts of professional misconduct during the years 2010 to 2014, as alleged in paragraphs 1, 2, 3, 4, 5, and 6 of the Notice of Hearing, dated August 17, 2017 (Exhibit 2).

38. Dr. McClure admits that, as described in the particulars to those allegations, he:

- contravened a standard of practice or failed to maintain the standards of practice of the profession;
- treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other heath related purpose in a situation in which a consent is required, without such a consent;
- failed to keep records as required by the regulations;
- signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement;
- submitted an account or charge for dental services that he knew or ought to have known was false or misleading; and
- accepted an amount in full payment of an account or charge that was less than the full amount of the account or charge submitted by him to a third party payer without making reasonable efforts to collect the balance from the patient or obtain the written consent of the third party payer.

DECISION

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

REASONS FOR DECISION

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

The Panel was satisfied that the evidence established that Dr. McClure failed to provide endodontic and restorative treatment to a number of his patients in a manner that met the standards of practice of the profession, and submitted false and excessive insurance claims for treatment. He failed to respond to the College's request for patient records in a timely manner, he failed to properly obtain informed consent before providing treatment, and he failed to keep records as required by the Regulations. The particulars for these matters are set out above.

PENALTY SUBMISSIONS

The parties presented the panel with a Joint Submission with respect to Penalty and Costs, which provides as follows.

> The Royal College of Dental Surgeons of Ontario ("the College") and Dr. Ronald Joseph McClure ("the Member") jointly submit that the Discipline Committee should make the following order:
>
> 1. The Member shall appear before the Panel of the Discipline Committee to be reprimanded, on a date to be fixed by the Registrar.
>
> 2. The Registrar shall suspend the Member's certificate of registration for a period of six (6) months. The suspension shall commence thirty (30) days following the Order becoming final, or on a date selected by the Member provided that such date is within six (6) months of this Order becoming final, and shall run without interruption.
>
> 3. The Registrar shall impose the following terms, conditions and limitations on the Member's certificate of registration ("the Suspension 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 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 all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

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

(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 Suspension Conditions imposed in clauses (a)-(d) of paragraph 3 above shall be removed at the end of the period during which the Member's certificate of registration is suspended.

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

(a) the Member shall, at his own expense, prior to proceeding with any endodontic treatment or extraction, have his diagnosis and treatment plan(s), including relevant radiographs, reviewed and approved by a practice mentor, who shall be a member of the College and approved in advance by the Registrar;

(b) the Member shall successfully complete, at his own expense, the following remedial courses (the "Courses"), within six (6) months of this Order becoming final, except as noted:

(i) a didactic course in endodontic diagnosis, treatment planning, restorability of teeth and referral protocols, as approved by the Registrar;

(ii) a didactic course on restorative dentistry, including diagnosis and treatment planning, as approved by the Registrar;

(iii) the College's course on recordkeeping, or equivalent, as approved by the Registrar;

(iv) a course on informed consent, as approved by the Registrar; and

(v) the ProBE Program on Professional/Problem-Based Ethics, to be completed with an unconditional pass, within twelve (12) months of this Order becoming final;

(c) the Member's practice shall be monitored by the College by means of office visits 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 twenty-four (24) months following written confirmation to the Registrar that the Member has completed all of the Courses referred to in clause (b) of paragraph 4 above. The Member shall cooperate with the College during the monitoring visits and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per visit, such amount to be paid immediately after completion of each of the visits, provided that the overall cost of monitoring paid by the Member shall not exceed $4,000.00, regardless of the number of visits;

(d) the Practice Conditions imposed by virtue of clause (a) of paragraph 4 above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that both the didactic course on endodontics described in clause (b)(i) of paragraph 4 above and, additionally, a

comprehensive "hands on" course in endodontics with an evaluative component, including diagnosis, treatment planning, and endodontic procedures, as approved by the Registrar, have been completed successfully;

(e) the Practice Conditions imposed by virtue of clause (b) of paragraph 4 above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that all of the Courses described in clause (b) of paragraph 4 above have been completed successfully; and

(f) the Practice Conditions imposed by virtue of clause (c) of paragraph 4 shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clause (c) of paragraph 4 above have been completed successfully.

5. The Member shall pay costs to the College in the amount of $10,000.00 no later than thirty (30) days following this Order becoming final.

Counsel for both parties argued that the Panel should accept the Joint Submission. The parties submitted that the joint proposal meets the goals of public protection, specific and general deterrence and rehabilitation. They argued that the proposed penalty reflects the seriousness of the misconduct and is appropriate having regard to the aggravating and mitigating factors, to prior decisions of this Discipline Committee in similar cases, and to the interests of the public, the profession and the Member.

PENALTY DECISION

The Panel agreed and accepted the Joint Submission with respect to Penalty and Costs and ordered that:

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

2. The Registrar is directed to suspend the Member's certificate of registration for a period of six (6) months. The suspension shall commence thirty (30) days following the Order becoming final, or on a date selected by the Member provided

that such date is within six (6) months of this Order becoming final, and shall run without interruption.

3. The Registrar is directed to impose the following terms, conditions and limitations on the Member's certificate of registration ("the Suspension 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 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 all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

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

(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 Suspension Conditions imposed in clauses (a)-(d) of paragraph 3 above shall be removed at the end of the

period during which the Member's certificate of registration is suspended.

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

(a) the Member shall, at his own expense, prior to proceeding with any endodontic treatment or extraction, have his diagnosis and treatment plan(s), including relevant radiographs, reviewed and approved by a practice mentor, who shall be a member of the College and approved in advance by the Registrar;

(b) the Member shall successfully complete, at his own expense, the following remedial courses (the "Courses"), within six (6) months of this Order becoming final, except as noted:

(i) a didactic course in endodontic diagnosis, treatment planning, restorability of teeth and referral protocols, as approved by the Registrar;

(ii) a didactic course on restorative dentistry, including diagnosis and treatment planning, as approved by the Registrar;

(iii) the College's course on recordkeeping, or equivalent, as approved by the Registrar;

(iv) a course on informed consent, as approved by the Registrar; and

(v) the ProBE Program on Professional/Problem-Based Ethics, to be completed with an unconditional pass, within twelve (12) months of this Order becoming final;

(c) the Member's practice shall be monitored by the College by means of office visits 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 twenty-four (24) months following written confirmation to the Registrar that the Member has completed all of the Courses referred to in clause (b) of paragraph 4 above. The Member shall cooperate with the

College during the monitoring visits and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per visit, such amount to be paid immediately after completion of each of the visits, provided that the overall cost of monitoring paid by the Member shall not exceed $4,000.00, regardless of the number of visits;

(d) the Practice Conditions imposed by virtue of clause (a) of paragraph 4 above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that both the didactic course on endodontics described in clause (b)(i) of paragraph 4 above and, additionally, a comprehensive "hands on" course in endodontics with an evaluative component, including diagnosis, treatment planning, and endodontic procedures, as approved by the Registrar, have been completed successfully;

(e) the Practice Conditions imposed by virtue of clause (b) of paragraph 4 above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that all of the Courses described in clause (b) of paragraph 4 above have been completed successfully; and

(f) the Practice Conditions imposed by virtue of clause (c) of paragraph 4 shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clause (c) of paragraph 4 above have been completed successfully.

5. The Member is ordered to pay costs to the College in the amount of $10,000.00 no later than thirty (30) days following this Order becoming final.

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 concluded that the jointly proposed penalty was

appropriate in all circumstances of this case. It therefore accepted the Joint Submission and made an order in accordance with its terms.

The Panel was satisfied that a six (6) month suspension, a reprimand and the recording of the results of these proceedings on the College register will deter the Member from repeating this behaviour again, and would also send a clear message to the members of the profession that professional misconduct of this magnitude will not be tolerated by the College.

The terms, conditions and limitations serve to protect the public as well as remediate the Member. Dr McClure is required to take courses in endodontics, restorative dentistry, record keeping and informed consent, and to complete the ProBE program on professional ethics. He must obtain a mentor's approval before commencing any endodontic treatment or extractions. The Member's practice will be monitored at his expense for 24 months.

The Panel found that the Joint Submission was within the appropriate range of penalties as demonstrated by the cases relied on by the College, and the penalty 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 co-operated with the College to arrive at an Agreed Statement of Facts and Joint Submission with respect to Penalty and Costs. He pled guilty and in doing so, prevented a more drawn out hearing.

The Member waived his right of appeal and received the reprimand at the conclusion of the hearing, after the Panel had rendered its decision orally.

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

R Hunter

Chairperson

May 31, 2018

Date

RCDSO v. Dr. Ronald McClure

Oral Reprimand Delivered on May 15, 2018

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

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

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

The panel has found that you engaged in multiple acts of professional misconduct. The misconduct related to virtually all aspects of your practice, including deficient record-keeping, breaching the standards of practice, poor restorative and endodontic work, treating patients without informed consent, charging excessive or unreasonable fees, and failing to be forthright with the College.

The cumulative effect of your conduct would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

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

Of special concern to us is the fact that the professional misconduct in which you engaged has involved multiple patients in which the treatment you provided was substandard and caused harm. The panel acknowledges your remorse and lack of previous history with the Discipline Committee.

We trust you have learned from this experience and expect that you will not appear before this Committee again.