H180014
H190001
H200001

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. MONIR MINA**, of the City of Waterloo, 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");

AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

NOTICE OF PUBLICATION BAN

This is formal notice that on July 6, 2021, the panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario made an Order directing that no person shall publish or broadcast the identity of any patients of the Member, 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.

This Order is made pursuant to subsection 45(3) of the *Code*.

Subsection 93(1) of the *Code* reads:

93(1) Every person who contravenes an order made under subsection 7(3) or Section 45 or 47, or who contravenes subsection 76(3), 82(2) or (3), 85.2(1), 85.5(1) or (2) or 85.14(2) or Section 92.1 is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than $50,000 for a first office and not more than $200,000 for a second or subsequent offence.

Dr. Richard Hunter, Chair
Discipline Panel

July 6, 2021
Date

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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. Monir Mina, of the City of Waterloo, 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").

AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S. 22, as amended; 1993, Chapter 27; Chapter 27.

Members in Attendance: Dr. Richard Hunter, Chair
Ms. Judy Welikovitch
Mr. Brian Smith
Dr. Ian Brockhouse
Dr. Elliot Gnidec

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Ian Roland and Kartiga Thavaraj
	)	For the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. MONIR MINA	)	No one appearing For the Member

Hearing held by way of videoconference

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on July 6, 7 and 8, 2021. This matter was heard by way of videoconference.

At the outset of the hearing, the College sought an order banning the publication of the name of patient or any information that could be used to identify the patient. The Panel granted the order, which extends to the exhibits filed, as well as to these reasons for decision.

The Member did not appear despite being served with the Notices of Hearing, as shown in the Affidavit of Service marked as Exhibit 1. The Panel was satisfied that the Member had been given proper notice of the date, time and platform for the hearing. In the circumstances, the Panel decided to proceed with the hearing in the Member's absence.

THE ALLEGATIONS

The allegations against the Member were contained in three separate Notices of Hearing, dated December 6, 2018, January 22, 2019, and January 17, 2020 (Exhibits 2, 3 and 4) respectively.

H180014

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 you contravened the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation relative to the following patients during the year specified opposite that patient's name, contrary to paragraph 11 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patient	Year
H.B.	2017
E.D.	2017

A.P.	2017
C.N.	2017
E.B.	2017
S.P.	2017
M.H.	2017
C.K.	2017
C.D.	2017
D.N.	2017
Y.D.	2017
N.G.	2017
C.B.	2017
H.B.	2017
A.T.	2017
I.C.	2017
K.M.	2017
V.R.	2017
A.R.	2017
A.B.	2017
S.S.	2017
M.A.	2017
C.T.	2017
R.K.	2017
X.Z.	2017
A.W.	2017
S.S.	2017
A.Q.	2017
F.A.	2017
J.B.	2017
B.O.	2017
E.H.	2017
M.S.	2017
J.K.	2017
A.M.	2018
D.C.	2018
S.N.	2018
J.P.	2018
H.D.	2018
T.P.	2018
K.R.	2017

Particulars:

- You provided sedation services beyond the minimal level without the required member authorization, in contravention of the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012), to
  - H.B. on or about 23/09/2017
  - E.D. on or about 23/09/2017
  - A.P. on or about 05/10/2017
  - C.N. on or about 06/10/2017
  - E.B. on or about 06/10/2017
  - S.P. on or about 06/10/2017
  - M.H. on or about 06/10/2017
  - C.K. on or about 12/10/2017
  - C.D. on or about 13/10/2017
  - D.N. on or about 26/10/2017
  - Y.D. on or about 27/10/2017 and/or 03/11/2017
  - N.G. on or about 03/11/2017
  - C.B. on or about 03/11/2017
  - H.B. on or about 09/11/2017
  - A.T. on or about 10/11/2017
  - I.C. on or about 10/11/2017
  - K.M. on or about 10/11/2017
  - V.R. on or about 15/11/2017
  - A.R. on or about 24/11/2017
  - A.B. on or about 27/11/2017
  - S.S. on or about 27/11/2017
  - M.A. on or about 28/11/2017
  - C.T. on or about 04/12/2017
  - R.K. on or about 05/12/2017
  - X.Z. on or about 06/12/2017
  - A.W. on or about 07/12/2017
  - S.S. on or about 11/12/2017
  - A.Q. on or about 13/12/2017
  - F.A. on or about 15/12/2017
  - J.B. on or about 18/12/2017
  - B.O. on or about 19/12/2017
  - E.H. on or about 19/12/2017
  - M.S. on or about 20/12/2017
  - J.K. on or about 21/12/2017
  - A.M. on or about January 4, 2018
  - D.C. on or about January 5, 2018
  - S.N. on or about 11/01/2018

- J.P. on or about 19/01/2018
- H.D. on or about 19/01/2018
- T.P. on or about 20/01/2018

- You provided sedation services beyond the oral moderate level without the required member authorization in contravention of the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012), to
  - K.R. on or about 18/12/2017
- In or about 2017 and/or 2018, you provided sedation services beyond the minimal level in a facility, namely University Dental and Hygiene Clinic office at #10-258 King St. N, Waterloo ON, that lacked a facility permit, in contravention of the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012).
- In or about 2017 and/or 2018, you provided sedation services in a facility, namely University Dental and Hygiene Clinic office at #10-258 King St. N, Waterloo ON, that lacked the supplies and emergency drugs as required by the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012).
- Your sedation records were inadequate for the following patients, in contravention of the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012):
  - H.B. on or about 23/09/2017
  - E.D. on or about 23/09/2017
  - A.P. on or about 05/10/2017
  - C.N. on or about 06/10/2017
  - E.B. on or about 06/10/2017
  - S.P. on or about 06/10/2017
  - M.H. on or about 06/10/2017
  - C.K. on or about 12/10/2017
  - C.D. on or about 13/10/2017
  - D.N. on or about 26/10/2017
  - Y.D. on or about 27/10/2017 and/or 03/11/2017
  - N.G. on or about 03/11/2017
  - C.B. on or about 03/11/2017
  - H.B. on or about 09/11/2017
  - A.T. on or about 10/11/2017
  - I.C. on or about 10/11/2017
  - K.M. on or about 10/11/2017
  - V.R. on or about 15/11/2017
  - A.R. on or about 24/11/2017
  - A.B. on or about 27/11/2017

- S.S. on or about 27/11/2017
- M.A. on or about 28/11/2017
- C.T. on or about 04/12/2017
- R.K. on or about 05/12/2017
- X.Z. on or about 06/12/2017
- A.W. on or about 07/12/2017
- S.S. on or about 11/12/2017
- A.Q. on or about 13/12/2017
- F.A. on or about 15/12/2017
- J.B. on or about 18/12/2017
- B.O. on or about 19/12/2017
- E.H. on or about 19/12/2017
- M.S. on or about 20/12/2017
- J.K. on or about 21/12/2017
- A.M. on or about January 4, 2018
- D.C. or about 11/01/2018
- J.P. on or about 19/01/2018
- H.D. on or about 19/01/2018
- T.P. on or about 20/01/2018
- K.R. on or about 18/12/2017

• You allowed a level II dental assistant to administer sedation medication to the following patients in contravention of the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012):

- K.R. on or about 18/12/2017
- J.B. on or about 18/12/2017
- B.O. on or about 19/12/2017
- E.H. on or about 19/12/2017
- M.S. on or about 20/12/2017
- J.K. on or about 21/12/2017
- A.M. on or about January 4, 2018
- D.C. on or about January 5, 2018
- S.N. on or about 11/01/2018
- J.P. on or about 19/01/2018
- H.D. on or about 19/01/2018
- T.P. on or about 20/01/2018

H190001

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of

the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that, during the year 2018, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely C.K, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- With respect to the endodontic treatment that you provided to C.K:
    - In or about the year 2018, you placed a composite restoration on tooth 16 without waiting for the pulpal tissue to heal. This contributed to irreversible pulpitis, which necessitated root canal treatment.
    - You perforated C.K's sinus during the endodontic treatment on tooth 16 and extruded a large quantity of calcium hydroxide into the sinus cavity.
    - You failed to advise C.K of the sinus perforation and of the extrusion of calcium hydroxide.
    - You did not take radiographs using trial files, nor did you document the length of the canals.
- With respect to the extraction of C.K.'s tooth 16:
    - You failed to prioritize the preservation of bone structure which was necessitated given the patient's young age.
    - You did not properly manage an oro-antral communication from the extraction site, which exposed the patient to a prolonged healing period and infection, and the possible need for further surgical procedures. You failed to refer the patient to an oral surgeon.
    - You prepared a bridge one week after the extraction which did not allow for an appropriate healing time.
- Your clinical and billing records for C.K. from January 29, 2018 to February 9, 2018, were not fulsome and may not be accurate:
    - You billed for a filling of 36 MOB; however, this was not charted.
    - The charts did not include copies of prescriptions for medications.
    - You took four panoramic films within a very short period unnecessarily exposing C.K. to harm.
    - You failed to obtain C.K.'s informed consent for the bridge, and failed to discuss the option of an implant.
    - Contrary to the RCDSO Guidelines for the Role of Opioids in the Management of Acute and Chronic Pain in Dental

Practice, you prescribed Percocet and Tylenol 4 without first attempting to manage the patient's pain with non-opioids.

H200001

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 2019, you failed to comply with an order of a panel of the ICR Committee requiring you to appear before a panel of the Committee to be cautioned, contrary to paragraph 53 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On May 2, 2019, you did not attend the meeting of the ICR Committee to receive your caution as was required of you pursuant to a decision of the ICR Committee issued on January 15, 2019, and of which date you were given notice. You did not respond to the College's communication to arrange an alternate date. For this reason, you are now in breach of this ICR Committee decision.

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 2019, 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, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On May 2, 2019, you did not attend the meeting of the ICR Committee to receive your caution as was required of you pursuant to a decision of the ICR Committee issued on January 15, 2019, and of which date you were given notice. You did not respond to the College's communication to arrange an alternate date. For this reason, you are now in breach of this ICR Committee decision.

THE MEMBER'S PLEA

As the Member was not present, the Panel recorded a plea of not guilty to all of the allegations on the Member's behalf.

THE EVIDENCE

The Professional Conduct and Regulatory Affairs department at the RCDSO received a letter of complaint dated February 14, 2018 from the owners of University Dental & Hygiene Clinic in Waterloo, Ontario (the Clinic). The Clinic owners complained that Dr. Mina, a dentist employed at the Clinic for a short period of time, contravened sedation guidelines, conducted himself in a manner that was unprofessional and kept inaccurate clinical records. As a result of this complaint, the College initiated an investigation of Dr. Mina's conduct.

In addition to the Clinic owner's complaint, on March 21, 2018, the College received an online complaint from BKK regarding dental services she received from Dr. Mina at the Clinic in January 2018.

Testimony of BKK, Witness 1

On January 17, 2018, BKK attended the Clinic for a dental check up and was advised by the Member that she needed 7 fillings and 4 wisdom teeth extracted. BKK testified that Dr. Mina did tell her that tooth 16 had deep decay and might need endodontic treatment exhibit 5, pg 9. Instead, Dr. Mina did the fillings but due to deep decay in tooth 16 he placed a temporary filling to allow the nerve to heal. He advised BKK that she may experience sensitivity and possibly need root canal treatment in tooth 16.

On January 23, 2018 Dr. Mina replaced the sedative filling with a permanent resin filling. The clinical notes provided to the Panel indicate that tooth 16 was asymptomatic, but the Patient testified that on January 23rd, she reported to Dr. Mina that her tooth was hurting a lot and that he advised her to take Advil and Tylenol.

On January 26, 2018, BKK returned to the Clinic complaining of pain in tooth 16. Dr. Mina told her that he would proceed to extract her wisdom teeth and that the patient would have to return for endodontic treatment on tooth 16. BKK says she was given 2½ tablets of Triazolam for sedation and testified that she experienced a "panic attack". According to BKK's testimony, Dr. Mina injected her twice in the arm with an unknown substance to "lower her blood pressure". The Member proceeded with the procedure.

On January 29, 2018, BKK returned to the Clinic due to persistent severe pain from tooth 16. She was advised that she needed a root canal on tooth 16 and she could see an endodontist but was not offered any explanation as to why she might want to see a specialist. The Member commenced root canal treatment on tooth 16 at that visit. BKK testified that Dr. Mina told her that there was a cyst/granuloma in her jaw that needed to drain. That night BKK noticed blood dripping from her nose and testified that she could smell and taste something medicinal in her mouth. She testified that the area around her tooth was also painful. When BKK returned to the Clinic on February 1st, 2018, a dental assistant told her that her symptoms did not sound normal, but the Member told her that they were normal. The radiographs taken that day show a large amount of calcium hydroxide (a disinfectant paste) extruding beyond the roots of tooth 16 into BKK's sinus cavity. In addition, in a clinical note prepared on February 2nd by Leslie Brekola, a dental assistant, indicates that she advised the owners of the Clinic that a "sinus perforation" occurred while BKK was being treated and that an excess amount of calcium hydroxide was injected into the sinus cavity. Further, the panorex taken of the area shows a white substance in the sinus.

BKK testified that when she returned to the Clinic on February 2, 2018, Dr Mina told her that her infection was severe and that tooth 16 needed to be extracted to prevent further damage to the adjacent teeth. Dr. Mina's clinical notes, indicate that there was resorption of the MB and DB roots which prevented a good apical seal. The patient consented to the extraction of tooth 16 and agreed to return for a bridge once the area healed. An oral-antral fistula resulted at the extraction site. BKK denies ever being given the option to see an oral surgeon for closure of the oral- antral fistula. BKK was prescribed Percocet for pain relief and was told by the Member that she could take Tylenol and Advil as well. The February clinical notes indicate that the patient "feels great" and has "No pain symptoms". Yet the next line in the Clinic's notes state "Pt feels mild-mod pain that is well controlled by Tylenol #4." BKK's notations indicate that she was in pain all weekend and that Percocet did not control her pain. The Member prescribed BKK 20 tablets of Tylenol #4.

BKK returned to the Clinic on February 20, 2018 where she saw a new dentist, Dr. Rubinoff due to the continued pain and swelling in and around the extraction site. Dr. Rubinoff took a radiograph of the tooth 16 site and referred BKK to an oral surgeon. Dr. Rubinoff's clinical notes of February 22nd, confirm that the oral surgeon was surprised at how much bone was removed by Dr. Mina and also includes a note that BKK advised that she had not been told by the Member that he had injected calcium hydroxide into her sinus.

Testimony of Anu Dhugee Witness 2

Ms. Dhugee is one of two owners of the Clinic. She is a Dental Hygienist registered with the College of Dental Hygienists of Ontario.

She employed Dr. Mina at her clinic between the years 2017-2018.

Ms. Dhugee confirmed that she and her partner, Ms. Gil filed a letter of complaint with the College against Dr. Mina. She and Ms. Gil were concerned with Dr. Mina's treatment of BKK. Ms. Dhugee testified that according to the Clinic's records, Dr. Mina provided moderate sedation to 39 patients and she confirmed that the Clinic does not have a Facility Permit, nor does the Clinic keep emergency drugs as is required when providing sedation.

Testimony of Mr. Mark Edelstein Witness 3

Mark Edelstein is a College Investigator with Regulatory Affairs. He testified as to the relevant Standards of Practice in place in January 2018. In particular, he confirmed that the Standard of Practice: Use of Sedation and General Anaesthesia in Dental Practice (June 2012) sets out the responsibilities expected of a dentist, equipment, supplies and emergency drugs required to safely provide sedation. Mr. Edelstein also confirmed that in the 2014 Dispatch (Communication to RCDSO's Members), the College specified that the maximum dose of Triazolam allowed is 0.25 mg for minimal sedation and 0.5 mg for moderate sedation.

Mr. Edelstein confirmed that according to the College's records, Dr. Mina was not authorized to provide minimal or moderate sedation in 2017 or 2018.

Finally, Mr. Edelstein identified a number of documents relating to the ICRC decision of January 15, 2019 requiring the Member to appear before it to be cautioned. Mr. Edelstein confirmed that the Member failed to respond to the decision or appear for his caution, despite the College's efforts to contact him.

Testimony of Dr. Bohdan Kryshtalskyj Witness 4

Dr. Kryshtalskyj was called by the College to provide his expert opinion evidence with respect to Oral and Maxillo-Facial Surgery and Anaesthesia. The Panel accepted Dr. Kryshtalskyj as an expert as requested by the College.

Dr. Kryshtalskyj testified that he reviewed the radiographs, photos and clinical notes relating to patient, BKK. He confirmed that according to the records reviewed, the Member provided BKK with 2 ½ tablets of Triazolam when

removing her wisdom teeth. Dr. Kryshtalskyj testified that 0.5 mg of Triazolam is considered moderate sedation and that a registered nurse is required to be present when administering moderate sedation as outlined in the Standards of Practice for Sedation.

Dr. Kryshtalskyj testified that the "panic attack" BKK said she experienced during the procedure was likely as a result of being oversedated. He opined that the Member did not follow the College's Standards of Practice for Sedation in that he failed to have a registered nurse, respiratory therapist, or a registered dentist or physician with basic life support certification on his sedation team. He also failed to record BKK's vital signs every 15 minutes as is required.

Dr. Kryshtalskyj testified that the bloody drainage recorded in the clinical notes as coming from the patient's nose was a severe inflammatory reaction caused by the calcium hydroxide in the sinus. Tooth 16 did not appear to have a cyst or granuloma associated with it. BKK should have been referred to either an Endodontist or an Oral Maxillo-Facial Surgeon because it is dangerous to leave such caustic material in the sinus cavity. In Dr. Kryshtalskyj's opinion, Dr Mina failed to maintain the standards of the profession by failing to refer BKK to a specialist for proper treatment. Dr. Kryshtalskyj proposed that the reason excessive bone was removed from the extraction site was to allow easier access for removal of the calcium hydroxide. Dr. Mina's attempt to remove the material caused some of it to be pushed dangerously close to the floor of the orbit. Further, Dr. Kryshtalskyj testified that Dr. Mina failed to properly prescribe an analgesic and document it appropriately as required by the College. Dr. Mina also prepared the teeth in the area for a bridge without allowing proper healing time after an extraction of this nature.

Testimony of Leslie Brekalo Witness 5

Ms. Brekalo is a Level II Certified Dental assistant and worked at the Clinic during the relevant time. During that time, she worked with Dr. Monir Mina. Ms. Brekalo testified that she did not recall whether BKK was weighed or whether blood pressure was taken prior to the Member providing her with sedation. Ms. Brekalo said that she remembered that the Member gave BKK two tablets of Triazolam on two separate occasions. The witness confirmed that she took the Panorex radiograph of BKK's mouth on January 29th, 2018. She did so to record the extrusion of calcium hydroxide in the sinus. She did not tell the Member that she had done so.

Ms. Brekalo assisted the Member with the tooth 16 extraction on February 2, 2018. She explained that the sinus was irrigated and sunctioned in an attempt to

remove the material. She thought that the Member had removed a lot of bone from the site during the procedure. The witness explained that she spoke with Dr. Mina about the sinus injury, but he still did not advise the patient.

Ms. Brekalo testified that she left her employment at the Clinic because she was not comfortable working with Dr. Mina whom she felt was "unethical".
A review of the patient records listed in the last particular of the Notice of Hearing H180014 confirms that the sedation notes are totally inadequate. Pulse oximeter and blood pressure readings are not recorded preoperatively and every 15 minutes during a procedure and copies of prescriptions to patients are not recorded as required in the Standard of Practice on the Use of Sedation and General Anaesthetics in Dental Practice (June 2012).

DECISION

The Panel finds that the Member engaged in professional misconduct as alleged in the Notices of Hearing filed as Exhibits 2, 3 and 4.

In brief, with respect to the allegations set out in Notice of Hearing (H180014), the Panel finds that the Member committed professional misconduct as alleged. In particular, the Panel finds that the Member provided sedation services beyond the minimal level without the required member authorization, in contravention of the Standard of Practice; in the case of one patient, the Member provided sedation services beyond the oral moderate level without the required authorization in contravention of the Standard of Practice; the Member provided sedation services in a Clinic that lacked a facility permit and that lacked the supplies as required by the Standard of Practice; the Member's sedation records were inadequate; and the Member allowed a level II dental assistant to administer sedation medication in contravention of the Standard of Practice.

With respect to the allegations set out in Notice of Hearing (H190001), the Panel finds that the Member committed professional misconduct as alleged. In particular, the panel finds that with respect to the endodontic treatment provided to BKK, the Member failed to advise BKK of the sinus perforation and the extrusion of calcium hydroxide. With respect to the extraction of BKK's tooth 16, the Member failed to prioritize the preservation of bone structure; did not properly manage an oro-antral communication from the extraction site, which exposed the patient to a prolonged healing period and infection; the Member failed to refer the patient to an oral surgeon. Further, the Member prepared a bridge one week after the extraction which did not allow for an appropriate healing time. With respect to the Member's clinical records for BKK, the panel

finds that the charts did not include copies of prescriptions for medication, the Member failed to obtain informed consent for the bridge and failed to discuss the option of an implant and prescribed Tylenol 4 in a manner contrary to the RCDSO Guidelines for the Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice.

With respect to the allegations set out in Notice of Hearing (H200001), the Panel finds that the Member committed professional misconduct as alleged. In particular, the Panel finds that the Member failed to attend the meeting of the ICR Committee to receive a caution as was required pursuant to a decision of the ICR Committee issued on January 15, 2019 and that the Member's failure to attend would reasonably be regarded by members as disgraceful, dishonourable, unethical or unprofessional.

REASONS for DECISION

The Panel recognized that the College bears the onus of proving the allegations against the Member on the balance of probabilities, using clear, cogent and convincing evidence.

The evidence against Dr. Mina was provided by his patient, BKK, his dental assistant and one of the owners of the Clinic. In addition, the Panel received a number of documents, including Dr. Mina's patient records, radiographs and photographs of patient BKK's teeth.

The Panel accepted that the testimony of BKK, the expert Dr. Kryshtalskyj, Anu Dhugee and Mark Edelstein. The evidence was largely corroborated by the documentary evidence and was presented in a clear, orderly, and factual manner.

While the Panel found that at times the testimony of Ms. Brekola was vague with respect to some small details, the Panel nonetheless found her evidence to be largely consistent with the documentary evidence. While the Panel could not be certain whether Dr. Mina was in possession of the emergency drugs needed when using sedation, the Panel was nonetheless satisfied that in all other aspects, the Member fell below the standards and engaged in professional misconduct as alleged.

Allegation 1: Dr. Mina contravened the standards of practice related to general anaesthesia or conscious sedation.

The Standard of Practice: Use of Sedation and General Anaesthesia in Dental Practice (June 2012) exhibit 11 and the RCDSO Bylaws exhibit 19, outlines the requirements and procedure to obtain authorization for the provision of sedation in a dental setting. In addition, exhibit 15 clearly distinguishes the maximum doses for minimal and moderate sedation. Minimal sedation using Triazolam is capped at 0.25 mg whereas Moderate sedation is capped at 0.5 mg.

The Controlled Substance Dispensing Record exhibit 14, indicates that multiple patients were given Triazolam 0.5mg. a level considered to be moderate sedation. At that time, Dr Mina was not authorized to provide minimal or moderate sedation. In at least one instance, a patient received 0.75 mg of Triazolam.

The Member failed to abide the standards of practice by providing sedation at a clinic that did not have a Facility Permit, and permitting a dental assistant to administer the sedation in numerous cases. Moderate sedation records are required to document vital signs every 15 minutes during a procedure and the sedation team must consist of one of the following in addition to the dentist providing the treatment: a registered nurse, respiratory therapist, dentist or physician certified in BLS. Sedation records for the 41 patients listed in the Notice of Hearing H180014 were inadequate. Blood pressure recordings and vital signs were missing in contravention of the Standard of Practice on the Use of Sedation and General Anaesthetics in Dental Practice. (June 2012).

Testimony from Anu Dhugee and Leslie Brekalo substantiate that in 2017 and 2018, Dr. Mina provided sedation services at a facility that lacked adequate supplies and emergency drugs. Leslie Brekalo testified she wasn't sure if Dr. Mina carried emergency drugs but testified that she never saw a stethoscope and sphygmonmanometer which is a breach of the Standard of Practice on the Use of Sedation and General Anaesthetics in Dental Practice (June 2012).

Allegation 2: Dr. Mina contravened the standards of practice of the profession relative to one of his patients, namely BKK.

The Member failed to inform the patient that during endodontic treatment of tooth of tooth 16 the sinus had been perforated and a large amount of calcium hydroxide was extruded into the sinus. A panorex taken by Leslie Brekalo confirmed the presence of a large amount of calcium hydroxide in the sinus.

With regards to the extraction of tooth 16:

i) He failed to prioritize the preservation of bone which was important given the patient's young age.
ii) He failed to properly manage an oro-antral communication from the extraction site and did not refer the patient to a competent oral surgeon.
iii) He prepared the site for a bridge without allowing for adequate healing of the oro-antral fistula.

The Member's clinical and billing records for BKK from January 29, 2018 to February 9, 2018 were not fulsome and may not be accurate:

I) The College withdrew the particular related to the billing for a restoration of tooth 36.
II) Charts did not include copies of prescription medications.
III) The College alleged that the 4 panoramic radiographs were excessive. The Panel noted that one PAN was taken without Dr. Mina's permission; one was taken as a new patient exam, one was taken prior to Dr. Mina's attempt to remove the calcium hydroxide and the final Pan was taken to see if the calcium hydroxide had been removed. The Panel makes no findings with respect to the panoramic radiographs.
IV) Dr. Mina failed to obtain BKK's informed consent prior to starting a bridge and failed to discuss an implant option.
V) Regarding the final particular, the Panel did not feel it was inappropriate for Dr. Mina to prescribe Percocet initially due to the amount of tissue injury which resulted from the endodontic treatment and the large quantity of calcium hydroxide which had been extruded into the sinus cavity. The expert witness, Dr. B. Kryshtalskyj testified that the material was caustic and would have caused a lot of tissue injury and pain. When the patient reported that the Percocet was not controlling her pain the Panel felt it was inappropriate to prescribe Tylenol #4, another narcotic.

Allegation 3:

1. Dr. Mina failed to comply with an order of a panel of the ICR Committee**.**

- On May 2, 2019 Dr. Mina did not attend the meeting of the ICR Committee to receive a caution as was required pursuant to a decision of the ICR Committee issued January 15, 2019. The Member did not respond to the numerous attempts the College staff made to contact him. Dr. Mina has breached the ICR Committee decision.

2. Dr. Mina committed acts of professional misconduct that having regard to all the circumstances, would reasonably be considered by members as disgraceful, dishonourable, unprofessional and unethical.

    - Dr. Mina did not attend the meeting of the ICR Committee to receive a caution as required pursuant to a decision of the ICR Committee issued on January 15, 2019 and of which he was given notice. The Member did not respond to the College's communication to arrange an alternate date. For this reason, the Member is now in breach of this ICR Committee decision.

PENALTY SUBMISSIONS

The College sought an order revoking the Member's certificate of practice.

It was established that Dr. Mina breached the standards of practice providing sedation services beyond the minimal level. College By-laws exhibit 19, require members to be authorized to provide sedation beyond the minimal level. He was not authorized to provide moderate sedation. The Member provided sedation services at a clinic that did not have a Facility Permit as required by the College By-laws. 41 patients listed in exhibit 13, the Index, all received doses of Triazolam consistent with what the College designates moderate sedation. As documented in the Controlled Substance Dispensing Record, exhibit 14 one patient received a sedative dose that is considered beyond a moderate level.

Dr Mina did not comply with exhibit 11, the Standards of Practice for Sedation by not supplying proper sedation monitoring supplies and emergency drugs. His sedation records were inaccurate and incomplete and he permitted a dental assistant to administer the sedatives in contravention of the Standards of Practice.

Dr. Mina:

- Failed to inform BKK that calcium hydroxide had been extruded into her sinus cavity during endodontic treatment.
- Failed to prioritize the preservation of bone during extraction of tooth 16.
- Failed to manage an oral-antral fistula properly and did not refer her to a specialist for proper care.
- Prepared a bridge without waiting for adequate healing of the 16 extraction site.
- Neglected to record accurately progress notes and details of medications he prescribed, as detailed in exhibits 18 & 19.

- Took 4 Panorex radiographs in a short period of time which exposed the patient to excessive radiation
- Failed to properly obtain informed consent as specified in exhibit 17: Advisory on Informed Consent. BKK felt pressured into accepting the option of restoring the 16 site with a bridge instead of an implant.
- Prescribed an opioid analgesic for pain relief instead of considering an alternative with less side effects.

Counsel presented Dr. Mina's extensive and troubling history with the ICRC. On February 23, 2018 an Interim Order was imposed on Dr. Mina preventing him from providing any sedation, exhibit 20. The ICRC panel deemed Dr. Mina a risk to the public.

On March 21, 2018 a panel of the ICRC imposed another Interim Order on Dr. Mina. It prevented him from performing extractions as well as endodontic procedures. After reviewing Dr. Mina's submissions a panel of the ICRC imposed a third Interim Order denying the Member from performing extractions and endodntic procedures.

The serious nature of BKK's complaint about the treatment she received from Dr. Mina prompted the ICRC panel to refer the case to Discipline for a hearing. Prior to these events, Dr. Mina was found guilty of professional misconduct in 2009 and 2010. He received a reprimand and a 3 month suspension. In 2014, he was directed to undergo 24-months of monitoring by the ICRC due inadequate prosthodontics.

On May 4, 2016 an ICRC Panel found the Member provided inadequate endodontic treatment, failed to properly obtain consent, and improper record keeping. He was ordered to take a SCERP and a course in record keeping.

Counsel for the College emphasized that revocation was the only appropriate penalty under these circumstances. Dr, Mina had numerous dealings with the ICRC and the remediation imposed by those panels failed to remediate his repeated pattern of providing inadequate treatment and dangerous procedures on his unassuming patients.

Dr. Mina's lack of communication with the College and his absence at an ICRC caution demonstrates his lack of willingness to be governed.

PENALTY DECISION

The Panel directs the Registrar to revoke the Member's certificate of practice.

REASONS FOR PENALTY DECISION

The Panel concluded that Dr. Mina is a danger to his patients. The Member's serious misconduct is a breach of his fundamental obligations to his patients. We are aware of at least one patient (BKK) suffering serious consequences due to his actions. He failed to chart and disclose the extrusion of a medicament into a patient's sinus cavity and then compounded the dilemma by removing excess bone while attempting to remove the material. He attempted to cover up his actions by telling the patient that the tooth was severely infected which was not the case. His attempt to repair an oral-antral fistula was not an accepted or clinical proven technique. Inadequate and falsified records were unabated. His failure to attend an ICRC meeting for a caution demonstrates his lack of accountability.

The primary guiding principle in a hearing such as this is to act in the public interest. Members are regulated and must abide by the College's rules. Sanctions against a member who does not follow the rules must increase proportionately with repeated offences. The fact that Dr. Mina does not communicate with the College and his failure to attend this hearing is consistent with his disdain for the College's process. It demonstrates his unwillingness to be governed by the process.

Revocation is the only means to protect the public and restore confidence in the profession. It sends a loud and clear message to the profession that this cavalier attitude and brazen disregard for his patients' well being and the College's standards of practice will not be tolerated by the College.

Dr. Mina was given ample opportunity through the ICRC and Discipline Committee to reform his manner of practice but chose to ignore the warnings. Professional misconduct of this nature cannot be remediated.

COSTS

College counsel presented a Bill of Costs that sets out the legal costs and expenses incurred by the College in respect of the three matters before the Panel. The College asked for an order that the Member be required to pay $129,959.70 to the College. The amount sought represents 75% of the College's costs. The costs do not include the costs and expenses of the College in both investigating the matter and conducting the hearing. The legal costs reflect not only the three days of hearing, but also the very significant preparation required in light of Dr. Mina's lack of cooperation or even his engagement in the process

The Member was invited to make submissions but did not respond to the College's request.

The Panel is satisfied that the amount sought by the College is reasonable and appropriate in the circumstances. Had the Member provided submissions regarding costs, the Panel may have been inclined to consider a lesser amount, but without any information regarding the Member's ability to pay or his particular financial circumstances, the Panel is not prepared to reduce the amount sought.

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

August 11, 2021

Dr. Richard Hunter — Date

Ms. Judy Welikovitch
Mr. Brian Smith
Dr. Ian Brockhouse
Dr. Elliot Gnidec