H190002

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. RYAN KIRSCHNER** of the City of Ottawa, 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. Sandy Venditti
Dr. Vinay Bhide
Mr. Marc Trudell

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 -	)	
	)	Ms. Emily Lawrence
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. RYAN KIRSCHNER	)	Mr. Matthew Wilton
	)	For Dr. Kirschner

Hearing held on February 7, 2020

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 February 7, 2020.

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 Member consented to the request. The Panel granted the order, which extends to the Notice of Hearing, exhibits filed, as well as to these reasons for decision.

THE ALLEGATIONS

The allegations against the Member were contained in the Notice of Hearing, dated June 4, 2019 (Exhibit 1),which provides 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 2017, you contravened the standards of practice, as published by the College, in relation to inducing general anaesthesia or conscious sedation relative to one of your patients, namely D.D., contrary to paragraph 11 of Section 2 of Ontario Regulation 853, Regulations of Ontario , 1993, as amended .
>
> **Particulars:**
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> - 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 D.D. on or about October 10, 2017.
> - On or about October 10 , 2017, you provided oral moderate sedation services to your patient, D.D., without monitoring her level of consciousness and assessing her vital signs which may include heart rate, blood pressure and respiration, as required by the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 2012).
> - On or about October 10, 2017, you failed to ensure your patient, D.D., to whom you provided oral moderate sedation, was oriented, ambulatory, with stable vital signs, and showing increasing alertness prior to discharging her, as required by the Standard of

Practice on the Use of Sedation and General Anesthesia Dental Practice (June 2012).

- On or about October 10, 2017, you failed to provide your patient, D.D., with adequate pre and post-operative instructions in relation to the moderate sedative you provided to her, as required by the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 202):
  - o You did not instruct your patient ahead of treatment that she would need to be discharged to the care of a responsible adult when she was oriented , as the Standard of Practice requires of you .
  - o You did not instruct the patient not to drive a vehicle, operate hazardous machinery or consume alcohol for a minimum of 18 hours, or longer if drowsiness, or dizziness persists, as the Standard requires of you.
- Your sedation records were inadequate for your patient, D.D., in contravention of the Standard of Practice on the Use of Sedation and General Anesthesia in Dental Practice (June 012).

2. You committed an act or acts of professional misconduct as provided by x. 5 1(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Status of Ontario, 1991, Chapter 18 in that, during the year 2017, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one of your patients, namely, D.D., contrary to paragraph 7 of Section 2 of Ontario Regular 853, Regulations of Ontario, 1993 as amended.

Particulars:

- On or about October 10, 2017, you failed to obtain informed consent from your patient, D.D., to administer an oral moderate sedative to her. The record does not reflect that you discussed with your patient the types of oral moderate sedation available, or the associated risks.
- On or about October 10, 2017, you asked the patient, D.D., to sign a consent document after Triazolam was administered.

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 year 2017, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would

reasonably be regarded by member as disgraceful, dishonourable, unprofessional or unethical relative to one of your patients, namely, D.D., contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On or about October 6, 2017, you relied on an American Standard of Practice for sedation that does not apply to the jurisdiction in which you practice to prescribe an improper dosage of Triazolam to your patient, D.D..
- On or about October 6, 2017, you wrote a prescription for your patient D.D., the upper range of which, you knew or ought to have known, constituted moderate sedation .
- In your February 1, 2018, response to the College about this complaint, the position that you take is inconsistent with the entry in the patient record dated September 6, 2017. Namely, you say that you discussed with D.D. the option of providing Triazolam or Ativan to manage her dental anxiety during treatment and that D.D. expressed concern with the use of Ativan and agreed to use Triazolam. The record does not reflect that this discussion took place, or that the patient agreed to take Triazolam.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in the Notice of Hearing, marked as Exhibit 1.

The parties provided the Panel with a written plea inquiry (Exhibit 2), which was signed by the Member. The Panel confirmed with the Member that he understood the plea inquiry and as such was satisfied that Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

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

Background

1. Dr. Kirschner has been registered with the College as a general dentist since 2015. He received his dental education at McGill University.

2. Dr. Kirschner works at Chapman Mills Dental, a dental clinic in Ottawa. At the time of the event set out in the allegations, he worked as an associate dentist at Trillium Dental. Dr. Kirschner was not registered with the College to perform moderate sedation.

Events Giving Rise to Allegations

3. On December 14, 2017, the College received a formal complaint from Ms. D.D. concerning treatment Dr. Kirschner provided to her on October 10, 2017. Dr. Kirschner placed a crown on D.D.'s tooth 17. D.D. complained that Dr. Kirschner prescribed Triazolam as an oral sedative, when she understood that she would be receiving Ativan.

4. D.D. was a long-term patient of Trillium Dental, back to 1980. She first met Dr. Kirschner in 2017.

5. On September 6, 2017, Dr. Kirschner met with D.D. for an examination. A dentist hygienist, Ms. Murray, also attended. Dr. Kirschner and D.D. discussed the need for a crown placement. In respect of their discussion about oral sedation, the hygienist made the following notes:

   Disc. Sedation options DV, oral, N2O

   -Pt willing to try oral sed. Dr RK said RX will be given ~ 3 days prior apt + for pt to picked up by pt

   RX will still need to be taken in office 1 hr prior to apt. (Triazolam)

6. D.D. and Dr. Kirschner have differing recollections about the content of the discussion about oral sedation. If Dr. Kirschner were to testify, he would state that he specifically mentioned Ativan and Triazolam as sedation options for D.D., that D.D. expressed concern that Ativan would not be adequate, and that D.D. advised him that she wanted to try Triazolam for the procedure. If D.D. were to testify, she would state that she did not consent to taking Triazolam, and understood that she would be prescribed Ativan, which she had taken previously.

7. On September 6, 2017, D.D. signed an estimate of total cost, on which she ticked a box beside the sentence "I acknowledge that all treatment options have been explained to me." This form did not reference the use of oral sedation. On the Proposed Treatment Plan Notes in the Progress Notes, the office documented the treatment plan for tooth 17 as "crown with triazolam".

8. For procedures in which there is a significant time gap between the initial appointment and the treatment, it was Dr. Kirschner's practice to have the patient attend at the office one week prior to the scheduled treatment to obtain the prescription and discuss the procedure, changes to medical information and post-operative instructions. His practice was also to have patients attend at least one hour prior to treatment to take the oral sedation in the office, in front of the receptionist. He advised D.D. of this practice on September 6, 2017.

9. The procedure was scheduled for October 10, 2017.

10. D.D. did not come to meet with Dr. Kirschner and pick up the prescription for oral sedation. Instead, on October 6, 2017, she requested that Dr. Kirschner's office fax the prescription to her pharmacy.

11. The receptionist at Dr. Kirschner's office faxed the prescription to D.D.'s pharmacy.

12. The prescription was for 2 tablets of Triazolam 0.25mg with instructions "1-2 tabs 1 hr prior to dental appointment".

13. If Dr. Kirschner were to testify, he would state that the receptionist did not obtain Dr. Kirschner's permission before she faxed the prescription and he would not have allowed her to do so if he had been asked.

14. D.D.'s sister picked up the prescription for her.

15. On October 10, 2017, D.D. arrived one hour prior to the procedure. She received no instructions from anyone at the office about how many tablets she should take. She took two tablets while waiting in the waiting room.

16. If D.D. were to testify, she would state that she had the prescription faxed, and had taken two tablets, because she had previously taken two tablets of Ativan and did not require further information about taking Ativan.

17. She did not meet with Dr. Kirschner in advance of taking the two tablets.

18. D.D. signed a form that indicated that she had received an information form and consented in writing to the procedure by signing her initials on the form. The procedure listed was "CM 17 w/triazolam". If D.D. were to testify, she would state that she has no memory of receiving or signing that form.

19. Dr. Kirschner performed the crown procedure to tooth 17. The procedure took less than two hours.

20. Dr. Kirschner's charting of the procedure noted "Administered 2 x 0.25 mg triazolem", and that D.D. fell asleep during the procedure but was easily aroused. He documented that after the procedure, she stood on her own and walked with slight impairment, that she was picked up by her sister who "helped her in the car", and that "next time oral sedation done on [D.D.], evaluate with 0.25 mg triazolam instead of 0.50mg."

21. D.D.'s sister called the office at 12:00 because D.D. was "loopy". The next day, D.D. called Dr. Kirschner to complain because she had no memory of the procedure or the subsequent 8 hours, and had not understood that she would be prescribed and had taken Triazolam.

Admissions relating to Standards of Practice

22. The College's Use of Sedation and General Anesthesia in Dental Practice (June 2012) (the "Sedation Standard") defines minimal sedation and moderate sedation, and the clinical interventions and requirements for the use of minimal and moderate sedation.

23. The Professional Practice Information in the November/December 2014 edition of the Dispatch states that, for appointments of two hours or less, a 0.125mg-0.25mg dose of Triazolam will constitute minimal sedation and a 0.325-0.50mg dose of Triazolam will constitute moderate sedation.

24. Only dentists who are authorized by the College to perform moderate sedation are entitled to do so. Dr. Kirschner acknowledges that he was not authorized to perform moderate sedation.

25. Dr. Kirschner admits and acknowledges that in prescribing 1-2 0.25mg tablets of Triazolam, he prescribed D.D. oral sedation medication that resulted in moderate sedation, for which he did not have authorization. If Dr. Kirschner were to testify, he would state that he did not intend to prescribe oral sedation medication that would achieve moderate sedation. Dr. Kirschner would have testified that if the patient had taken a one .25 mg tablet of Triazolam this would have achieved minimal sedation only.

26. Dr. Kirschner admits and acknowledges that D.D. was moderately sedated, based on his own documentation and the Professional Practice Information, when she took 0.50mg of Triazolam as prescribed. If Dr. Kirschner were to testify, he would state that he did not follow the Sedation Standard because he did not intend to provide moderate sedation.

27. For moderate sedation, the Sedation Standard sets out specific clinical monitoring processes and requires dentists to provide patients with written pre- and post-procedure instructions.

28. Dr. Kirschner admits and acknowledges that after he prescribed moderate sedation to D.D., he was required to act in accordance with the Sedation Standard for moderate sedation and failed to so do when he:

(a) did not follow the specific clinical monitoring processes for moderate sedation required by the Sedation Standard including monitoring D.D.'s level of consciousness and vitals, documenting D.D.'s vital signs and condition during sedation, and that his sedation records were inadequate in this regard;

(b) did not ensure that D.D. was oriented, ambulatory, had stable vital signs, and showed increased alertness prior to discharging her. His progress notes state that she was slightly impaired to walk and that her sister helped her to the car; and

(c) did not advise D.D. of pre- and post-operative instructions in that he did not instruct D.D. verbally or in writing that she needed to be discharged to the care of a responsible adult or that she could not operate a vehicle, hazardous machinery or consume alcohol for a minimum of 18 hours. For moderate sedation, the Sedation Standard requires dentists to provide written instructions.

29. Therefore, Dr. Kirschner admits that he contravened a standard of practice of the profession relative to his patient, D.D., contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

Admissions Relating to a Failure to Obtain Informed Consent

30. Dr. Kirschner admits and acknowledges that he failed to obtain informed consent from D.D. to administer oral sedation to her, in that he did not discuss the types of oral sedation available or the associated risks of Triazolam in sufficient detail such that D.D. understood that she would be prescribed Triazolam or that she could have memory loss as a result.

31. He acknowledges that he failed to follow his practice regarding the prescription and administration of oral sedation in that he completed the crown procedure even after he was aware that D.D. had not attended a second meeting

with him in the week in advance of the procedure, and without discussing the procedure and the oral sedation with D.D. on the day of the procedure prior to her taking the oral sedation.

32. Dr. Kirschner also acknowledges and admits that he permitted D.D. to sign a consent document after she had taken the 0.50mg dose of Triazolam. He acknowledges and admits that it is inappropriate to obtain consent after a patient has taken an oral sedative and that he should have spoken to D.D. and obtained verbal or written consent on the day of the procedure before her self-administration of the medication he prescribed to her.

33. Therefore, Dr. Kirschner admits that he treated D.D. for a therapeutic purpose in a situation in which consent was required, without consent, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing.

Allegations Relating to Disgraceful, Dishonourable, Unprofessional or Unethical Conduct

34. Dr. Kirschner admits and acknowledges that he relied on "The Little Dental Drug Booklet," an American reference text that does not reflect the Sedation Standard, when he prescribed 1-2 0.25 mg tablets of Triazolam to D.D.

35. Dr. Kirschner admits and acknowledges that his reliance on this reference text and his prescription of 1-2 0.25 mg tablets of Triazolam, the upper range which he knew or ought to have known constituted moderate sedation, is conduct that would be reasonably regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical conduct.

36. Therefore, Dr. Kirschner admits that he engaged in conduct that would be reasonably regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

Remediative Efforts

37. Dr. Kirschner successfully completed a one-day one-on-one refresher course on dental anaesthesia in the Spring of 2019, prior to the referral of the allegations.

General

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

39. Dr. Kirschner 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 panel is satisfied that based on the agreed upon facts, the Member failed to follow the College's Sedation Standard (as defined in the Agreed Statement of Facts). Only dentists authorised by the College to perform moderate sedation are entitled to do so. Dr. Kirschner was not authorized to do so at the time he treated D.D. While the panel recognizes that the Member did not intend to prescribe oral sedation medication that would achieve moderate sedation, he nonetheless was aware that the patient was moderately sedated and he failed to follow the specific monitoring processes required of dentists treating patients under moderate sedation. The panel finds therefore that the Member contravened the standards of practice in his handling of the sedation of patient D.D.

Further, the panel finds based on the agreed facts that the Member failed to obtain informed consent from D.D. He did not discuss the types of oral sedation available or the particular risks of Triazolam in sufficient detail such that the patient understood that she had been prescribed Triazolam. More troubling still for the panel is that the Member permitted the patient to sign a consent document after she had taken the 0.5mg dose of Triazolam. It was inappropriate to obtain consent after the patient had taken a sedative. The Member should have arranged for the patient to provide her written or oral consent before her self-administration of the sedation medication.

Finally, the panel finds that the Member's use of an American reference text, instead of the College's Sedation Standard is conduct that would be reasonably regarded by members of the profession as dishonourable and unprofessional conduct. The Member ought to have consulted with Ontario standards and information readily available from the College to its members. While the outcome for the patient in this case was not bad, the Member put the patient at great risk in the circumstances.

PENALTY SUBMISSIONS

The parties presented the panel with a Joint Submission with respect to Penalty and Costs (Exhibit 4), which provides as follows.

1. The Royal College of Dental Surgeons of Ontario ("College") and Dr. Ryan Kirschner ("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:

(a) requiring the Member to 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;

(b) directing the Registrar to suspend the Member's certificate of registration for a period of one (1) month, to be served consecutively, such suspension to commence within ninety (90) days of this Order becoming final;

(c) that the Registrar 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 subparagraph 1(b) above has been fully served, namely:

(i) 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;

(ii) 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;

(iii) 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;

(iv) 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 this 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

(v) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(iv) above shall be removed at the end of the period the Member's certificate of registration is suspended.

(d) directing that the Registrar also impose the following additional terms, conditions and limitations on the Member's Certificate of Registration (the "Practice Conditions"), namely:

(i) requiring that the Member successfully complete, at his own expense, a course on informed consent, approved by the College, and provide proof of

successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(ii) requiring that the Member successfully complete, at his own expense, a course on recordkeeping, approved by the College and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(iii) the Member's practice shall be monitored by the College by means of office visit(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 date of the finalization of this Order and ending twenty-four (24) months from the College receiving proof of the Member's successful completion of the courses referred to above, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(iv) that the Member shall cooperate with the College during the office visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1,000.00 per office visit, such amount to be paid immediately after completion of each of the office visit(s);

(v) that the representative or representatives of the College shall report the results of those office visit(s) to the Inquiries, Complaints and Reports Committee of the College and the Inquiries, Complaints and Reports Committee may, if deemed warranted, take such action as it considers appropriate;

(vi) requiring that the Member is prohibited from administering any form of sedation, except minimal sedation using nitrous oxide, specifically, nitrous oxide and oxygen sedation;

(vii) the Practice Conditions imposed by virtue of subparagraphs (1)(d)(i) and (ii) 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 the courses described in subparagraph (1)(d)(i) and (ii) above have been completed successfully;

(viii) the Practice Condition imposed by virtue of subparagraph (1)(d)(iii) above 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 subparagraphs (1)(d)(iii) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later;

(ix) the Practice Conditions imposed by virtue of subparagraphs 1(d)(vi) shall remain on the Member's certificate of registration indefinitely.

(b) that the Member pay costs to the College in the amount of $2,500.00 in respect of this discipline hearing, such costs to be paid in full within three (3) months of this Order becoming final.

2. The College and the Member further submit that pursuant to the *Code*, as amended, the results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and address of the Member included.

3. This joint submission on penalty and costs was reached as a result of a pre-hearing conference held with respect to these matters.

4. Dr. Kirschner has not previously appeared before the Discipline Committee of the College.

PENALTY DECISION

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

(a) 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;

(b) The Registrar suspend the Member's certificate of registration for a period of one (1) month, to be served consecutively, such suspension to commence within ninety (90) days of this Order becoming final;

(c) The Registrar 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 subparagraph 1(b) above has been fully served, namely:

(i) 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;

(ii) 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;

(iii) 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;

(iv) 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 this 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

(v) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(iv) above shall be removed at the end of the period the Member's certificate of registration is suspended.

(d) The Registrar also impose the following additional terms, conditions and limitations on the Member's Certificate of Registration (the "Practice Conditions"), namely:

(i) requiring that the Member successfully complete, at his own expense, a course on informed consent, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(ii) requiring that the Member successfully complete, at his own expense, a course on recordkeeping, approved by the College and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(iii) the Member's practice shall be monitored by the College by means of office visit(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 date of the finalization of this Order and ending twenty-four (24) months from the College receiving proof of the Member's successful completion of the courses referred to above, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(iv) the Member shall cooperate with the College during the office visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1,000.00 per office visit, such amount to be paid immediately after completion of each of the office visit(s);

(v) the representative or representatives of the College shall report the results of those office visit(s) to the Inquiries, Complaints and Reports Committee of the College and the Inquiries, Complaints and Reports Committee may, if deemed warranted, take such action as it considers appropriate;

(vi) requiring that the Member is prohibited from administering any form of sedation, except minimal sedation using nitrous oxide, specifically, nitrous oxide and oxygen sedation;

(vii) the Practice Conditions imposed by virtue of subparagraphs (1)(d)(i) and (ii) 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 the

courses described in subparagraph (1)(d)(i) and (ii) above have been completed successfully;

(viii) the Practice Condition imposed by virtue of subparagraph (1)(d)(iii) above 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 subparagraphs (1)(d)(iii) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later;

(ix) the Practice Conditions imposed by virtue of subparagraphs 1(d)(vi) shall remain on the Member's certificate of registration indefinitely.

(b) The Member pay costs to the College in the amount of $2,500.00 in respect of this discipline hearing, such costs to be paid in full within three (3) months of this Order becoming final.

2. The results of these proceedings must be recorded on the Register of the College and any publication of the Decision of the panel would therefore occur with the name and address of the Member included.

REASONS FOR PENALTY DECISION

In considering the Joint Submission on Penalty and Costs, the panel was aware of its obligations when reviewing joint submissions. The panel understands that it ought to accept a joint submission unless doing so would bring the administration of justice into disrepute or otherwise be contrary to the public interest. The panel was satisfied that the penalty and costs order proposed was appropriate in all the circumstances of this case.

This is the Member's first time before the Discipline Committee. He has no prior record of complaints. The Member was clearly regretful of the circumstances that led him to Discipline. He cooperated with the College, pleaded guilty to the allegations and was engaged in the discipline process throughout, including at the hearing itself.

At paragraph 1(d)(vi) of the Joint Submission, the Member agreed to only provide nitrous oxide minimal sedation going forward. The panel was advised that the Member volunteered to subject himself to this particular prohibition. The panel was impressed with the Member's decision to do so, as it reveals a

real willingness to learn from these particular circumstances and to ensure moving forward that the public is well protected.

The publication of this decision will act as a general deterrent for the membership at large. Strict adherence to the College's standards, especially around sedation, is a must and informed consent is a fundamental requirement for those practicing in this Province.

The reprimand and one-month suspension drive home the seriousness of this case and serve as a specific deterrent. Conduct of this nature will not be tolerated.

Members must practice safely, competently and according to the standards of practice of this College. The Member took a one day anesthesia course on his own initiative, which is to be commended.

Required courses in record keeping and informed consent plus practice monitoring will contribute to the Member's rehabilitation.

The panel is satisfied that through this penalty order, public confidence in the profession is maintained and the public is protected.

I, Dr. Sandy Venditti, sign these Reasons for Decision as Chairperson of this Discipline Panel.

Sandy Venditti

FEB. 20, 2020

Date

RCDSO v. DR. RYAN KIRSCHNER

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

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

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

The panel has bound that you have engaged in multiple acts of professional misconduct.

Your breach of the College's Use of Sedation and EA Standard of Dentistry could have had more significant, if not fatal, consequences, when not strictly adhered to.

Your failure to obtain informed consent from the patient is very troublesome. Trust is the essence of the patient-dentist relationship and failure to have a dialog with the patient at the proper time to address any issues/concerns especially with respect to sedatives is a breach of Section 2 of the *Dentistry Act Regulation*, as you've admitted.

We find that your conduct as admitted constitute dishonourable and unprofessional conduct.

This should impress upon you the importance of abiding by, understanding and being knowledgeable of the standards of dentistry set forth by the RCDSO.

Further, you need to keep current on any changes in the Standards going forward.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is **not** an opportunity for you to debate the merits or the correctness of the decisions we have made.

Do you have any questions or do you wish to make any comments?

(*Hear the Member's comments at this point*)

Thank you for attending today. We are adjourned.