H190013

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. ROLANDO ESTRABILLO**, of the City of Ancaster, 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 April 28, 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

April 28, 2021
Date

H190013

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. ROLANDO PINEDA ESTRABILLO,** of the City of Ancaster, 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.

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Amelia Chan
Dr. Paul Jackson
Mr. Rod Stableforth
Mr. Brian Smith (audio only)

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	

	)	Megan Shortreed,
	)	For the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. ROLANDO PINEDA ESTRABILLO	)	Brian Greenspan and Michelle
	)	Biddulph 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 April 28, 2021. This matter was heard electronically.

At the outset of the hearing, the College sought an order banning the publication of the names of any patients mentioned or any information that could be used to identify any patients. 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 December 13, 2019 (Exhibit 1).

1. You committed an act or acts of professional misconduct as provided by 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(s) 2017 and 2018, you recommended and/or provided an unnecessary dental service relative to one of your patients, namely Ms. N.B., contrary to paragraph 6 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - You recommended, and performed, unnecessary tooth extractions for this patient. Specifically, the following teeth were recommended for extraction, and were extracted, by you, unnecessarily: teeth 16, 21, 22, 24, 31, 32, 41, 42 and 46.

- You subsequently inserted implants at the extraction sites of teeth 16, 21, 22, 24, 32 and 42. These implant treatments were unnecessary, insofar as the original extractions of the natural teeth at these sites were unnecessary.
- You also inserted implants at the sites of teeth 14, 26 and 45. You did not extract the natural teeth at these sites; they were already missing. The implants placed at these extraction sites were unnecessary in that they were done to support the patient's dentition after the extractions of teeth 16, 21, 22, 24, 31, 32, 41, 42 and 46.
- You performed implant dentistry-related treatments for the patient, including bone grafting, that were unnecessary insofar as the original extractions of the natural teeth 16, 21, 22, 24, 31, 32, 41, 42 and 46 were unnecessary.

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(s) 2017 and 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 Ms. N.B., contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - You extracted the patient's tooth 47 and, on the same date, placed an implant at the tooth 47 extraction site, which was infected. In doing so, you failed to allow for an appropriate waiting period after the extraction for the infection to heal.
   - You placed implants for the patient without doing adequate treatment planning and case work-up.
   - You placed implants for the patient without first taking measurements of the patient's bone levels.
   - You placed implants for the patient without adequately assessing the patient's occlusion.
   - You placed implants for the patient without adequately considering and accounting for the physical and medical suitability of the patient to undergo implant treatment, including the patient's significant limitations for implant placement in terms of sufficiency of bone.
   - You placed implants for the patient without adequately accounting for and treatment-planning for the medical condition of the patient in terms of her difficulties in withstanding lengthy procedures.
   - You placed implants for the patient without considering or taking other minimally invasive or non-invasive steps first, including using a bite

plate and deprogrammer.

- You placed implants for the patient without adequate site preparation.
- The temporaries that you used were of poor quality and did not reflect the final results to be achieved.
- The inadequate results of the implant dentistry you performed for this patient include asymmetrical and unequal compression, inadequate interocclusal clearance, and poor esthetics.
- During appointments with the patient, you failed to adhere to proper infection prevention and control standards, including the following:
  - You touched multiple surfaces with your gloved hand such as the patient's shoulder and your phone;
  - You reached into your pocket with your gloved hand;
- You had a staff member take instruments from an instrument bag and pass them to you while not wearing gloves.

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(s) 2017 and 2018, you made a representation about a remedy, treatment, device or procedure for which there is no generally accepted scientific or empirical basis relative to one of your patients, namely Ms. N.B., contrary to paragraph 13 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - The patient reported to you that she had Lyme disease and suffered from health issues associated with this condition. You represented to the patient that she had infections or toxins in her teeth as a result of receiving root canal therapy in the past, despite the fact that her teeth were asymptomatic. You represented that such infections or toxins in her teeth were causing or exacerbating her health issues.
   - You represented to the patient that her health issues that she reported suffering in connection to Lyme disease would be treated or remedied by the extraction of her teeth which had previously been treated with root canal therapy.
   - You represented to the patient that if she did not have an implant placed, her bone would collapse.

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(s) 2017 and 2018, 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 Ms. N.B., contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- The patient reported to you that she had Lyme disease and suffered from health issues associated with this condition. You represented to the patient that she had infections or toxins in her teeth as a result of receiving root canal therapy in the past, despite the fact that her teeth were asymptomatic. You represented that such infections or toxins in her teeth were causing or exacerbating her health issues.
- You represented to the patient that her health issues that she reported suffering in connection to Lyme disease would be treated or remedied by the extraction of her teeth which had previously been treated with root canal therapy.
- You represented to the patient that if she did not have an implant placed, her bone would collapse.
- You did not inform the patient that nine (9) of the tooth extractions recommended by you were not dentally necessary.
- You did not comprehensively inform the patient of the risks, benefits and costs of the treatment that you recommended and performed.
- You did not comprehensively inform the patient of treatment alternatives.
- During the several stages of extractions and implant dentistry performed at multiple appointments for this patient, you did not comprehensively inform her on an ongoing basis of the results of treatment already performed, and the treatment options going forward including the risks, benefits and costs of such options and treatment alternatives.

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 year(s) 2017 and 2018, you charged a fee that was excessive or unreasonable in relation to the service performed relative to one of your patients, namely Ms. N.B., contrary to paragraph 31 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- Insofar as the extractions of the patient's teeth 16, 21, 22, 24, 31, 32, 41, 42 and 46 were unnecessary, and the implant dentistry performed for

teeth 16, 14, 21, 22, 24, 26, 32, 42 and 45 was also unnecessary, the fees you charged to the patient for these services were excessive or unreasonable.

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 year(s) 2017 and 2018, 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 one of your patients, namely Ms. N.B, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - You placed tools on the patient's chest during treatment, and picked up items from her chest. In conducting yourself in this manner, you failed to comply with the College's Practice Advisory on Prevention of Sexual Abuse and Boundary Violations (November 2015/November 2017).
   - You misled the patient by representing to her that she had infections or toxins in her teeth that were causing or contributing to her health issues. You misled her into undergoing significant, life-altering, costly, invasive treatment that was dentally unnecessary. You performed this treatment without adequate consideration of the patient's medical and physical suitability, without adequate treatment planning and case work-up, and without the patient's informed consent. The results were inadequate and you caused the patient harm. Your conduct was disgraceful, dishonourable, unprofessional and unethical.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in the Notice of Hearing. With respect to the allegations set out at paragraph 6, the Member admitted that his conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical

The Panel confirmed with the Member that he understood the effect of pleading to the misconduct 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 (Exhibit 2) which substantiated the allegations. The Agreed Statement of Facts provides as follows:

> **Allegations of Professional Misconduct**
>
> **Background**
>
> 1. Dr. Ronaldo Pineda Estrabillo ("Dr. Estrabillo" or the "Member") has been registered with the Royal College of Dental Surgeons of Ontario (the "College") as a general dentist since 1987.
>
> 2. At the material times, Dr. Estrabillo practiced at his clinic, Estrabillo Dental Group, located in Ancaster, Ontario (the "Clinic").
>
> **The Notice of Hearing**
>
> 3. The allegations of professional misconduct against Dr. Estrabillo are set out in the Notice of Hearing dated December 13, 2019 (attached at Tab A). The allegations arose following a complaint by N.B., a patient (the "Patient"), and a resulting investigation under s. 75(1)(c) of the Code.
>
> 4. In the course of College's investigation, it obtained the Patient's records from the Clinic as well as from dentists from whom the Patient received opinions or treatment after the Member's treatment, including Dr. Gregory Fichter, Dr. Cecilia Aragon, Dr. Neena D'Souza, Dr. Mark Kochman and Dr. George Arvanitis.
>
> 5. The College and the Member have agreed to resolve the allegations on the basis of the facts and admissions set out below.
>
> Facts and Admissions
>
> 6. The allegations in this matter relate to Dr. Estrabillo's treatment of the Patient.
>
> 7. Dr. Estrabillo treated the Patient at the Clinic in 2017 and 2018. With her consent, Dr. Estrabillo video recorded five of his appointments with the Patient.
>
> 8. The Patient reported that she suffered from significant health issues, including a diagnosis of chronic Lyme disease.

9. The Patient first went to the Clinic and met with Dr. Estrabillo in February 2017 for pain in tooth 47. Dr. Estrabillo took radiographs and determined the tooth was infected and required extraction. The Patient consented. The Member extracted the infected tooth and placed an implant that same day in the site of tooth 47, which was infected.

10. During this appointment, Dr. Estrabillo placed tools on the Patient's chest during treatment and picked up items from her chest.

11. The Patient advised Dr. Estrabillo that she had been diagnosed with Lyme disease in 2014 and experienced a vast array of associated symptoms including pain in her neck, jaw and shoulders, dizziness and electrical shocks in her skull, as well as hypersensitivity to sounds, motion and touch.

12. During her first appointment, the Patient asked the Member to conduct a full dental assessment, with a focus on mercury filling amalgams. She was previously advised by a holistic doctor and had read articles about the possibility that mercury presence in the body could be generating symptoms like those she was experiencing.

13. In addition to radiographs, Dr. Estrabillo took a CT scan.

14. A few weeks later, the Patient returned to discuss Dr. Estrabillo's treatment recommendations. Based on the radiographic and CT images and his examination, Dr. Estrabillo advised the Patient that all of her teeth with previous root canals were infected and/or had toxins that were leaching into her body and exacerbating her health issues. As detailed below, these teeth were, in fact, asymptomatic.

15. Dr. Estrabillo recommended that these teeth be extracted and replaced with implants. Dr. Estrabillo's records reveal that he recommended this treatment plan without adequate consideration of the Patient's medical and physical suitability, and without adequate treatment planning and case work-up.

16. He briefly provided the Patient with alternative options of doing nothing, re-treating the root canals, or obtaining a second opinion. The discussion of the alternative treatment opinions lasted less than one minute during the appointment of February 14, 2017. However, the Member represented to the Patient multiple times that the

infections or toxins in her teeth were causing or exacerbating her health issues.

17. The Patient visited the Member on February 27, March 15, March 28, and May 15, 2017 for further consultation and discussion about the treatment plan. The attendances on March 15, 2017 and May 15, 2017 were video recorded with the Patient's consent.

18. The Patient was not experiencing any pain or discomfort in these teeth. The Patient considered the Member's advice about extracting the teeth, but did not act on it at that time, in part because her family doctor told her he would not recommend such a significant treatment plan given her poor health.

19. The Patient continued to have concerns about the possibility of mercury in her mouth. As a result, she visited the Member again in February 2018 to request another assessment and consultation.

20. The Patient brought a list of nine questions to her consultation appointment on February 13, 2018, including questions about "possible toxicity of a dead tooth"; whether "10 implants [would] be beneficial or create more adverse changes"; and questions about Zirconia ceramic implants.

21. The Member again recommended that the teeth with prior root canal treatment be extracted. If the Patient were to testify she felt that the Member was quite adamant about this, and stressed both the urgency required and the potential for health related problems if she failed to do so. He also presented the procedure in a non-threatening, low risk manner, with no mention of longer-term risks. Specifically, he did not adequately explain to the Patient that she would be undergoing significant, life-altering, costly, invasive treatment that was dentally unnecessary. He did not adequately explain to the Patient the time required for the proposed treatment, and pain she would have to endure, in light of her difficulties in withstanding lengthy procedures.

22. At one point, he also told her that if she did not have an implant, her bone would collapse.

23. The Patient agreed to proceed with Dr. Estrabillo's recommendation in February 2018. She signed an informed consent on March 2, 2018

with respect to the extraction of tooth 16 and the placement of an implant at site 16. She signed a further informed consent on March 28, 2018 with respect to the extraction of tooth 24 and the placement of Zirconia implants at sites 24 and 26.

24. From February to November 2018, over the course of numerous appointments, Dr. Estrabillo treated the Patient which included the extraction of teeth 16, 21, 22, 24, 31, 32, 41, 42 and 46, implantation of teeth at sites 14, 16, 21, 22, 32, 42, 46 and a bridge placed between 33-43.

25. For the implants, Dr. Estrabillo used Zirconia implants, some of which were one piece implants (post and abutment).

26. During appointments with the Patient, Dr. Estrabillo:

    a. touched multiple surfaces with his gloved hand such as the Patient's shoulder and his phone;
    b. reached into his pocket with his gloved hand; and
    c. had a staff member take instruments from an instrument bag and pass them to him while not wearing gloves.

27. The Patient was not satisfied with Dr. Estrabillo's treatment. She was experiencing significant pain and was unable to chew. As a result, she sought opinions from other dental professionals between late 2018 and early 2019. One of the subsequent treating dentists obtained a new CT scan in December 2018.

28. Each of these professionals noted significant concerns with the treatment performed by Dr. Estrabillo. In particular, they noted protrusion and uneven occlusal contact, over contouring and open margins, excessive cement, splinting of natural teeth to implants, some implants not embedded in bone, and poor esthetics. Each recommended that the treatment performed by Dr. Estrabillo be redone.

29. The Patient submitted both the pre-treatment (February 2017) and post-treatment (December 2018) CT scans to Canaray for a radiological report. Subsequently, the College submitted all of the pre- and post-treatment radiographs to the same dental radiology expert, Dr. Milan Madhavi, who opined that:

a. The February 2017 CT scan and radiographs indicate no radiographic evidence of decay or infection necessitating the extraction of teeth 16, 21, 22, 24, 31, 32, 41, 42 or 46; and

b. The December 2018 CT scan and radiographs indicate that the implants placed at sites 14, 21, 22, 26, 31, 42, 45, 47 were not embedded in bone.

30. Dr. Madhavi's opinion was supported by all of the other subsequent treating dentists who reviewed the radiographs and CT scans.

31. Ultimately, in February 2019, the Patient commenced treatment with Dr. George Arvanitis, who is registered with the College as a general dentist and is also a fellow of the American Academy of Implant Dentistry and a board certified implantologist of the American Board of Oral Implantology. Dr. Arvanitis' practice focuses on reconstructive dentistry and implants.

32. After using a deprogrammer to recalibrate the Patient's bite, Dr. Arvanitis first removed the temporary bridge on the lower teeth and the crown at tooth 45. Dr. Arvanitis noticed mobility at the implant site at tooth 45 and was able to unscrew the implant by hand. The implant had failed; it was only being held in place with soft tissue contact and the temporary bridge, instead of being affixed in bone. Dr. Arvanitis concluded that the crown preparation had not been done well and there was not sufficient bone at the implant site which was likely the case from the outset.

33. During subsequent treatment sessions, when he cut into the crowns, Dr. Arvanitis found that Dr. Estrabillo's crowns and implants had no or inadequate margin preparation resulting in over contoured and open margins. The cause of the margins being overcontoured was that Dr. Estrabillo had not properly tapered the teeth; he did the opposite, resulting in crowns of larger diameter. It appeared that cement had been used to rectify the lack of margins; cement was visible at the gum line and could not be removed as it was structural in nature. The excessive cement was leading to discomfort for the Patient.

34. Dr. Arvanitis also noted that the Patient's upper front teeth were too large and too far forward. The reason for this was that the upper front implant was of a one piece design and due to the angulation of the bone and the implant, it led to the attached abutment sticking out.

This then led to this prosthesis being placed too far anterior and the rest of the anterior teeth then having to be built too far forward to match. Dr. Arvanitis had to significantly shave back the implants/abutments in order to try and achieve a more aesthetic smile. If Dr. Arvanitis were to testify he would state that the one-piece Zirconia implants were a poor choice for this area of the mouth and revealed a lack of proper treatment planning by Dr. Estrabillo.

35. Dr. Arvantis continued to treat the Patient throughout 2019 and 2020. As at the fall of 2020, he had yet to commence the work on the lower right side of the Patient's mouth. He expects this work to be challenging as there is very little bone left to support those teeth.

1. Allegation 1 – Unnecessary dental services

36. Dr. Estrabillo recommended the extraction of, and extracted, teeth 16, 21, 22, 24, 31, 32 41, 42 and 46.

37. The radiographs and CT scan taken by Dr. Estrabillo in February 2017 do not show any significant pathology or infection in the teeth he decided to extract. They were all stable and asymptomatic of pain.

38. Dr. Estrabillo admits that he recommended and performed unnecessary tooth extractions for the Patient with respect to teeth 16, 21, 22, 24, 31, 32 41, 42 and 46.

39. As a result, Dr. Estrabillo admits that the implants he inserted at teeth 16, 21, 22, 24, 32 and 42 were unnecessary insofar as the original extractions of the natural teeth at these sites were unnecessary.

40. Dr. Estrabillo also inserted implants at the sites of teeth 14, 26 and 45. He did not extract the natural teeth at these sites as they were already missing when he commenced treatment of the Patient. Dr. Estrabillo admits that the implants at these sites were unnecessary in that they were done to support the Patient's dentition after the extraction of teeth 16, 21, 22, 24, 31, 32 41, 42 and 46.

41. In addition to the implants themselves, Dr. Estrabillo admits that he performed implant dentistry-related treatments for the Patient that were unnecessary insofar as the original extractions of teeth 16, 21, 22, 24, 31, 32 41, 42 and 46 were unnecessary.

42. Therefore, Dr. Estrabillo admits that he recommended and/or provided an unnecessary dental service, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

2. Allegation 2 – failed to meet the standards of practice

43. Dr. Estrabillo admits that he failed to meet the standards of practice in respect of his treatment of the Patient as follows:

a. he extracted the infected tooth 47 and, on the same day, placed an implant at the tooth 47 extraction site. In doing so, he failed to allow for an appropriate waiting period after the extraction for the infection to heal;

b. he placed implants for the Patient without doing adequate treatment planning and case work-up;

c. he placed implants for the Patient without first taking measurements of the patient's bone levels;

d. he placed implants for the Patient without adequately assessing the patient's occlusion;

e. he placed implants for the Patient without adequately accounting for and treatment-planning for the medical condition of the Patient in terms of her difficulties in withstanding lengthy procedures;

f. he placed implants for the Patient without considering or taking other minimally invasive or non-invasive steps first, including using a bite plate and deprogrammer;

g. he placed implants for the Patient without adequate site preparation;

h. the temporaries that he used were of poor quality and did not reflect the final results to be achieved;

i. the inadequate results of the implant dentistry he performed for the Patient included asymmetrical and unequal compression, over contouring and open margins, excessive cement, splinting

of natural teeth to implants, failure to embed implants in bone, and poor esthetics; and

j. during appointments with the Patient, he failed to adhere to the College's Standard of Practice: Infection Prevention and Control in the Dental Office, when he:

a. touched multiple surfaces with his gloved hand such as the Patient's shoulder and his phone;

b. reached into his pocket with his gloved hand; and

c. had a staff member take instruments from an instrument bag and pass them to him while not wearing gloves.

44. Therefore, Dr. Estrabillo acknowledges that he failed to maintain the standards of practice of the profession contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing.

3. Allegation 3 – representations without scientific or empirical basis

45. Dr. Estrabillo was aware of the Patient's Lyme disease and associated health issues.

46. Dr. Estrabillo admits that he made the following representations about treatments and remedies to the Patient for which there was no generally accepted scientific or empirical basis:

a. she had infections or toxins in her teeth as a result of her prior root canal therapy (despite the fact that her teeth were asymptomatic);

b. such infections or toxins in her teeth were causing or exacerbating her health issues;

c. her reported health issues in connection with Lyme disease would be treated or remedied by the extraction of her previously root-canaled teeth; and

d. if she did not have an implant placed, her bone would collapse.

47. Therefore, Dr. Estrabillo admits that he made a representation about a remedy, treatment, device or procedure for which there is no generally accepted scientific or empirical basis relative to the Patient, contrary to paragraph 13 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

4. Allegation 4 - failure to obtain informed consent

48. Dr. Estrabillo admits that he failed to obtain informed consent prior to commencing, and while providing, treatment to the Patient.

49. In particular, Dr. Estrabillo did not obtain informed consent for the extractions and implants as his treatment was based on the following misrepresentations:

    a. the Patient had infections or toxins in her teeth as a result of receiving root canal therapy in the past (despite the fact that her teeth were asymptomatic) and that such infections or toxins were causing or exacerbating her health issues;

    b. the Patient's health issues that she reported suffering in connection to Lyme disease would be treated or remedied by the extraction of her teeth which had previously been treated by root canal therapy; and

    c. if she did not have an implant placed, her bone would collapse.

50. Dr. Estrabillo admits that he did not inform the Patient that nine (9) of the tooth extractions he recommended were not dentally necessary.

51. Dr. Estrabillo admits that he did not comprehensively inform the Patient of the risks, benefits and costs of the treatment he recommended and performed. For example, Dr. Estrabillo spent less than one minute informing the Patient of the option of obtaining further root canal treatment on the teeth for which she had previously received root canal therapy.

52. Dr. Estrabillo admits that during the several stages of extractions and implant dentistry performed at multiple appointments for the Patient, he did not comprehensively inform her on an ongoing basis of the results of the treatment already performed, and the treatment options going forward including the risks, benefits and costs of such options and treatment alternatives.

53. Therefore, Dr. Estrabillo admits that he treated the 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 consent, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 of the Notice of Hearing.

5. Allegation 5 – excessive or unreasonable fees

54. Dr. Estrabillo admits that he charged a fee that was excessive and unreasonable insofar as the extractions of the Patient's teeth 16, 21, 22, 24, 31, 32 41, 42 and 46 were unnecessary and the implant dentistry performed for teeth 14, 16, 21, 22, 24, 26, 32, 43, and 45 were unnecessary.

55. Therefore, Dr. Estrabillo admits that he charged a fee that was excessive or unreasonable in relation to the service performed relative to the Patient, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 5 of the Notice of Hearing.

6. Allegation 6 – DDUU

56. Dr. Estrabillo admits that he engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical when he:

    a. placed tools on, and picked tools up from, the Patient's chest during treatment. In doing so, he failed to comply with the College's Practice Advisory on Prevention of Sexual Abuse and Boundary Violations;

    b. misled the Patient by representing to her that she had infections or toxins in her teeth that were causing or contributing to her health issues;

    c. misled the Patient into undergoing significant, life-altering, costly, invasive treatment that was dentally unnecessary;

    d. performed this treatment without adequate consideration of the Patient's medical and physical suitability, without adequate

treatment planning and case work-up, and without the Patient's informed consent; and

e. achieved results that were inadequate and caused the Patient harm.

57. Therefore, Dr. Estrabillo admits that he 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 the Dentistry Act Regulation, as set out in Allegation 6 of the Notice of Hearing.

Past History

58. In December 2011, the Discipline Committee made findings of professional misconduct against Dr. Estrabillo for failing to maintain the standards of practice and disgraceful, dishonourable, unprofessional and unethical conduct. The findings of misconduct related to Dr. Estrabillo's treatment of 17 patients. Specifically, Dr. Estrabillo:

a. failed to adequately probe and/or document patients' medical condition(s);

b. failed to examine/chart patients' condition(s);

c. lacked support for a diagnosis;

d. performed unnecessary dental services;

e. had incomplete record keeping; and

f. charged inappropriate fees.

59. The Discipline Committee imposed a penalty consisting of a reprimand, four month suspension, practice restrictions, course work, mentoring, and payment of costs of $10,000 to the College. A copy of this decision is attached at Tab B.

60. The ICRC has also considered Dr. Estrabillo's practice on a number of other occasions. Copies of these decisions are attached at Tabs C to I. Those matters were resolved as follows:

a. in 2001, an Undertaking in relation to misleading and comparative advertising, including an apology, agreement to have future ads vetted for one year, and a commitment to comply in the future;
b. in 2004, an Undertaking in relation to further problematic advertising, including an apology, agreement to have future ads vetted for five years, and a commitment to comply in the future;
c. in 2016, a Caution for making a false, inaccurate and misleading statement in a newspaper article regarding Health Canada's view on dental amalgam use in children; and publishing an advertisement that was confusing, misleading, and suggested superiority over other dental practices;
d. in 2018, advice and recommendations from the ICRC regarding the need to obtain informed consent from patients for video recording prior to the commencement of each recording;
e. in 2018, advice and recommendations from the ICRC regarding not performing or billing for unnecessary bone curettage, not taking excessive radiographs, and that if he removes a lesion large enough to bill separately for, he should also send it out to have a biopsy performed;
f. in 2018, a Remedial Agreement to undergo practice monitoring with respect to his sedation practices; and
g. in 2020, a Caution for an extraction and implantation that exhibited an aggressive approach where root canal therapy could have been used, where the patient had not been informed of the aggressive nature of the approach, a failure to adequately prepare the site of the tooth for an implant in terms of sufficiency of bone resulting in multiple implant failures, a failure to obtain informed consent with respect to splinting crowns, and a failure to exercise professional judgment in not referring the patient to a specialist in a timely manner.

Summary

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

62. Dr. Estrabillo's admissions in this agreement and his plea to allegations 1, 2, 3, 4, 5 and 6 in the Notice of Hearing are voluntary, informed and unequivocal.

63. Dr. Estrabillo has had the opportunity to take independent legal advice with respect to his admissions, and has done so.

DECISION AND REASONS FOR DECISION

The Panel finds that the Member engaged in professional misconduct as set out in the Notice of Hearing and the Agreed Statement of Facts.

The Member pleaded guilty. He did not dispute the allegations, particulars or facts presented in the Agreed Statement of Facts, which was jointly submitted. .

The Panel concluded that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations and demonstrates the Member's disregard for his obligations as a dentist to provide necessary treatment to a patient who is fully informed and aware of the risks and benefits associated with the treatment. In this case, the Member displayed a lack of concern for his patient's well being, which resulted in irreversible harm.

The evidence filed demonstrated that the Member:

- Provided unnecessary dental services to one of his patients
- Contravened the standards of practice with respect to one of his patients
- Made a representation about a remedy, treatment, device or procedure for which there is no generally accepted scientific or empirical basis relative to one of his patients
- Charged a fee that was excessive or unreasonable in relation to the service performed relative to one of his patients
- 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; and
- Failed to properly obtain informed consent

In light of his admissions and the clear misconduct described in the Agreed Statement of Facts, the Panel unanimously found Dr. Estrabillo guilty of professional misconduct as set out in the six allegations contained within the Notice of Hearing. The Panel further found that the conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical.

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission on Penalty and Costs (Exhibit 3), which proposed the following sanctions:

1. Requiring the Member to appear before the Panel of the Discipline Committee to be reprimanded, on the date of this Order becoming final.

2. Directing the Registrar to suspend the Member's certificate of registration for a period of ten (10) months. The suspension shall commence on May 15, 2021, and shall run without interruption.

3. Directing that 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 immediately inform the following people about the suspension:

        i. staff in the offices or practices in which the Member works, including other regulated professionals and administrative staff

        ii. dentists with whom the Member works, whether the Member is a principal in the practice or otherwise associated with the practice

        iii. dentists or other individuals who routinely refer patients to the Member

        iv. faculty members at Faculties of Dentistry, if the Member is affiliated with the Faculty in an academic or professional capacity

        v. owners of a practice or office in which the Member works

        vi. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Member may assign

administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

b. while suspended, the Member must not engage in the practice of dentistry, including but not limited to:

i. acting in any manner that suggests the Member is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Member must ensure that administrative or office staff do not suggest to patients in any way that the Member is entitled to engage in the practice of dentistry

ii. giving orders or standing orders to dental hygienists

iii. supervising work performed by others

iv. working in the capacity of a dental assistant or performing laboratory work

v. acting as a clinical instructor;

c. while suspended, the Member must not be present in offices or practices where the Member works when patients are present, except for emergencies that do not involve patients. The Member must immediately advise the Registrar in writing about any such emergencies;

d. while suspended, the Member must not benefit or profit, directly or indirectly from the practice of dentistry;

i. The Member may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Member may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.

ii. The Member is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.

iii. The Member must not sign insurance claims for work that has been completed by others during the suspension period;

e. the Member shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Member has complied with the Suspension Conditions. The Member must provide the College with access to any records associated with the practice that the College may require to verify that the Member has not engaged in the practice of dentistry or profited during the suspension; and

f. the Suspension Conditions imposed by virtue of subparagraphs 3(a)-(e) above shall be removed at the end of the period that the Member's certificate of registration is suspended.

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

a. the Member shall be restricted permanently from performing implant dentistry;

b. the Member shall successfully complete, at his own expense, the following courses approved by the Registrar:

i. the ProBE Program for Professional/Problem-Based Ethics (must obtain an "unconditional pass" grade); and

ii. a comprehensive one-on-one course on informed consent;

such courses to be completed within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

c. the Member's practice shall be monitored by the College by means of periodic inspection(s) or periodic chart review(s) by a representative or representatives of the College at such time or times and in such manner as the College may determine, during the twenty-four (24) months following the date he returns to practice following the suspension in paragraph 2 above;

d. the Member shall cooperate with the College during the inspections and/or chart reviews and, further, shall pay to the

College in respect of the cost of monitoring, the amount of $1,000.00 per inspection or review session, such amount to be paid immediately after completion of each inspection or review session;

e. the representative or representatives of the College shall report the results of the inspections and/or chart reviews 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;

f. the Practice Conditions imposed by virtue of clause (b) of paragraph 4 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 have been completed successfully; and

g. the Practice Conditions imposed by virtue of clauses (c), (d) and (e) of paragraph 4 shall be removed from the Member's certificate of registration 24 months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clauses (c), (d) and (e) 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.

5. The Member shall pay costs to the College in the amount of $30,000.00, within thirty (30) days of the date of this Order becoming final.

PENALTY DECISION

The Panel accepts the Joint Submission on Penalty and Costs and orders that:

1. The Member appear before the Panel of the Discipline Committee to be reprimanded, on the date of this Order becoming final.
2. The Registrar suspend the Member's certificate of registration for a period of ten (10) months. The suspension shall commence on May 15, 2021, 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 immediately inform the following people about the suspension:

      i. staff in the offices or practices in which the Member works, including other regulated professionals and administrative staff

      ii. dentists with whom the Member works, whether the Member is a principal in the practice or otherwise associated with the practice

      iii. dentists or other individuals who routinely refer patients to the Member

      iv. faculty members at Faculties of Dentistry, if the Member is affiliated with the Faculty in an academic or professional capacity

      v. owners of a practice or office in which the Member works

      vi. patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Member may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

   b. while suspended, the Member must not engage in the practice of dentistry, including but not limited to:

      i. acting in any manner that suggests the Member is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Member must ensure that administrative or office staff do not suggest to patients in any way that the Member is entitled to engage in the practice of dentistry

      ii. giving orders or standing orders to dental hygienists

      iii. supervising work performed by others

      iv. working in the capacity of a dental assistant or performing laboratory work

      v. acting as a clinical instructor;

c. while suspended, the Member must not be present in offices or practices where the Member works when patients are present, except for emergencies that do not involve patients. The Member must immediately advise the Registrar in writing about any such emergencies;

d. while suspended, the Member must not benefit or profit, directly or indirectly from the practice of dentistry.

i. The Member may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Member may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.

ii. The Member is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension.

iii. The Member must not sign insurance claims for work that has been completed by others during the suspension period;

e. the Member shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Member has complied with the Suspension Conditions. The Member must provide the College with access to any records associated with the practice that the College may require to verify that the Member has not engaged in the practice of dentistry or profited during the suspension; and

f. the Suspension Conditions imposed by virtue of subparagraphs 3(a)-(e) above shall be removed at the end of the period that the Member's certificate of registration is suspended.

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

a. the Member shall be restricted permanently from performing implant dentistry;

b. the Member shall successfully complete, at his own expense, the following courses approved by the Registrar:

i. the ProBE Program for Professional/Problem-Based Ethics (must obtain an "unconditional pass" grade); and

ii. a comprehensive one-on-one course on informed consent;

such courses to be completed within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

c. the Member's practice shall be monitored by the College by means of periodic inspection(s) or periodic chart review(s) by a representative or representatives of the College at such time or times and in such manner as the College may determine, during the twenty-four (24) months following the date he returns to practice following the suspension in paragraph 2 above;

d. the Member shall cooperate with the College during the inspections and/or chart reviews and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per inspection or review session, such amount to be paid immediately after completion of each inspection or review session;

e. the representative or representatives of the College shall report the results of the inspections and/or chart reviews 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;

f. the Practice Conditions imposed by virtue of clause (b) of paragraph 4 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 have been completed successfully; and

g. the Practice Conditions imposed by virtue of clauses (c), (d) and (e) of paragraph 4 shall be removed from the Member's certificate of registration 24 months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clauses (c), (d) and (e) 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.

5. The Member shall pay costs to the College in the amount of $30,000.00, within thirty (30) days of the date of this Order becoming final.

REASONS FOR PENALTY DECISION

The Panel concluded that the proposed penalty was appropriate in all the circumstances of this case. It therefore accepted the Joint Submission and ordered that its terms be implemented.

The Panel was satisfied that the reprimand and 10-month suspension, the fact of which will be made public on the College's register, will act as both a specific deterrent for the Member and as a general deterrent for the membership at large.

Further, the public will be protected with the permanent restriction on the Member's ability to perform implant dentistry. This prohibition sends a clear message to all members of the profession that the College will not tolerate members performing unnecessary dental services, submitting false, excessive or unreasonable claims, failing to properly obtain informed consent, failing to meet the standards of practice.

The imposition of the terms, limits and conditions also serve to protect the public. While under suspension, Dr Estrabillo must not engage in the practice of dentistry. Prior to and upon his return to the practice, he is required to take a course in ethics (ProBe) and Informed Consent.
In addition, once he returns to practice, the Member's office will be monitored for 24 months to ensure that he is meeting professional standards.

Rehabilitation of the Member is met by the successful completion of the mandated courses and the office monitoring.

When considering the appropriateness of the penalty, the Panel considered the wide range of penalties ordered from previous disciplinary hearings and both aggravating and mitigating factors. The Panel was satisfied that the Joint Submission was fair and reasonable.

Aggravating factors include the seriousness of the misconduct affecting the patient. It involved 2 (two) years of unnecessary treatment including 9 (nine) extractions of asymptomatic teeth and inappropriate placement of multiple implants that required revision. As well, the treatment performed by the Member had no scientific basis. In fact, it appears that the Member compounded the patient's unsubstantiated fears that her dental staus caused her complicated medical condition. The Member's treatment resulted in harm and suffering and therefore the Member breached Medicine's Hippocratic Oath: "Do No Harm". In 2011, a Discipline Panel made findings of professional misconduct in relation to 17 (seventeen) patients.

A mitigating factor the Panel considered was that the Member admitted the facts and pled guilty which circumvented the need for a drawn out and costly hearing.
The Panel accepted the costs as appropriate in this case.

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

May 4, 2021

Date

RCDSO v. Dr. Estrabillo

Dr. Estrabillo, 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 found that you have engaged in multiple acts of professional misconduct. The misconduct related to – among other things - providing unnecessary dental services that resulted in significant and irreversible harm to the patient that required extensive corrective therapy; failing to obtain informed consent; charging excessive fees; making representations without a scientific basis for doing so; and failing to meet the standards of practice. 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:

- Extractions of healthy teeth;
- Failure to adequate educate or inform the patient of the risk/benefit of scientifically unproven procedures;
- Preying upon a vulnerable and uninformed patient;
- Failure to take into account the patient's underlying medical disease;
- Lack of appropriate infection control;
- Lack of sensitivity regarding the placement of dental instruments on the patient's chest

Dr. Estrabillo, we are satisfied that the penalty we have ordered is fair and in the public interest. We trust that you will use the time away from practice to reflect on your misconduct and strive towards more responsible practice values. We certainly would not want to see you before a panel of the Discipline Committee again.

In the future, we hope that you will make evidence-based and clinically acceptable decisions when recommending and performing treatment.