DISCIPLINE COMMITTEE
OF THE COLLEGE OF DENTURISTS OF ONTARIO

PANEL:	Chair, Hanno Weinberger Anita Kiriakou Keith Collins Eugene Cohen Bruce Selinger

BETWEEN:

COLLEGE OF DENTURISTS OF ONTARIO	)	REBECCA DURCAN for College of Denturists of Ontario
- and -	)	
VOLODYMYR IRODENKO	)	Self Represented
	)	LUISA RITACCA Independent Legal Counsel
	)	Heard: October 5, 6 & 7, 2015

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on October 5, 6 & 7, 2015 at Victory Verbatim in Toronto, Ontario.

At the outset of the hearing, the College advised that there were two Amended Notices of Hearing relating to the Member and that the parties consent to the allegations contained in both Amended Notices to be combined into one proceeding. The panel was satisfied based on ss. 9.1(a) of the Statutory Powers Procedure Act that it had the jurisdiction to combine the matters into one proceeding.

At the request of the parties, the panel marked as Exhibit 1 the Amended Notice of Hearing, dated October 17, 2014, relating to patient, "IL" and as Exhibit 2 the Amended Notice of Hearing, also dated October 17, 2014, relating to patient, "VC".

Counsel advised that the College would be seeking to withdraw allegations 7(b), (c), (d), and (e) in Exhibit 1 ("IL" Matter). The Member consented to the request and as such the panel withdrew those allegations.

Exhibit #1 ("IL Matter") - Allegations

The allegations against Volodymyr Irodenko (the "Member") as stated in the Amended Notice of Hearing #1 dated October 17, 2014, are as follows.

1. At all material times, Volodymyr Irodenko was a member of the College. Mr. Irodenko's clinic was located in London, Ontario.

   Interactions with Patient, I.L.

2. In or about April 23, 2013, I.L. attended Mr. Irodenko's clinic for a consultation regarding upper and lower partial dentures. I.L. was suffering from a misalignment of a crown and bridge. At the conclusion of the consultation, Mr. Irodenko issued or caused to be issued an account in the amount of $1292. Mr. Irodenko is identified as "Dr. Irodenko, DD" on the account.

3. Approximately five weeks later, on or about May 30, 2013, I.L. returned to Mr. Irodenko's clinic where Mr. Irodenko fitted I.L. with new upper and lower partial dentures. After the procedure, Mr. Irodenko issued or caused to be issued a second account in the amount of $958. Again, Mr. Irodenko is identified as "Dr. Irodenko, DD" on the account.

4. The next day, on or about June 1, 2013, I.L. returned to Mr. Irodenko's clinic complaining about his dentures including the pain they were causing to his upper gums and the damage they were causing to an abutted tooth. Mr. Irodenko performed a corrective procedure on the dentures.

5. Approximately four days later, on or about June 5, 2013, I.L. returned to Mr. Irodenko's clinic complaining about pain to his gums and the dentures falling out. As a result, Mr. Irodenko offered to reset the dentures and the occlusion, and I.L. made an appointment to return to Mr. Irodenko's clinic on or about August 5, 2013. However, on the day of the appointment, I. L. received a text message from Mr. Irodenko cancelling the appointment and advising I.L. that he would not create new dentures. Although Mr. Irodenko offered to refund I.L. the cost of the dentures, he has not done so despite I.L.'s repeated requests.

6. I.L. can no longer use the dentures due to the pain that they cause and their poor fit.

7. It is alleged that Mr. Irodenko engaged in the following acts of professional misconduct as set out in Ontario Regulation 854/93, section 1:

   a. He failed to maintain the standards of the profession (paragraph 2);

   b. *Withdrawn*;

   c. *Withdrawn*;

d. *Withdrawn*;

e. *Withdrawn*;

f. He contravened by act or omission the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those acts (paragraph 33); and/or;

g. He engaged in conduct or performed an act, in the course of practicing Denturism that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable, unethical or unprofessional (paragraph 47).

8. It is alleged that Mr. Irodenko used a name or title other than his name as set out A in the register in the course of providing or offering to provide denturist services, which is an act of professional misconduct as set out in Ontario Regulation 854/93, sub-section 2(1).

9. Further particulars of the specified allegations of professional misconduct relied upon by the College are contained in the documentary disclosure provided to Mr. Irodenko in support of the allegations in the Notice of Hearing.

The Allegations

The allegations against Volodymyr Irodenko (the "Member") as stated in the Amended Notice of Hearing #2 dated October 17, 2014, are as follows.

1. At all material times, Volodymyr Irodenko was a member of the College. Mr. Irodenko's clinic was located in Campbellford, Ontario.

Interactions with Patient V.C.

2. On or about May 7, 2013, V.C. attended Mr. Irodenko's clinic for a consultation regarding maxillary and mandibular full dentures.

3. When Mr. Irodenko provided V.C. with the dentures approximately four weeks later, on or about June 11, 2013, he advised her that she could return to him regarding any concern with the dentures free of charge for one year.

4. By July 2013, Mr. Irodenko had shut down his clinic and was no longer working there. At no point did Mr. Irodenko advise V.C. that he would be moving.

5. Although Mr. Irodenko offered to refund V.C. $2500, which was the cost of the dentures, approximately one year later, he has not done so.

Unlawfully Holding Out as a Registered Dental Technologist

6. Mr. Irodenko provided V.C. with his business card which identified him as "Vladimir Irodenko DD, RDT".

7. Mr. Irodenko is not a member of the College of Dental Technologists of Ontario.

8. It is alleged that Mr. Irodenko engaged in the following acts of professional misconduct as set out in Ontario Regulation 854/93, section 1:

    a. He failed to maintain the standards of the profession (paragraph 2);

    b. He discontinued denturist services to V.C. without adequate reason;

    c. He failed to fulfill the terms of an agreement with a patient (paragraph 7);

    d. He made a misrepresentation to a patient including a misrepresentation respecting a remedy, treatment, device or procedure (paragraph 1 O);

    e. He used a term, title or designation other than one authorized by the Act or the regulations or as provided in section 2 (paragraph 18); and/or

    f. He engaged in conduct or performed an act, in the course of practicing Denturism that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable, unethical or unprofessional (paragraph 47).

9. It is alleged that Mr. Irodenko used a name or title other than his name as set out in the register in the course of providing or offering to provide denturist services which is an act of professional misconduct as set out in Ontario Regulation 854/93, sub-section 2(1).

10. Further particulars of the specified allegations of professional misconduct relied upon by the College are contained in the documentary disclosure provided to Mr. Irodenko in support of the allegations in the Notice of Hearing.

Member's Plea

While the Member initially admitted to some of the factual allegations contained in both Exhibits 1 and 2, he denied that he engaged in any professional misconduct, as described at paragraphs 7-8 of Exhibit 1 and paragraphs 8-9 of Exhibit 2.

Overview

The allegations contained in the Notices of Hearing concern two individual patients (IL and VC) and stem from a time when the Member was actively practicing in London, Ontario. Both matters deal with issues relating to patient-relations and failing to maintain the standards of the profession. In the case of IL, the allegations also include an allegation of misuse of title and in the case of VC, a breach of contract between the Member and the patient.

The panel heard opening and closing submissions from College Counsel as well as the Member himself. The panel also heard from two witnesses called by the College, a factual witness (VC) and an expert witness (FO). As discussed in more detail below, the panel considered the weight it was prepared to assign to the testimony of the expert witness. In its deliberation, the panel considered the submissions made by College Counsel and the Member, the evidence contained in the exhibits and the testimony of the witnesses.

Based on the submissions by College Counsel and the Member, the exhibits and the testimony of the witnesses, the panel made a finding of professional misconduct against the Member. More specifically, the panel found that the Member had breached standards of practice by improperly using a protected title, and by failing to honour an agreement made with a patient.

The Evidence

The panel heard from two witnesses called by the College.

VC provided factual evidence in relation to the allegations contained in the second Notice of Hearing (*Exhibit #2*). In her examination in chief, VC stated that she had met the Member when she went for her initial visit to his clinic in May 2013. Following the fabrication of her dentures, VC testified that the Member had told her she could return free of charge for a full year to deal with any issues or concerns related to her dentures. Upon returning from her cottage in the summer of 2013, VC went to see the Member because she felt her dentures were not right. The clinic was locked, with a sign on the door advising that the clinic had been permanently closed. VC did finally manage to contact the Member by phone, at which time he made an offer to refund a significant portion of the payment she had made. However, at the time of the hearing, VC stated that no refund had been received.

Under cross examination by the Member, VC could not recall ever having seen the business card contained in *Exhibit 4* in which it appears that the Member improperly used the title "Doctor". VC maintained that her dentures did not fit properly. In response to questioning, VC stated that she had received the Member's return phone call about four months after he had closed the clinic. She reiterated that all she wanted was "to go back, but you weren't there". It was at that point that VC decided to contact the College and initiate a complaint against the Member.

The second witness appearing on behalf of the College was Frank Odorico (FO). The College sought to have FO qualified to give evidence as an expert in clinical practice, denturist services and in agreements between denturists and their patients. College submitted that given FO's extensive experience as a practitioner and the fact that he has conducted numerous assessments for the CDO, it was appropriate for him to provide his expert opinion.

The Member objected to the panel qualifying FO as an expert. The Member argued that FO was in a conflict of interest given his current role as vice-president of the Denturist Association of Ontario ("DAO"). The Member argued that in that role, FO worked as an advocate for the profession.

College Counsel argued that FO's position within the DAO spoke to a position of leadership and a level of tenure and knowledge. If anything, College Counsel argued any conflict could be viewed as a conflict against the College, since FO held a senior position within the DAO, an or-

ganization whose mandate is to advocate on behalf of the profession. College Counsel reiterated its belief that FO was appearing as an expert, there to assist the panel and not there to assist the College. College Counsel also pointed out to the panel that the Member had been provided with FO's opinion months ago, giving him ample opportunity to prepare a cross examination.

The Member argued that the panel should be concerned that a witness whose mandate was to advocate for the profession and not to serve and protect the public interest was to be offered by the College as an expert witness. The Member argued that there had to be more seasoned professionals available to the College.

The panel looked to ILC and was advised that it only had to decide whether FO could be qualified in the areas sought by the College. The Member's objection was that someone employed by the association was inherently in a position of conflict. Qualifying FO did not mean that the panel had to accept his opinions. In fact, the panel was obligated to consider the testimony and the weight of all testimony presented. The panel's task was to determine whether FO could provide it with impartial assistance in understanding the facts in this matter.

The panel deliberated and decided to qualify FO as an expert witness. In doing so however, it assured the Member that it would ultimately determine the weight to be assigned to FO's testimony during its deliberation.

During College's examination in chief, FO stated that he had reviewed both complaints about one year ago. He had read the complaints, looked objectively at the complaint letters and responses and had been asked to provide feedback.

In the matter of IL (*Exhibit #1*), it was FO's opinion that the Member had indeed met the standards of the profession. FO recognized that this was a difficult case and that the Member's efforts to address the issues presented by IL were "by the book". Where FO expressed concern was over the fact that the Member had allowed IL to go home with a set of dentures that still required some adjustments. In FO's opinion, the dentures sent home with IL posed a potential risk as they were non functioning dentures. FO stated that the Member had recognized the need for further adjustments in order to correct the bite. However, FO's concern was that the patient did not have fit and function with the set of dentures sent home during the monitoring phase.

In the VC matter, FO stated that the expected standard of the profession regarding post insertion care was three months. The Member was not obligated to offer twelve months post insertion care, however FO opined that if an offer of twelve month post insertion care was made, it must be honoured. It was FO"s opinion that the Member had made a misleading promise as to the length of post insertion care he could provide to VC.

FO stated that in reviewing IL's file, it became apparent that the Member was intending to close his practice and relocate out of the province. VC had initially come to the Member in the spring of 2013. By the end of 2013, the Member was no longer certified to work in Ontario, had relocated to Alberta and been certified to practice in that province. There was no evidence in VC's file that the Member's plan to relocate had been communicated to her. Further there was no evidence in VC's file to indicate that the Member had facilitated a transfer to another denturist. No referral name or number was provide to VC.

In the matter of the refund offer by the Member to VC, FO stated that a denturist is entitled to be paid for services provided. The Member promised to refund or partially refund the fees VC had paid. In FO's opinion, to make that offer showed good faith on behalf of the Member. However, to make that offer and not honour that offer showed a lack of good faith on behalf of the Member.

Under cross examination, FO agreed that the IL matter was a complex case. He stated that his opinions were based on a review of the patient's record. FO's concern arose from the fact that the Member had recognized that IL's dentures had dislodged and that IL was having trouble with retention under function, but that the Member allowed IL to wear the dentures home while he continued to monitor the situation.

In the matter of VC, FO stated that the Member was aware that he was relocating yet he nonetheless made a twelve month post insertion care promise that he knew he could not keep.

FO stated that in his opinion, in the IL matter the Member attempted to take care of the situation; however, in the VC matter the Member was aware he was closing his practice and leaving yet failed to communicate information to her.

When asked by College Counsel whether upon hearing the questions posed by the Member during his cross, FO had changed his opinion about what he had previously stated, FO responded that he had not. FO concluded by stating that the Member fell below the standard of practice by allowing, in the IL case, dentures that had come loose under function to go home with the patient and in providing, in the VC case, a guarantee of twelve-month's service (regardless of whether it was made in May or June 2013) that he knew he could not honour.

College Counsel's Closing Submissions

College Counsel reminded the panel that the onus was on the College to prove the allegations contained in the Notices of Hearing based on clear, cogent and convincing evidence. The panel must be satisfied that the allegations have been made out on a balance of probabilities (i.e. more likely than not that the alleged conduct occurred).

In the matter of IL (*Exhibit #1*), College Counsel submitted that there had been a breach of the standards of the profession. Further, the inappropriate use of a title was a contravention of the *RHPA.* The title of doctor is a protected one and few people can use it. As set out in *Exhibit #3*, the invoices given to IL list the Member as a doctor. The use of this title is a breach of section 33 of the *RHPA.*

The second area of evidence in the IL matter was presented by the expert witness FO. FO was satisfied with the bulk of care provided by the Member. In his opinion however, a breach of practice occurred when dentures that did not have fit and function were sent home with the patient in a "wait and see" scenario. As of June 1, 2013, the Member was aware that fit and function had not been achieved. Nevertheless, the Member had sent the dentures home with IL with the intention of monitoring the situation and calling IL back to refit accordingly. In the opinion of FO, by doing so, the Member failed to maintain the standards of the profession.

Based on the testimony of FO and the invoices which clearly demonstrated that the Member used the title "Doctor", College Counsel argued that it had met its burden and that this conduct would reasonably be viewed by the profession to be unprofessional. The College further stated that it was not proceeding with the allegations contained in paragraph 7 b), c), d), and e) in the Notice of Hearing (*Exhibit #1*).

College Counsel argued that in the matter of VC, the Member had breached the standards of the profession, discontinued services without reason and failed to maintain a service agreement. By so doing, the Member acted in a dishonourable, unethical and unprofessional manner. Regarding the allegation of improper use of title in respect of the Member's dealings with VC, the College acknowledged that there was not sufficient evidence presented to make any finding.

College Counsel drew the panels' attention to *Exhibit #2* wherein in the Member agreed that VC had been promised one year's free post insertion care and thereafter promised to refund a significant portion of the fee VC had paid. College Counsel reminded the panel that VC testified to the fact that a refund had been promised, but as of the date of the hearing, had not been received. The panel heard from VC that she had fully paid the Member and been advised by him that she could return for one year, free of charge to address any and all issues. Even though there was some discrepancy as to when the clock started ticking in that regard, by July of 2013, the Member had relocated. VC's clinical record (*Exhibit #4*) records numerous visits between May and July 11, 2013. There was nothing in VC's clinical record to suggest that the Member had advised her of his intention to relocate and/or that he was closing his clinic. Further, there was nothing in the clinical record to suggest that the Member had taken any steps to transfer VC's files to another denturist. College Counsel asked the panel how the Member was going to fulfill his agreement with VC (free post insertion care until May 2014) if he was no longer in the province.

College Counsel reminded the panel of the testimony given by FO wherein he stated that the standard of the profession for post insertion care was three months. FO agreed that the Member had gone above and beyond in guaranteeing twelve months of care. FO stated that it was a professional expectation to notify patients in the event of a clinic closure or relocation. The Member had an obligation to put his patients first. Rescinding agreements and leaving the province without notifying patients and/or transferring their files, did not honour the professional obligation to put patients' needs first. As to the refund offer, FO opined that even though the twelve-month post insertion care offer was not required, once it was offered and essentially paid for, the Member was obliged to honour it. By not doing so, the Member had engaged in professional misconduct.

College Counsel drew the panel's attention to Notice of Hearing in the VC matter (*Exhibit #2*). She argued that clear, cogent and convincing evidence had been presented to make a finding that the Member had failed to maintain the standards of the profession, failed to fulfill the terms of an agreement with the patient and had made a misrepresentation to his patient.

As set out above, College Counsel acknowledged that the College had not presented sufficient evidence to allow for a finding to be made regarding the allegations referred to in Paragraph 8e and 9.

As to the testimony of FO, College Counsel stated that the panel had qualified him as an expert witness, but it had to determine the weight to be given to his testimony. College Counsel stated that FO was clearly impartial and had expressed his praise for the Member as well as his concerns. The panel could not rely on its own personal experiences and therefore needed to hear from an expert.

College Counsel concluded by stating that in the IL matter it was seeking a finding that the Member's conduct would reasonably be regarded by members of the profession as unprofessional, but in the matter of VC, it was seeking a finding that the Member's conduct would reasonably be regard by members of the profession as dishonourable, unethical or unprofessional.

Member's Closing Submission

The Member made his closing submissions in two stages. Regarding the IL matter, the Member questioned the position of FO as an expert witness. The Member stated that the College had failed to provide a clinical assessment of the case and even if it had, he maintained that FO was not able to properly make a diagnosis in this matter. According to the Member, the College had failed to provide an expert to support its allegations.

The Member disagreed with the argument raised by College Counsel that IL's dentures did not have fit or function when they were sent home. The Member stated that on May 30th, 2013, IL's dentures were delivered in correct fit and function with the understanding that adjustments would take place following delivery. The Member submitted that one day of wearing dentures was not sufficient to make an adjustment and therefore the decision was made to monitor the patient for a period of time.

Regarding the allegation of misusing the title of doctor, the Member argued that since the College had agreed that there was no clear evidence to support that allegation in the VC matter, it should withdraw that allegation in the IL matter as well. Further, the Member argued that the College had failed to provide the panel with evidence that the invoices contained in IL's record (*Exhibit #3*) were factual.

The Member argued that he had acted with dignity and professionalism in both matters and that the panel should therefore not make a finding of professional misconduct.

The Member also argued that because he was no longer a member of the College, he was under no obligation to appear before the Discipline Committee. He argued that he chose to come and deal with these cases at great inconvenience and cost to himself.

As to the matter of VC, the Member stated that the College had not provided evidence as to the specific date his clinic was closed. Further, VC had not given a specific date as to when she had returned from the cottage and was attempting to contact him. VC's treatment was from May 7th to July 11th. The Member argued that VC's dentures were delivered on June 11, 2013 and that the three month post insertion care accepted as a standard of the practice should begin on that date. Standard three month post insertion care would therefore extend to September 11, 2013. The Member told the panel that VC had visited the clinic four times between June 11th and July 11th for adjustments and a reset. All of this constituted post insertion care and the Member asked the panel to accept the standard three month post insertion care had been met.

As to the specifics of College Counsel's closing, the Member made the following points to the panel. To the claim that the Member offered VC one year free post insertion care, the Member stated that he had not been sworn in as a witness and had not testified to this. VC had stated she had gone to her cottage for a while. The Member argued that the College had failed to provide dates as to the extent of VC's cottage vacation and as to when she arrived at the clinic and found the doors locked. Regarding the issue of the refund offer, the Member stated that College Counsel had not asked VC if any conditions had been attached to that offer. In his submissions, the Member suggested that he had offered to refund VC's money in exchange for her rescinding her complaint to the College. The Member reminded the panel that VC had said that she wanted nothing from the Member when he reached her by telephone. The refund had not been made because VC had not rescinded her complaint to the College. As to the issue of continuation of care, the Member stated that VC had left for her cottage on Rice Lake and therefore the Member assumed that all was OK. Further, the only contact information he had for VC was her home number and address. The Member stated that VC had been catered to and looked after for one month (from June 11, 2013 to July 11, 2013). There was no reason for the Member to contact VC as his services had been completed. The Member argued that his services had not been discontinued. Rhetorically, the Member asked, "How could the services have been discontinued if they had been carried out?". The Member argued that he had not failed to carry out the terms of his agreement with VC. She was still wearing the dentures he had fabricated, had not complained about fit or function and had he not sold his clinic, he would have continued to provide care to VC.

The Member submitted that College Counsel had not asked him for the date he had closed his clinic and therefore the date of closure should not even be considered. The Member reminded the panel that he prided himself on exceeding the standards of the profession by providing more than three months post insertion care. He argued that College Counsel proposed to punish him for exceeding the the standard of care. The Member asked the panel to understand that at that time, he was running multiple clinics in multiple locations. The Member stated that he became certified in Alberta in August of 2013 and continues to field calls from patients in Ontario, referring them to other practitioners.

The Member concluded by telling the panel that he continues to uphold the standards of the profession. His patients are well served and have not been misled. The Member concluded by telling the panel that the matter before them was a serious one. It was a matter of dignity, respect and internal beliefs to the Member and he had done his best to represent himself.

College Counsel's Reply

In her reply, College Counsel reminded the panel that the Member had not been sworn in as a witness and therefore, could not provide facts or expert testimony in his closing submissions.

College Counsel recognized that the Member had resiled from some earlier agreements taken during the plea inquiry. However, she reminded the panel that what he could not do during his closing submission was impugn the testimony of witnesses who had appeared during this hearing.

College Counsel clarified for the panel that it does in fact have jurisdiction over the Member. The Member is still accountable for his conduct during the time he was a member of the College. As a former member he is still accountable for his actions during that time.

As to the issue of VC, it was the Member himself who used the phrase "close down the clinic" when he questioned VC. In her response to the Member, VC stated that she had attempted to see him in July 2013, but when she attended the clinic, it was locked and a sign in the window said the clinic was closed. VC responded when asked, that all she wanted was "to go back, but you were not there". Further, College Counsel argued that the Member was not being punished for making a guarantee of twelve months post insertion care, but was being brought to task for not honouring a promise he had made to a patient. Even if the panel were to accept that three months was all that was needed to be provided for post insertion care, the Member had left the province and could not have honoured even that shorter time period.

Regarding the refund, College Counsel stated that the Member's claim that the refund he offered was conditional on VC rescinding her complaint had no bearing on this matter. No evidence was presented that conditions were attached to the offer of a refund. The time to raise that issue would have been during the Member's cross of VC. That is not an argument that can be raised in closing and in any event, does not take away from the fact that the Member offered but failed to provide a refund.

College Counsel urged the panel to review its notes and focus solely on the evidence presented.

ILC Advice

In providing her advice to the panel, ILC reminded the panel that the burden of proof rested solely with the College and that that proof was on a balance of probabilities. The panel needed to make a finding based only on the evidence before it. In this case, the universe of evidence consisted of the exhibits entered and the testimony of the two witnesses. Closing statements were not evidence, but rather submissions on how to interpret the evidence presented during the hearing.

There were two Notices of Hearing entered at the beginning of this hearing, and even though there was agreement to hear the matters together, the job of the panel was to go back to each Notice of Hearing and make findings based on the allegations contained therein. As to any allegation that had been withdrawn, the panel was to completely ignore it.

As to the expert witness, ILC reminded the panel that it had qualified FO as an expert and it had to decide the weight to give the testimony FO had provided.

Decision

Having considered the evidence and the onus and standard of proof, the panel finds that the Member committed acts of professional misconduct as alleged in paragraph 8 of *Exhibit #1* and and in paragraphs 8 a) b) c) d) and f) of *Exhibit #2*.

The panel made no findings with respect to the allegations listed at paragraphs 8e) and 9 of *Exhibit #2*.

Reasons for Decision

During its deliberation, the panel reviewed the evidence contained in the entered exhibits and the testimony of the two witnesses. In the matter of IL, the panel gave serious weight to the two invoices contained in *Exhibit #3.* Both invoices list IL's service provider as Dr. Irodenko DD. This confirmed for the panel that the Member had misused a protected title.

As to the opinions expressed by the expert witness FO, the panel appreciated that although concerns were expressed as to the conduct of the Member, there was also recognition that in some aspects the Member had gone above and beyond in the service he had provided to IL. The majority of the panel did not agree with the concern raised by FO with respect to the Member having sent IL home with dentures that may have had some "fit and function" problems. As a result, the panel gave little weight to this aspect of FO's testimony.

In the matter of misuse of title, the panel found the standard of proof had been met and concluded that the Member had committed an act of professional misconduct.

In the matter of VC, the panel found the evidence of FO to be helpful. The panel agreed with FO that the Member was not obligated to offer a twelve month post insertion care guarantee when the standard of the profession was only three months. Further, the Member deserved to be fairly compensated for the services he provided and was not obligated to offer a refund. However, the panel also concluded that once an offer is made it must be honoured. In both instances, the panel was convinced that the agreement made between the Member and VC had not been fulfilled by the Member.

VC's testimony was clear, cogent and convincing. She did not appear to be angry with the Member, but did convincingly express her disappointment that he was not there for her when she needed him. In fact, when questioned by the Member, VC simply stated that she just wanted to "go back, but you weren't there".

The panel acknowledged that no evidence had been presented that the impact of the clinic closure and relocation had been properly addressed with VC. There was no evidence in VC's record (*Exhibit# 4*) or in the testimony that she gave to the panel that she had been informed of the Member's relocation, that her files had been referred or that arrangements had been made to uphold the twelve-month post insertion care guarantee. Further, it was clear that the Member knew he could not honour a guarantee of one year's service (which should extend to May 2014) when he knew he was relocating and in fact, had become certified in Alberta on or about August of 2013.

Based on the evidence presented and the clear, cogent and convincing testimony of the two witnesses, the panel finds that the Member breached the standards of the profession, discontinued services without reason and failed to maintain a service agreement. Further, the panel concluded that the Member's conduct would reasonably be regarded by members of the profession as dishonourable, unethical or unprofessional.

Penalty

College Counsel's Penalty Submissions

College Counsel argued for the following sanctions in each matter.
In the matter of IL, the College sought a reprimand and a suspension of the Member's certificate for a period of one month, if or when the Member seeks reinstatement in Ontario.

In the matter of VC, College Counsel sought a reprimand, a suspension of the Member's certificate for one month if or when he seeks reinstatement in Ontario and terms, conditions and limitations on the Member's certificate, in the form of a course in ethics. Within thirty days of reinstatement, the Member must provide to the Registrar proof that he has registered in a pre-approved course in ethics and within six months of reinstatement, the Member is to have successfully completed the course in ethics, at his own expense. The Member is further required to provide a summary of the course to the Registrar within thirty days of completing same.

In her submissions, College Counsel addressed the four principles of sanction or penalty. General deterrence speaks to the profession and informs them that similar conduct can result in similar sanctions. Specific deterrence speaks to the individual Member and communicates to him that what he did was serious and should not happen again. Public protection ensures that the public at large can have confidence in the profession, the College and the panel's decision. It assures the public that misconduct by any member of the College is taken seriously. And lastly, remediation provides the Member with an element of education and the ability to learn from this experience.

In this matter , the reprimand addresses the principle of specific deterrence. Further, the fact of the reprimand is in the public domain, and it thereby also addresses the principle of general deterrence. The suspension sought speaks to specific and general deterrence as well as protecting the public and ensuring their confidence in the profession and the College. The terms, conditions and limitations (in the form of the course on ethics) addresses not only the principle of remediation but also ensures public confidence in this process and will ensure that should the Member return to practice in Ontario, he will do so having the benefit of remediation.

College Counsel also asked the panel to consider the mitigating and aggravating factors in this case. The conduct described was an aggravating factor. The Member made improper use of a protected title, failed to honour an agreement and his conduct breached the standards of the profession.

As to the mitigating factors, the Member consented to having both matters heard simultaneously which cut down on the overall costs. The Member allowed the College's expert witness to testify and agreed to certain facts at the outset, although a few of those facts were rescinded later on in the proceedings.

Specifically, in the matter of IL, the Member made improper use of a protected title. By doing so, he confused the public, reflecting poorly on his profession and indicating a lack of awareness of the statutory landscape.

In the matter of VC, the conduct of the Member was serious, unethical and unprofessional. The Member failed to honour an agreement made with VC and failed to make appropriate arrangements to transfer her care after leaving the province and setting up a practice in Alberta.

College Counsel clarified that the sanctions being sought were being sought separately. Specifically, the suspensions were to be served consecutively and not concurrently. Therefore the total time for the suspensions was two months.

Member's Penalty Submission

The Member told the panel that there was really no argument to consider. He no longer resided in this province and had taken the time to fly hear to participate in this hearing. The Member stated that having an active practice was important to him. He did not believe that his conduct had been unethical. He concluded by stating that a two month suspension would be costly for him.

ILC advised the panel that its job was to send an appropriate message to the Member, the profession and the public. In response to a specific question posed by the panel, ILC advised that while the panel's findings may or may not not have an impact on the Member's registration in Alberta, this should not influence the panel's response in this matter. In its deliberations, the panel was to consider the principles of sanction, as well as the mitigating and aggravating factors.

Penalty Decision

The panel makes the following order as to penalty and costs:

1. Mr. Irodenko is required to appear before a panel of the Discipline Committee to be reprimanded on or before January 7, 2016.
2. If and when Mr. Irodenko becomes a member of the College, the Registrar is directed to suspend Mr. Irodenko's certificate of registration for a period of one month, to commence on a date to be set by the Registrar.
3. If and when Mr. Irodenko becomes a member of the College, the Registrar is directed to impose the following terms, conditions or limitations on Mr. Irodenko's certificate of registration:

    a. Mr. Irodenko must submit proof of registration in a course of ethics, approved by the Registrar, within thirty (30) days of becoming a member of the College, to the Registrar;
    b. Within six (6) months after the date of becoming a member of the College, Mr. Irodenko must, at his own expense, successfully complete to the Registrar's satisfaction, a course in ethics, as approved by the Registrar; and
    c. Within thirty (30) days of completing the course, Mr. Irodenko must provide proof acceptable to the Registrar that he has completed the course in ethics and submit a summary of the learning outcomes of the ethics course.
4. Mr. Irodenko is required to pay to the College costs in the amount of $5,000.00, payable in full no later than April 7, 2016.

Reasons for Penalty Decision

The panel is satisfied that the penalty is fair, considered and serves to promote public confidence in the profession.

The reprimand is a specific deterrent and provides an opportunity for the panel on behalf of the profession and the public, to express its concern and disappointment to the Member for his misconduct. The Member's misconduct not only reflects poorly on himself, but on the profession as a whole. The fact of the reprimand will appear on the public register thereby also serving as a general deterrent to the profession at large.

The one month suspension, to take effect if and when the Member applies to be reinstated in Ontario serves as a specific deterrent, a general deterrent and ensures ongoing public confidence in the profession and this proceeding. College Counsel had sought a total suspension of two months, one month for each matter. The panel however decided that a one month suspension (in total) was reasonable and appropriate. The panel felt that a one month suspension was not insignificant. A suspension of that length, with the attendant financial hardship, as a result of not being able to work in one's chosen profession, will serve to remind the Member that his conduct was unprofessional (as well as dishonourable and unethical in the VC matter). The suspension also informs the profession as well as the public that conduct of this nature will be not be tolerated by the College and will be dealt with seriously.

The terms, conditions and limitations placed on the Member's certificate (in the form of a course in ethics) addresses the principle of remediation. The coursework will allow the Member to reflect on the conduct that brought him to this point and provide guidance and education as he continues to advance his practice. The coursework will also provide assurance to the public that the necessary remedial steps have been put into place to address the issues of deterrence and education. This remedial step ensures the public that its confidence in the profession is well placed.

The panel is satisfied that the penalty is fair, considered and appropriate. It speaks to all four principles of sanction and ensures the public's trust in the profession, the College and the College's disciplinary process.

I, Hanno Weinberger, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

_____ _____

Chairperson, Hanno Weinberger Date

Anita Kiriakou
Keith Collins
Eugene Cohen
Bruce Selinger