21-0809

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. Eduardo Antonio Segura**, of the City of Peterborough, 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 May 24, 2023, 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 **Dr. Eduardo Antonio Segura** (the Registrant), 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 offence and not more than $200,000 for a second or subsequent offence.

Judy Welikovitch, Chair
Discipline Panel

May 24, 2023
Date

21-0809

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. EDUARDO ANTONIO SEGURA,** of the City of Peterborough, 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,* R.S.O. 1990, c. S.22, as amended ("*Statutory Powers Procedure Act*")

Members in Attendance: Ms. Judy Welikovitch
Dr. Noha Gomaa
Mr. Brian Smith

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Andrea Gonsalves
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Emily Lawrence
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. EDUARDO SEGURA	)	David McFadden
	)	For Dr. Eduardo Segura

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 May 24, 2023. This matter was heard electronically.

At the outset of the hearing, the College sought an order that no person shall publish or otherwise disclose the name of the patient whose treatment is the subject of this hearing as referred to in any exhibits filed at the hearing or in submissions before the panel. The Registrant consented to the request. The Panel granted the order.

THE ALLEGATIONS

The allegations against Dr. Segura (the "Member" or the "Registrant") are set out in the Notice of Hearing, as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2017, 2018 and/or 2019 you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely T.M, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - With respect to the teeth extractions, implant treatment, prosthetics and subsequent care provided for this patient:

     - Your case selection was inadequate. You failed to recognize that T.M. was not an appropriate candidate for implant treatment, including because she had generalized chronic moderate to severe periodontitis, type 2 diabetes and was a smoker.

     - Your pre-treatment work-up lacked the necessary diagnostic records.

- You failed to adequately assess the patient's dentition and bone levels prior to implant treatment.

- You failed to formulate an appropriate treatment plan that took into consideration the patient's periodontal and systemic medical conditions. The pre-operative CBCT scan indicated insufficient bone levels, but it did not appear that you considered a sinus lift.

- You placed immediate implant supported prostheses instead of allowing the patient's tissue the necessary healing time.

- You improperly placed two implants in the patient's sinus and one in the nasal cavity.

- You saw the patient at over 60 appointments and made several attempts to have dentures fabricated for the patient. You had numerous opportunities to refer her to a specialist or consider other treatment options, but you failed to do so, despite being unsuccessful in completing her case.

- You allowed the patient to direct the treatment.

- You failed to recognize the limits of your own abilities.

- In making decisions, you placed too much reliance on the lab director.

- You prescribed opioid medication to T.M. on June 7, 2017 without justification in that you did not document an appropriate diagnosis or assessment of the patient's pain, that you tried a non-opioid medication first or the instructions for use of the medication prescribed.

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 2017 you failed to keep records as required by the regulations, relative to one of your patients, namely T.M., contrary to paragraph

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

Particulars:

- You failed to obtain adequate diagnostic records prior to your treatment of T.M. for implant treatment performed on or about June 5, 2017. You failed to adequately assess and record the patient's dentition and bone levels.

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, 2018 and/or 2019, you treated or attempted to treat a disease, disorder or dysfunction of the oral-facial complex that you knew or ought to have known was beyond your expertise or competence relative to one of your patients, namely T.M., contrary to paragraph 5 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - Your case selection was inadequate. You failed to recognize that T.M. was not an appropriate candidate for implant treatment, including because she had generalized chronic moderate to severe periodontitis, type 2 diabetes and was a smoker in your case selection.
   - You improperly placed two implants in the patient's sinus and one in the nasal cavity.
   - You failed to recognize the limits of your own abilities.
   - You saw the patient at over 60 appointments and made several attempts to have dentures fabricated for the patient. You had numerous opportunities to refer her to a specialist or consider other treatment options, but you failed to do so, despite being unsuccessful in completing her case.

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, in or around the years during the year(s) 2015, 2016, 2017 and/or 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, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- With respect to the teeth extractions, implant treatment, prosthetics and subsequent care provided for this patient:
    - You allowed the patient to direct the treatment.
    - You saw the patient at over 60 appointments and made several attempts to have dentures fabricated for the patient. You had numerous opportunities to refer her to a specialist or consider other treatment options but you failed to do so, despite being unsuccessful in completing her case.
    - You failed to recognize the limits of your own abilities.
    - You provided misleading communication to T.M. when you advised her by email on July 6, 2019 that the implants were either into or pushing up on the sinus floor, when it was clear that implants 15 and 25 extended beyond the floor of the maxillary sinus as shown in the CBCT scans dated March 28, 2018.
    - In making decisions, you placed too much reliance on the lab director.
    - You made unprofessional remarks about specialists in your correspondence to the patient.
    - You did not maintain proper professional boundaries including that you shared information with the patient about your own health and emotions in relation to her case.

THE REGISTRANT'S PLEA

The Registrant admitted the allegations of professional misconduct contained in the Notice of Hearing. The Registrant signed a written plea inquiry, which was entered into evidence at the hearing as Exhibit 2. The Panel also conducted an oral plea inquiry at the hearing and was satisfied that the Registrant'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 3). The Agreed Statement of Facts provides as follows:

Background

1. Dr. Eduardo Segura ("Dr. Segura") has been registered with the Royal College of Dental Surgeons of Ontario (the "College") as a general dentist since 2004.

2. At all material times, Dr. Segura practised as a general dentist at the Kawartha Dental Clinic in Peterborough, Ontario (the "Clinic").

Notice of Hearing

3. The allegations of professional misconduct against Dr. Segura are set out in the Notice of Hearing dated September 29, 2021. The allegations arose following a complaint by T.M., a patient (the "Patient"), and a resulting investigation under s. 75(1)(c) of the Code.

4. In the course of the 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 first surgery on the Patient on June 5, 2017, including Dr. Annabel Braganza and Dr. Ali Khadivi.

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. Segura's treatment of the Patient from 2017 to 2019.

Pre-Treatment Misconduct

7. The Patient first saw Dr. Segura on May 9, 2017, for a consultation. During the consultation, the Patient reported that she had Type II diabetes and hypertension, although she claimed that both were well-controlled, and that she was a smoker. Dr. Segura determined at the initial consultation that the Patient had generalized chronic moderate to severe periodontitis and poor to hopeless prognosis with respect to her periodontal condition as a result of bone loss.

8. Dr. Segura did not independently confirm the Patient's claim that her diabetes and hypertension were well-controlled by obtaining an HbA1c from her family doctor, taking her blood pressure during in-office visits, and/or receiving written confirmation from her family doctor that her diabetes and hypertension were stable. The medical records indicate that the Patient was taking metformin, insulin, valsartan and amlodipine indicating that her diabetes and hypertension were not well-controlled.

9. During the initial consultation, Dr. Segura and the Patient discussed a few treatment options. One of the treatment options that Dr. Segura discussed with the Patient was implant-supported overdentures. Dr. Segura acknowledges that this Patient was not an ideal candidate for this treatment given that she had generalized chronic moderate to severe periodontitis, Type II diabetes and was a smoker, and that he should have obtained more information in order to determine if she was an appropriate candidate, which he did not do.

10. The Patient decided that she wanted implant-supported overdentures, which involved extracting the Patient's remaining 22 teeth and placing eight implants (four per arch) to hold implant-supported overdentures.

11. Dr. Segura saw the Patient for a pre-operative appointment on May 18, 2017. He ordered a CBCT scan on May 18, 2017, and it was completed

in-house on May 18, 2017. He charted on May 18, 2017, that the Patient was sent for the scan and he “reviewed it”. The CBCT Report was dated July 6, 2017, one month after he completed the surgery. If he were to testify, he would state that he had access to the CBCT imaging prior to the surgery and relied on it to plan the surgery.

12. Prior to the surgery, on May 10, 2017, Dr. Segura requested radiographs from the Patient’s previous dental provider, which are undated. He did not take a fresh panoramic radiograph prior to surgery.

13. The CBCT imaging and CBCT Report indicated insufficient bone height to place 12mm implants. As noted below, he placed 12mm implants on June 5, 2017.

14. Dr. Segura did not document any substantive review or consideration of the CBCT scan or radiographs before proceeding with the surgery on June 5, 2017, nor any information about the length of implants he selected nor an assessment of vertical dimension of occlusion.

15. Dr. Segura now acknowledges that his documentation does not reveal that he adequately assessed the Patient’s dentition, bone height for implant length selection, or vertical dimension of occlusion. He acknowledges that reviewing the CBCT Report and/or obtaining a fresh panoramic radiograph may have provided him with more detailed information for surgery planning purposes, including the bone height, width and density, as well as the position for the proposed implant relevant to any anatomical structures. Dr. Segura now acknowledges that he failed to obtain and review relevant diagnostic records.

16. As a result of his failure to consider the Patient’s dentition, bone height for implant length selection, or vertical dimension of occlusion, Dr. Segura did not consider a sinus lift before the surgery or other options to ensure that the Patient had sufficient bone height and density for implants, and sufficient vertical dimension of occlusion for overdentures. He acknowledges that he should have considered it, as it would have avoided or reduced the likelihood for the subsequent surgeries he later completed.

The First Surgery and Medication Prescriptions

17. On June 5, 2017, Dr. Segura removed the Patient's teeth and placed four 12mm implants at sites 12, 15, 21, and 25. Dr. Segura acknowledges that for this Patient, with her medical presentation, he should have placed bone grafts and allowed them heal for 3-6 months before placing the implants to see whether the bone, as grafted, was adequate in dimension and density to support the implants.

18. Dr. Segura prescribed Ibuprofen on May 18, 2017, to be taken before the surgery. On the day of the surgery, rather than prescribing an NSAID, Dr. Segura prescribed Tylenol 3 for pain. Dr. Segura also prescribed Tylenol 3 despite having prescribed Ibuprofen 800 on May 18, 2017.

19. Two days later, on June 7, 2017, the Patient was seen for post-surgical reassessment and Dr. Segura prescribed Dilaudid (hydromorphone).

20. Dr. Segura did not document or record in his clinical notes that he prescribed opioids to the Patient on June 5, 2017 or June 7, 2017, nor did he document or record on either day that he had conducted an appropriate diagnosis or assessment of the Patient's pain, that he tried a non-opioid mediation first or that he provided the Patient with the instructions for use of the medication prescribed.

The First Three Sets of Dentures

21. Dr. Segura gave the Patient a set of temporary dentures following her surgery on June 5, 2017. The Patient returned to Dr. Segura's office complaining that she was unable to wear the temporary dentures due to soreness. Dr. Segura attempted to make adjustments, but the Patient continued to return to the office with complaints regarding her dentures. As a result, in July 2017, Dr. Segura made the Patient a new set of temporary dentures.

22. Dr. Segura provided the implant-supported overdentures he had fabricated to the Patient on or around November 23, 2017. After receiving the implant-supported overdentures, the Patient continued to return to Dr. Segura's office complaining of soreness and discomfort. At these

appointments, Dr. Segura made adjustments.

The Patient Seeks a Second Opinion

23. In January 2018, the Patient saw Dr. Braganza, a periodontist, for a periodontal evaluation of the maxillary and mandibular implants. Dr. Braganza referred the Patient to Dr. Khadivi, a prosthodontist, to determine which implants could be used to secure her dentures.

24. A second CBCT scan was ordered by a dentist at LightHouse Dental on January 11, 2018. The CBCT imaging revealed that bone loss on the buccal was present on the some of the implants; implant 15 extended through the right maxillary sinus and implant 25 extended through the left maxillary sinus; the buccal half of implant 12 was not embedded in bone; and implant 21 had buccal exposure and extended through the nasal floor.

25. Dr. Khadivi recommended that he remove the anterior two implants followed by an alveoplasty, placement of a provisional CD, and to remove posterior implants followed by an alveoplasty. Dr. Khadivi also recommended that once the implants were fully integrated, he would begin the process of fabricating new implant-supported complete dentures.

26. After Dr. Khadivi advised the Patient of the cost of his services and the length of time it would take to treat her, the Patient contacted Dr. Segura to discuss her treatment options. Dr. Segura told the Patient that he disagreed that getting treatment from an oral surgeon was the best option, or necessary. Dr. Segura offered to treat the Patient at the Clinic at his cost by removing the implants and placing new ones as well as fabricating new prostheses.

The Second Surgery and Fourth Set of Dentures

27. On February 20, 2018, Dr. Segura removed implants 12 and 21, and replaced those implants with implants 13 and 23. Dr. Segura did not remove and replace implants 15 and 25, although he noted in his progress note that they may need to be removed in the future.

28. A week later, Dr. Segura began making another set of prostheses. A newly fabricated mandibular fixed hybrid prosthesis, as well as a maxillary overdenture were delivered to the Patient on April 11, 2018.

29. The maxillary overdenture was only loaded on the two posterior implants (implants 15 and 25) rather than four implants. In addition, because implants 15 and 25 extended through the Patient's sinuses, they were not fully osseointegrated (as they were in the sinus).

30. From April 2018 to June 2018, the Patient returned to Dr. Segura's office complaining about her implant-supported overdentures. Dr. Segura continued to make adjustments.

Fifth Set of Dentures

31. Dr. Segura made the Patient a new set of maxillary overdentures, which were delivered on September 14, 2018. Dr. Segura then decided to remake the Patient's lower mandibular overdentures, which she received on October 15, 2018. However, from October 2018 to March 2019, the Patient returned to Dr. Segura with complaints regarding her overdentures and, in response, further adjustments were made.

32. In March 2019, the Patient returned to Dr. Segura complaining of generalized pain, burning gums and discomfort. In response, in and around May 2019, Dr. Segura started making new prostheses. However, in and around June 2019, Dr. Segura advised the Patient that although new maxillary overdentures could be made, there was not enough vertical space to make new lower mandibular overdentures. As a result, Dr. Segura offered to perform a third surgery to remove the bottom four implants, reduce the bottom bone height by 6-7 mm to make more vertical space and place four new implants. He also offered to complete a sinus lift and to remove and replace the back implants.

33. Dr. Segura and the Patient exchanged an email on July 6, 2019 in which Dr. Segura advised the Patient that implants were either into or pushing up on the sinus floor when, in fact, implants 15 and 25 extended beyond the floor of the maxillary sinus. If he were to testify, he would state that he orally advised her that the implants had perforated the sinus.

34. Dr. Segura did not insist on referring out and transferring care of the Patient to a specialist for the implant treatment at any point in the two years he provided treatment, nor did he cease providing care when it was clear that he was unsuccessful in completing her case.

Unprofessional Communications with the Patient

35. Over the course of Dr. Segura's treatment of the Patient, Dr. Segura made unprofessional remarks about specialists. He suggested that a Toronto-based specialist would be expensive, and the treatment plan suggested sounded "excessive" and stated that specialists "don't do much different things than we generalists do. I have extracted 10's of thousands of teeth-but I am not an oral surgeon - one doesn't need to be a specialist to treat patients-that is a patient's option- an expensive one."

36. Over the course of Dr. Segura's treatment of the Patient, Dr. Segura also shared information with the Patient about his own health and emotions in relation to her case, including that her case was causing him a great deal of stress, that he had lost thousands of dollars in time trying to assist her, and that he was unable to sleep.

37. Finally, over the course of treatment, rather than provide the Patient with the most appropriate clinical course of action and direct the treatment plan, Dr. Segura allowed the Patient to direct the treatment. For example, Dr. Segura allowed the Patient to proceed with implant-supported overdentures when the treatment was not appropriate in her case; Dr. Segura created new dentures because the Patient did not like her dentures; Dr. Segura made adjustments to the Patient's dentures based on the Patient's requests without clinical justification in certain cases; and Dr. Segura prescribed medications requested by the Patient.

Admissions of Professional Misconduct

38. Dr. Segura admits that he engaged in all of the conduct set out in the Notice of Hearing and that this conduct constitutes professional misconduct.

Inadequate case selection

39. Dr. Segura admits that his case selection was inadequate and that he should not have proceeded to treat the Patient on the information he had in May 2017. Dr. Segura admits that he recommended implant treatment, even though the Patient was not an ideal candidate for implant treatment given her generalized chronic moderate to severe periodontitis, her type 2 diabetes, and her smoking. He further admits that he did not obtain her HbA1c, take her blood pressure, or obtain a medical clearance letter, which would have provided him with more information on which to determine if she was an appropriate candidate for implant treatment.

40. Dr. Segura admits that this conduct was a breach of standards of practice contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing and treatment beyond his expertise or competence, contrary to paragraph 5 of section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

Pre-treatment work up lacked the necessary diagnostic records, and adequate assessment of the Patient's condition prior to implant treatment

41. Dr. Segura admits that the pre-treatment work-up lacked the necessary diagnostic records, in that he did not obtain up-to-date panoramic radiographs prior to consultation on May 9, 2017, and he did not obtain the CBCT Report prior to conducting the surgery on June 5, 2017. Dr. Segura admits that he did not document any review of the CBCT scan or any planning arising of the review, including the bone height, width and density, the position for the proposed implant relevant to any anatomical structures, and the Patient's vertical dimension of occlusion. He admits this was a failure to obtain adequate diagnostic records prior to treatment.

42. Pre-surgery, Dr. Segura admits that he failed to identify the appropriate implant length and placement position to ensure appropriate placement, osseointegration, and adequate vertical dimension for occlusion once the overdentures were placed. His inadequate assessment of the Patient's

medical and anatomical structures caused him to fail to formulate an appropriate treatment plan with appropriate implants placed in bone and overdentures appropriate for the Patient. He further admits that he did not consider a sinus lift prior to the surgery on June 5, 2017. He acknowledges that his inadequate planning resulted in the subsequent surgeries he later completed or recommended.

43. Dr. Segura admits that it would have been preferable to phase her treatment by extracting her teeth and grafting, providing her with regular dentures for a period then considering implant-supported prostheses. This phasing would have allowed for healing and to determine if she could tolerate dentures.

44. Dr. Segura admits that this conduct was a breach of standards of practice, contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing and a failure to keep records as required, contrary to paragraph 25 of section 2 of the Dentistry Regulation Act, as set out in Allegation 2 of the Notice of Hearing.

Failure to Appropriately Document Justification for Prescription of Opioid Medication without justification

45. Dr. Segura admits that he failed to document an appropriate diagnosis or assessment of the Patient's pain or the instructions for use of the medication prescribed before he prescribed opioid medication on June 5, 2017 and June 7, 2017. He further admits that he did not try a non-opioid medication first.

46. Dr. Segura admits that this conduct was a breach of standard of practice, contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

Improper placement of two implants in the Patient's sinus and one in the nasal cavity

47. Dr. Segura acknowledges that he improperly placed implants 15 and 25 in the Patient's sinus, and implant 21 in the Patient's nasal cavity.

48. Dr. Segura admits that this conduct was a breach of standard of practice, contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing, and was treatment beyond his expertise or competence, contrary to paragraph 5 of section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

Immediate placement of implant supported prosthesis

49. Dr. Segura admits that in the second surgery, he loaded overdentures onto the two posterior implants (implants 15 and 25) that were not fully osseointegrated (as they were in the sinus) rather than four implants and did not load on implants 13 and 23 which had just been placed.

50. Dr. Segura admits that this conduct was a breach of standard of practice, contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

Failure to refer the Patient to a specialist or consider other treatment options

51. Dr. Segura admits that he saw the Patient at over 60 appointments and made several attempts to have dentures fabricated for her. He also admits that, although he was unsuccessful in completing her case and had numerous opportunities to properly refer her to a specialist in lieu of his completing the treatment, he failed to do so.

52. Dr. Segura admits that this conduct was a breach of standard of practice contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing, was treatment beyond his expertise or competence, contrary to paragraph 5 of section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing, and was 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 4 of the Notice of Hearing.

Dr. Segura did not direct the treatment

53. Dr. Segura admits that he allowed the Patient to direct treatment at times, rather than providing the most appropriate clinical course of action.

54. He also admits that he placed too much reliance on the lab director for the design of the implant-supported dentures and treatment plan, rather than directing the lab regarding the design of the dentures and treatment plan.

55. Dr. Segura admits this conduct was a breach of standard of practice contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing, and was 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 4 of the Notice of Hearing.

Failed to recognize the limits of his abilities

56. Dr. Segura admits that he failed to recognize the limits of his abilities by proceeding with implant treatment as follows:

    a. Dr. Segura failed to recognize that the Patient was not an appropriate candidate for implant treatment, or at a minimum that he did not have sufficient information to make that assessment when he recommended a treatment plan;

    b. Dr. Segura failed to formulate an appropriate treatment plan that took into consideration the Patient's periodontal and systemic medical conditions;

    c. Dr. Segura failed to conduct an appropriate diagnostic work-up and adequately assess the Patient prior to the implant treatment;

    d. Dr. Segura failed to ensure that the bone was adequate before immediately placing an implant-supported prosthesis;

e. Dr. Segura failed to fabricate appropriate implant-supported dentures and relied on the lab manager to design the dentures; and

f. Dr. Segura failed to recognize that he should have ceased treating the Patient and/or referred the Patient to a specialist, despite being unsuccessful in completing care of the Patient.

57. Dr. Segura admits that this conduct was a breach of standard of practice contrary to paragraph 1 of section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing, was treatment beyond his expertise or competence, contrary to paragraph 5 of section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing, and was 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 4 of the Notice of Hearing.

Misleading and Unprofessional Communication to the Patient

58. Dr. Segura admits that he sent a misleading communication to the Patient when he advised her by email on July 6, 2019 that the implants were either into or pushing up on the sinus floor, when it was clear that implants 15 and 25 extended beyond the floor of the maxillary sinus as shown in the CBCT scans dated January 11, 2018.

59. Dr. Segura also admits that he made unprofessional remarks about specialists in his correspondence with the Patient.

60. Dr. Segura also admits that he did not maintain proper professional boundaries when he shared information with the Patient about his own health and emotions in relation to her case.

61. In respect of all of the above communication, Dr. Segura 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 4 of the Notice of Hearing.

General

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

63. Dr. Segura's agreement and his plea to allegations 1, 2, 3 and 4 in the Notice of Hearing are voluntary, informed and unequivocal.

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

DECISION

Having considered the evidence and the submissions of the parties, the Panel found that the Registrant committed professional misconduct as set out in the Notice of Hearing, allegations one through four.

REASONS FOR DECISION

The Registrant pled guilty to the allegations as set out in the Notice of Hearing. He did not dispute the facts as presented in the Agreed Statement of Facts. The Panel found that the College discharged its burden in that it established, through the agreed facts and by the Registrant's own admissions, that he:

a. Failed to maintain the standards of practice of the profession relative to patient TM, as described above;

b. Failed to obtain adequate diagnostic records prior to his treatment of patient TM;

c. Failed to adequately assess and record patient TM's dentition and bone levels;

d. Treated patient TM for a disease, disorder or dysfunction of the oral-facial complex that was beyond his expertise and competence;

e. Failed to document an appropriate diagnosis or assessment of Patient TM's pain or the instructions for use of the medication prescribed before he prescribed opioid

medication on June 5 and June 7, 2017 and that he did not try a non-opioid medication first; and

f. Engaged in conduct that, having regard to all of the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional and/or unethical.

The Panel was satisfied that the evidence tendered by the parties established, on a balance of probabilities that Dr. Segura's conduct was in breach of:

a. The RCDSO Practice Advisory on maintaining a professional patient-dentist relationship;

b. The RCDSO Guideline on the Educational Requirements and Professional Responsibilities for Implant Dentistry; and

c. The RCDSO Guideline on The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice.

The Panel found, on a balance of probabilities that the professional misconduct in which Dr. Segura engaged caused harm to his patient, who endured two years of undue pain and discomfort.

In these very serious circumstances, the Panel found that the overall course of Dr. Segura's 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 with respect to Penalty and Costs (Exhibit 7). Following discussion during the hearing, the parties filed an addendum to the Joint Submission addressing the timeframes for certain terms. Reflecting the addendum, the Joint Submission asked the Panel to make an order on the following terms:

1. Requiring the Member to appear before the Panel of the Discipline Committee to be reprimanded within fifteen (15) days of the date [the] Order becomes final.

2. Directing the Registrar to suspend the Member's certificate of registration for a period of eight (8) months. The suspension shall commence on the date of this Order becoming final, 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. At his own expense, the Member will be subject to Practice Mentoring for a period of six (6) months, as follows:

i. the Member may not practice unless and until the Practice Mentor has been approved by the College.

ii. the Member will meet with a Practice Mentor approved by the College on the topics of case selection (with proper case work-up), formulating an appropriate treatment plan, and knowing when to refer to a specialist or transfer carriage to another practitioner.

iii. For the first 3 months of the Practice Mentoring,

1. the Member must obtain prior approval from the Practice Mentor for all treatment plans (except to oversee or provide dental hygiene, basic direct restorative treatment or placement of crowns or posts) involving oral surgery and/or involving the placement of implants and any prosthetics. Prior approval will not be required for emergency extractions.

2. Unless requested by the Practice Mentor, the Member is not required to meet in person or online with the Practice Mentor to obtain prior approval for all treatment plans detailed above, but must provide the patient chart and other necessary information to the Practice Mentor to properly review the treatment plan and determine whether it is acceptable to proceed with that plan.

3. At the conclusion of three (3) months of Practice Mentoring and the delivery of at least three reports from the Practice Mentor required by clause 4(a)(vii), if the Practice Mentor reports to the College in writing that the Member is progressing well and recommends that prior approval from the Practice Mentor for treatment plans cease, and if approved by the College, this term, condition and limitation will be removed from the Member's certificate of registration. This report may be combined with the third report required by 4(a)(vii).

iv. The Member must meet with the Practice Mentor in person or online at the Member's Practice Location or another location approved by the Practice Mentor on at least five (5) occasions within six (6) months. The Member and the Practice Mentor will meet at least monthly for the first four (4) months of the Practice Mentoring, and once at the conclusion of six (6) months, or more frequently if required by the Practice Mentor.

v. Prior to each meeting, the Practice Mentor will select and the Member shall provide charts of patients specifically,

1. For each of the first three monthly meetings, 10 charts of patients treated for any treatment involving oral surgery and/or involving the placement of implants and any prosthetics in the prior 30 days, inclusive of the patient charts submitted by the Member for approval of treatment plans, or if fewer than 10 applicable patients have been seen, all available patient charts for

applicable patients seen since the last meeting with the Practice Mentor.

2. For the fourth monthly meeting, 10 charts of patients treated for any treatment involving oral surgery and/or involving the placement of implants and any prosthetics in the prior 30 days, or if fewer than 10 applicable patients have been seen, all available patient charts for applicable patients seen since the last meeting with the Practice Mentor.

3. For the fifth meeting, 20 charts of patients treated for any treatment involving oral surgery and/or involving the placement of implants and any prosthetics since the last meeting with the Practice Mentor or if fewer than 20 applicable patients have been seen, all available patient charts for applicable patients seen since the last meeting with the Practice Mentor.

vi. At each meeting, the Practice Mentor shall discuss with the Member any concerns arising from the chart reviews and make recommendations to the Member for practice improvements and ongoing professional development.

vii. The Practice Mentor will report to the College monthly within 15 days of each meeting, detailing the date of the meeting, summarizing their discussions and the Member's progress on the topics identified in clause 4(a)(ii), specifying whether the treatment plans required in clause 4(a)(iii)(1) were approved (if applicable), summarizing at least 10 patient charts reviewed, listing any practice or treatment recommendations made to the Member and whether he implemented such recommendations.

viii. After the conclusion of six (6) months of Practice Mentoring and the delivery of at least five reports from the Practice Mentor required by clause 4(a)(vii), if the Practice Mentor

reports to the College in writing that the Member is progressing well and recommends that the Practice Mentorship cease, and if approved by the College, this term, condition and limitation will be removed from Dr. Segura's certificate of registration. This report may be combined with the fifth report required by 4(a)(vii).

b. The Member will be subject to Practice Monitoring with a College approved Practice Monitor for a period of twenty-four (24) months commencing immediately after the completion of the Practice Mentoring, as follows:

   i. The Practice Monitoring will relate to the topics of oral surgery, case selection (proper case work-up), formulating an appropriate treatment plan, and knowing when to refer.

   ii. The Practice Monitor will conduct practice visits at least quarterly for first year and semi-annually in the second year, for a minimum of six (6) visits.

   iii. The Practice Monitor will review six (6) patient charts at each practice monitoring visit.

   iv. The Practice Monitor will submit a report to the College after each visit detailing the Member's progress, summarizing the six (6) patient charts reviewed, listing any practice or treatment recommendations made to the Member and whether he implemented such recommendations.

   v. At the conclusion of 24 months of Practice Monitoring, if the Practice Monitor reports to the College in writing that the Member is progressing well and recommends that the Practice Monitoring cease, and if approved by the College, this term, condition and limitation will be removed from Dr. Segura's certificate of registration.

   vi. The Member shall pay to the College in respect of the cost of Practice Monitoring, the amount of $1,000.00 per inspection

or chart review, such amount to be paid immediately after completion of each inspection or review.

c. Within six (6) months of the Member's return to practice following his suspension and approval of the Practice Mentor, the Member shall successfully complete the following College-approved courses:

   i. A one-on-one course on informed consent;

   ii. One-on-one instruction in ethics and professionalism with a College-approved instructor; and

   iii. A record keeping course.

d. The Practice Conditions imposed by virtue of clause (c) 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

e. the Practice Conditions imposed by virtue of clauses (a), (b) and (c) 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 (a), (b) and (c) above have been completed successfully.

5. The Member shall pay costs to the College in the amount of $10,000.00 within ninety (90) days of date of the Discipline Hearing, being August 22, 2023.

PENALTY DECISION

The Panel accepted the Joint Submission on Penalty and made the following order (the "Order"):

1. The Registrant shall appear before the Panel of the Discipline Committee to be reprimanded within fifteen (15) days of the date this Order becomes final.

2. The Registrar shall suspend the Registrant's certificate of registration for a period of eight (8) months. The suspension shall commence on the date of this Order becoming final, and shall run without interruption.

3. The Registrar shall impose the following terms, conditions and limitations on the Registrant's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Registrant's certificate of registration as referred to in paragraph 2 above has been fully served, namely:

    a. while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

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

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

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

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

        v. owners of a practice or office in which the Registrant 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 Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

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

        i. acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that administrative or office staff do not suggest to patients in any way that the Registrant 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 Registrant must not be present in offices or practices where the Registrant works when patients are present, except for emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

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

i. The Registrant 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 Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period.

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

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

e. the Registrant shall cooperate with any office monitoring which the Registrar feels is needed to ensure that the Registrant has complied with the Suspension Conditions. The Registrant must provide the College with access to any records associated with the practice that the College may require to verify that the Registrant 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 Registrant's certificate of registration is suspended.

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

a. At his own expense, the Registrant will be subject to Practice Mentoring for a period of six (6) months, as follows:

   i. the Registrant may not practice unless and until the Practice Mentor has been approved by the College.

   ii. the Registrant will meet with a Practice Mentor approved by the College on the topics of case selection (with proper case work-up), formulating an appropriate treatment plan, and knowing when to refer to a specialist or transfer carriage to another practitioner.

   iii. For the first 3 months of the Practice Mentoring,

      1. the Registrant must obtain prior approval from the Practice Mentor for all treatment plans (except to oversee or provide dental hygiene, basic direct restorative treatment or placement of crowns or posts) involving oral surgery and/or involving the placement of implants and any prosthetics. Prior approval will not be required for emergency extractions.

      2. Unless requested by the Practice Mentor, the Registrant is not required to meet in person or online with the Practice Mentor to obtain prior approval for all treatment plans detailed above, but must provide the patient chart and other necessary information to the Practice Mentor to properly review the treatment plan and determine whether it is acceptable to proceed with that plan.

      3. At the conclusion of three (3) months of Practice Mentoring and the delivery of at least three reports from the Practice Mentor required by clause 4(a)(vii), if the Practice Mentor reports to the College in writing that the Registrant is progressing well and recommends that prior approval from the Practice Mentor for treatment plans cease, and if approved by the College, this term, condition and limitation will be removed from the Registrant's certificate of registration. This report may be combined with the third report required by 4(a)(vii).

   iv. The Registrant must meet with the Practice Mentor in person or online at the Registrant's Practice Location or another location approved by the Practice

Mentor on at least five (5) occasions within six (6) months. The Registrant and the Practice Mentor will meet at least monthly for the first four (4) months of the Practice Mentoring, and once at the conclusion of six (6) months, or more frequently if required by the Practice Mentor.

v. Prior to each meeting, the Practice Mentor will select and the Registrant shall provide charts of patients specifically,

1. For each of the first three monthly meetings, 10 charts of patients treated for any treatment involving oral surgery and/or involving the placement of implants and any prosthetics in the prior 30 days, inclusive of the patient charts submitted by the Registrant for approval of treatment plans, or if fewer than 10 applicable patients have been seen, all available patient charts for applicable patients seen since the last meeting with the Practice Mentor.

2. For the fourth monthly meeting, 10 charts of patients treated for any treatment involving oral surgery and/or involving the placement of implants and any prosthetics in the prior 30 days, or if fewer than 10 applicable patients have been seen, all available patient charts for applicable patients seen since the last meeting with the Practice Mentor.

3. For the fifth meeting, 20 charts of patients treated for any treatment involving oral surgery and/or involving the placement of implants and any prosthetics since the last meeting with the Practice Mentor or if fewer than 20 applicable patients have been seen, all available patient charts for applicable patients seen since the last meeting with the Practice Mentor.

vi. At each meeting, the Practice Mentor shall discuss with the Registrant any concerns arising from the chart reviews and make recommendations to the Registrant for practice improvements and ongoing professional development.

vii. The Practice Mentor will report to the College monthly within 15 days of each meeting, detailing the date of the meeting, summarizing their discussions and the Registrant’s progress on the topics identified in clause 4(a)(ii), specifying whether the treatment plans required in clause 4(a)(iii)(1) were approved (if

applicable), summarizing at least 10 patient charts reviewed, listing any practice or treatment recommendations made to the Registrant and whether he implemented such recommendations.

viii. After the conclusion of six (6) months of Practice Mentoring and the delivery of at least five reports from the Practice Mentor required by clause 4(a)(vii), if the Practice Mentor reports to the College in writing that the Registrant is progressing well and recommends that the Practice Mentorship cease, and if approved by the College, this term, condition and limitation will be removed from Dr. Segura's certificate of registration. This report may be combined with the fifth report required by 4(a)(vii).

b. The Registrant will be subject to Practice Monitoring with a College approved Practice Monitor for a period of twenty-four (24) months commencing immediately after the completion of the Practice Mentoring, as follows:

i. The Practice Monitoring will relate to the topics of oral surgery, case selection (proper case work-up), formulating an appropriate treatment plan, and knowing when to refer.

ii. The Practice Monitor will conduct practice visits at least quarterly for first year and semi-annually in the second year, for a minimum of six (6) visits.

iii. The Practice Monitor will review six (6) patient charts at each practice monitoring visit.

iv. The Practice Monitor will submit a report to the College after each visit detailing the Registrant's progress, summarizing the six (6) patient charts reviewed, listing any practice or treatment recommendations made to the Registrant and whether he implemented such recommendations.

v. At the conclusion of 24 months of Practice Monitoring, if the Practice Monitor reports to the College in writing that the Registrant is progressing well and recommends that the Practice Monitoring cease, and if approved by the College, this term, condition and limitation will be removed from Dr. Segura's certificate of registration.

vi. The Registrant shall pay to the College in respect of the cost of Practice Monitoring, the amount of $1,000.00 per inspection or chart review, such amount to be paid immediately after completion of each inspection or review.

c. Within six (6) months of the Registrant's return to practice following his suspension and approval of the Practice Mentor, the Registrant shall successfully complete the following College-approved courses:

i. A one-on-one course on informed consent;

ii. One-on-one instruction in ethics and professionalism with a College-approved instructor; and

iii. A record keeping course.

d. The Practice Conditions imposed by virtue of clause (c) of paragraph 4 shall be removed from the Registrant certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses have been completed successfully; and

e. the Practice Conditions imposed by virtue of clauses (a), (b) and (c) of paragraph 4 shall be removed from the Registrant'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 (a), (b) and (c) above have been completed successfully.

5. The Registrant shall pay costs to the College in the amount of $10,000.00 within ninety (90) days of date of the Discipline Hearing, being August 22, 2023.

REASONS FOR PENALTY DECISION

It is settled law that a decision-maker should not lightly depart from an agreement with respect to penalty that has been reached by the parties upon the Registrant agreeing to enter a plea of guilty to the allegations against him. The test is not one of "fitness of sentence" but rather,

the more stringent test as to "whether the proposed sentence would bring the administration of justice into disrepute or would otherwise be contrary to the public interest".[1]

The Panel accepted the Joint Submissions on Penalty and Costs, with some reservation. The goal of a penalty is to protect the public from dentists who have engaged in misconduct and to maintain public confidence in the profession and its ability to self-regulate. A penalty must serve as a measure of both general deterrence – in that it sends a message to the College membership that this type of conduct will not and cannot be tolerated – and specific deterrence with respect to the dentist concerned, in this case, Dr. Segura. An appropriate penalty should also provide for remediation or rehabilitation of the dentist, where possible.

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

In reaching its conclusion that the Joint Submission is appropriate in this case, the Panel considered the Registrant's prior regulatory history with the College. Although he has not appeared before the Discipline Committee prior to this matter, the parties provided the Panel with information that he has had prior matters before the Inquiries, Complaints and Reports Committee ("ICRC"), as follows:

a. ICRC Decision, 2011[2]

Pursuant to a complaint that commenced on December 16, 2010, the ICRC panel expressed concerns about Dr. Segura's conduct with staff at work and at out-of-office social functions. They also expressed concerns about "inappropriate remarks of a sexual nature" that Dr. Segura made both at work and at out-of-office social functions.

In its Decision and Caution delivered March 31, 2011, the ICRC panel noted that Dr. Segura had voluntarily agreed to take and successfully complete a course in Professional Boundaries. Dr. Segura further agreed that, following his successful completion of that

[1] *R v Anthony Cook* 2016 SCC 43 per Mr Justice Michael Moldaver
[2] ICRC Decision 2011, RCDSO File No. G100002W, Penalty Brief pp. 8 - 16

course, the College would monitor his practice for a period of two years to ensure that he had applied to his practice the knowledge gained in the course.[3]

In addition, the panel issued a caution to Dr. Segura with respect to his conduct in this case. It stressed that "an oral caution is a serious outcome for members of the dental profession."[4] An oral caution typically arises in circumstances in which the panel is concerned about an aspect of the dentist's practice, and believes that the dentist would benefit from some advice and/or direction as to how to conduct himself in future.

b. ICRC Decision 2015[5]

Evidence obtained pursuant to a Registrar's investigation that had been authorized on August 9, 2015, led a panel of the ICRC, in its decision dated November 24, 2017, to make a number of serious findings regarding Dr. Segura's professional practice. The panel identified clinical issues requiring remediation or significant improvement and that require him to receive direction, in person, on how to conduct himself in future and that pose a moderate risk of directly affecting patient care or safety or the public interest.[6]

In the result, the panel directed that Dr. Segura complete, at his own expense, the following specified continuing education or remediation programs ("SCERP"), namely

(a) A course in oral surgery;

(b) A mentorship in oral surgery with an oral and maxillofacial surgeon;

(c) A course in endodontics;

(d) A course in prosthodontics;

(e) A one-on-one course in informed consent;

(f) The RCDSO's course in record-keeping, including informed consent;

[3] *Ibid* p. 12
[4] *Ibid* p. 12
[5] ICRC Decision 24 November 2017, RCDSO File No. G150061G, Penalty Brief pp 17 - 37
[6] Ibid p. 32

(g) That the monitoring of Dr. Segura's work should begin immediately upon completion of his courses in endodontics, prosthodontics, informed consent and record-keeping.[7]

In addition, the ICRC panel cautioned Dr. Segura that:

(a) He should take a conservative approach to dental treatment and inform patients in a detailed and forthright manner about the risks and benefits of all of their potential treatment options. In some cases, this process should include the option for a patient to be seen by a specialist;

(b) Further in this regard, he should allow sufficient time to perform the treatment carefully to prevent as many complications as possible and allow for sufficient time to make adequate records reflecting the treatment; and

(c) When a complication does occur, he must inform the patient of the complication and the patient's options going forward.

(d) He must always be mindful that the best option for a patient when a complication has occurred may be a referral to a specialist.[8]

As in the previous case in 2011, the panel stressed that a caution is "a serious outcome" for a member of the profession.[9]

Although this Panel was aware of a complaint made against Dr. Segura in August 2020, and for which a decision was rendered by the ICRC in 2022, it was not considered in the Panel's decision since the events in that case post-date the events that are the subject of the complaints in the instant case.

To date, and not including the aforementioned case, Dr. Segura has appeared before the ICRC on two occasions to be cautioned. As a result of the Panel's order in the present matter, he has now also received a reprimand from this Discipline Panel (see below). He has taken numerous courses to upgrade both his clinical skill and expertise, and his in-office conduct including informed consent and record-keeping.

---

[7] Ibid pp 32 - 33
[8] Ibid p 34
[9] Ibid

Given the seriousness of the findings in this case, and the repetitive nature of the clinical, the record-keeping and the informed consent issues, the Panel has accepted the joint submission that an eight-month suspension will be appropriate and effective to protect the public while Dr. Segura takes upgrading courses. The Panel has further accepted that the term requiring Dr. Segura to have a practice mentor for a minimum of six months, and continued practice monitoring for a period of twenty months, both to take effect immediately following his return to practice, will provide the necessary supports and guidance to ensure that Dr. Segura is practising dentistry at an acceptable level.

The Panel has further ordered that Dr. Segura again take the following remedial courses:

(a) A one-on-one course on informed consent;

(b) A course in record-keeping;

(c) One-on-one instruction in ethics and professionalism with a College-approved instructor.

The objective of this course of action is to bring Dr. Segura's practice – including his clinical skills, his professional judgement and communications, and his record-keeping – up to an acceptable level such that the interest of the public is protected.

THE REPRIMAND

On July 6, 2023 the panel delivered the reprimand to the Registrant. A copy of the reprimand is attached as Appendix "A" to these Reasons.

I, Judy Welikovitch, sign these Reasons for Decision as Chairperson of this Discipline Panel.

August 17, 2023

Judy Welikovitch
Dr. Noha Gomaa
Brian Smith

Date

APPENDIX "A"

RCDSO v. Dr. Eduardo Antonio Segura

Dr. Eduardo Segura, 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 relates to many aspects of your practice. We have found that in your conduct as a registered dentist, you have failed to maintain the standards of the profession, including but not limited to:

a) Deficiencies in your record-keeping;

b) failing to obtain adequate diagnostic records prior to treatment;

c) failing to obtain informed consent; and

d) failing to recognize the boundaries of your competence and expertise and conducting yourself accordingly.

In these very serious circumstances, we have found that the overall course of your conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical.

Your professional misconduct is a matter of profound concern to the panel. 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:

a) the professional misconduct in which you engaged has caused harm to a patient, who endured two years of undue pain and discomfort;

b) you have persistently failed to recognize your own professional limitations; and

c) you have been required in the past to take courses to enhance your professional practice - including courses on record-keeping and a one-on-one course on informed consent - and yet the same issues persist in your practice.

We have ordered a penalty that includes extensive educational requirements, mentoring, and practice monitoring. It also includes an eight (8) month suspension, which is significant. We are satisfied that the penalty we have ordered is fair and in the public interest. We encourage, you, however, to use the suspension period to reflect on the issues in your practice that have led to our finding of professional misconduct, notwithstanding your more recent efforts at rehabilitation and remediation, including engaging in educational upgrading.

All that being said, the Panel wants to impress upon you its profound concern that your professional practice has not met that standards required of the profession, and has caused harm to your patient.

We also wish to caution you that while the penalty we have imposed on you is fair, you may expect a harsher penalty if you find yourself before the Discipline Committee again in the future.