H160006

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. STEVEN JOSEPH MASCARIN**, of the City of Cobourg in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation").

Members in Attendance: Susan Davis, Chair
Dr. Sandy Venditti
Dr. David Mock
Manohar Kanagamany
Dr. Kate Towarnicki

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Andrea Gonsalves
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Ms. Emily Lawrence
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. STEVEN JOSEPH MASCARIN	)	Mr. Paul Martin
	)	For Dr. Steven Mascarin

Hearing held on January 18 and May 1, 2018

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on January 18 and May 1, 2018.

PUBLICATION BAN

On the request of the College and on the consent of Dr. Steven Mascarin (the "Member" or "Dr. Mascarin"), the Panel made an order that no person shall publish, broadcast or in any manner disclose any facts or information concerning the personal health information of the Member or his patients referred to orally in evidence or in submission, or in the exhibits filed at the hearing. Further, the Panel ordered that there shall be no public release of any documentary evidence filed at the hearing that contain or identifies the Member's personal health information.

THE ALLEGATIONS

The allegations against the Member were contained in the Notice of Hearing, dated April 19, 2016. The allegations against the Member were as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that, during the year 2008, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely [R.S.], contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - You over-prepared teeth 13 (upper right cuspid), 12 (upper right lateral incisor), 11 (upper right central incisor), 21 (upper left central incisor) and 22 (upper left lateral incisor), 23 (upper left cuspid), and 24 (upper left 1st bicuspid) in the course of providing crowns.

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 2008, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law,

without such a consent relative to one of your patients, namely [R.S.], contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation.

Particulars:

- The patient wrote in his letter of complaint that he attended your office for a consultation about veneers.
- Your original/handwritten clinical records state that the patient originally attended your office for a consultation on or about May 9, 2008, about veneers.
- Your original/handwritten clinical records for that consultation indicate that the patient was a good candidate for porcelain veneers ("PVs").
- Your "Proposed Dental Treatment" document dated May 20, 2008, lists veneers for teeth 13 (upper right cuspid), 12 (upper right lateral incisor), 11 (upper right central incisor), 21 (upper left central incisor), 22 (upper left lateral incisor), 23 (upper left cuspid), and 24 (upper left 1st bicuspid).
- Your informed consent document, which was signed by the patient on or about May 20, 2008, lists veneers for the above-noted teeth.
- You placed full crowns on the above-noted teeth.
- Your invoice to the patient dated June 6, 2008, lists veneers for the above-noted teeth (except for tooth 21, for which a porcelain crown is listed).
- Your "Detailed Statement" for the patient for the period January 1, 2008, to November 11, 2015, lists veneers for six teeth on June 6, 2008. The teeth are not identified.
- The patient's letter of complaint was about veneers you placed.
- You did not place any veneers for the patient.
- In 2008, the ODA recommended fee for a veneer was $423 and the recommended fee for a crown was $632. You charged $795 for each crown. There is no indication in the patient's records that you discussed with him the recommended rate for the procedure or the reasons why your fees were higher than that recommended rate and obtained his consent.

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 2008, you charged a fee that was excessive or unreasonable in relation to the service performed relative to one of your patients, namely [R.S.], contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

Particulars:

- In 2008, the ODA recommended fee for a veneer was $423 and the recommended fee for a crown was $632. You charged $795 for each crown. There is no indication in the patient's records that you discussed with him the recommended rate for a procedure or the reasons why your fees were higher than that recommended rate and obtained his consent.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2008, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to one of your patients, namely [R.S.], contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

   Particulars:

   - Your original/handwritten clinical records for May 9, 2008, state, "Pt appears to be good candidate for PV's." However, you provided a transcript of your progress notes to the College, and the transcript for May 9, 2008, states, "Patient appears to be good candidate for crowns."
   - You indicated that your staff used the code for veneers instead of the code for ¾ crowns because they found this method of recording easier, but you did not provide ¾ crowns for the patient or document that you provided ¾ crowns in any of his clinical, financial or other records. You provided full crowns for the patient.
   - You were found guilty of professional misconduct related to falsifying records and informed consent by a panel of the Discipline Committee in 2005. You were found guilty of professional misconduct related to charging excessive fees and informed consent by a panel of the Discipline Committee in 2006. You were cautioned about your informed consent protocols in January 2008. All of these decisions had been issued before you began treating the patient in or about May 2008.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct. He also made admissions in writing in an Agreed Statement of Facts, which was signed by the Member.

The Panel conducted a plea inquiry at the hearing, and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

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

Background

1. Dr. Steven Mascarin has been registered with the College in the general class since May 1990. He received his dental education at the University of Western Ontario. Dr. Mascarin's primary place of practice is located on Taunton Road in Oshawa, Ontario.

The Notice of Hearing

2. Dr. Mascarin was served with a Notice of Hearing dated April 16, 2016. These allegations arose following a complaint by R.S., a patient.

3. The College and the Member have agreed to resolve the allegations on the basis of the facts and admissions agreed to and set out below.

Facts and Admissions

4. On or about May 9, 2008, R.S. met with Dr. Mascarin for a consultation to discuss cosmetic restoration of his upper smile, from approximately tooth 16 to tooth 25. Specifically, R.S. wanted Dr. Mascarin to provide him with veneers.

5. Dr. Mascarin's clinical records state that R.S. originally attended the office for a consultation about veneers. Dr. Mascarin's handwritten clinical notes of May 9, 2008 state: "Patient appears to be a good candidate for PV's". Tooth 12 and tooth 22 had some pre-existing restorations.

6. If R.S. were to testify, he would state that his teeth were in good condition at the time of the treatment. He would further state that during his initial consultation on May 9, 2008 or the subsequent treatments in May and June 2008, Dr. Mascarin did not raise any

concerns about his candidacy for veneers or the length of time that he could expect the veneers to last.

7. After the initial consultation, R.S. agreed to a treatment plan for the placement of veneers. Dr. Mascarin prepared and R.S. executed several treatment plan documents and financial estimates and agreements for the placement of veneers:

   - a Financial Agreement for Treatment executed by R.S. dated May 9, 2008 referencing "16-25 anterior veneers, upper right bridge";

   - a Proposed Dental Treatment Estimate prepared by Dr. Mascarin and dated May 20, 2008 referencing veneers for teeth 11-13 as well as and crowns for teeth 21 and 25;

   - a Major Restorative Treatment Consent executed by R.S. dated May 20, 2008 referencing "16-14 bridge, 13-24 veneers, 21 & 25 FCS";

   - a Detailed Financial Statement referencing veneers for six teeth (not identified); and

   - an Invoice Statement refers to veneers for teeth 11-13, 22-24 with crowns listed for teeth 21 and 25.

8. In fact, Dr. Mascarin completed a porcelain fused to metal bridge for teeth 16 to 14 and a full coverage crown preparation for teeth 13 to 25 on May 20, 2008 and June 6, 2008.

9. This treatment was uninsured and cost approximately $12,000. Dr. Mascarin charged R.S. $795 per crown. The ODA suggested fee for a veneer was $423 and the recommended fees guide was $632 for crowns.

10. If Dr. Mascarin were to testify, he would state that he does not recall the consultation with R.S. on May 9, 2008. However, Dr. Mascarin acknowledges that he did not provide information to R.S. in a manner that R.S. understood that he would receive a crown and a bridge. Dr. Mascarin acknowledges that his discussions with R.S. and his subsequent written treatment plans and financial documents left R.S. with the reasonable conclusion that R.S. was receiving veneers for this upper smile.

11. R.S. saw Dr. Mascarin for routine cleanings in 2008 to 2010.

12. In September 2011, R.S. returned to Dr. Mascarin's office because the crown over tooth 12 had broke at the gumline and was non-restorable. Dr. Mascarin recommended, and R.S. agreed, to remove tooth 12 and place an implant with crown. The implant was placed without complication.

13. In February 2014, R.S.'s tooth 22 also broke at the gumline, while R.S. was in Florida. R.S. saw a dentist in Florida, who provided him with a temporary denture, advised R.S. that he had crowns and not veneers, and noted concerns about Dr. Mascarin's over-preparation of teeth 13-25.

14. R.S. returned to Ontario to see Dr. Mascarin on April 24, 2014. At that meeting, R.S. expressed his dissatisfaction with Dr. Mascarin's past treatment.

15. Dr. Mascarin concluded that there was insufficient bone to complete an implant for tooth 22 and recommended a bone graft before attempting an implant, or to complete a 5 tooth bridge. R.S. was concerned about the costs of further treatment, and Dr. Mascarin advised him that he would agree to complete the treatment without cost, if R.S. covered the laboratory fees. R.S. did not elect to return for treatment, as he had lost confidence in Dr. Mascarin. R.S. complained to the College.

16. Following R.S.'s consultation with Dr. Mascarin, tooth 21 also broke at the gumline. R.S. obtained a bone graft and implant for tooth 21 and tooth 22 by another dentist, at significant cost.

i. Failure to meet the standards of practice

17. Dr. Mascarin admits that he failed to meet the standards of practice expected of a general dentist in respect of his provision of crowns to R.S.

18. Dr. Mascarin acknowledges that he over-prepared teeth 13-25 when he completed his treatment of R.S. in May and June 2008, in that he removed and shaped the teeth more than was necessary, and in a manner that weakened the teeth and made them susceptible to breakage. Dr. Mascarin further acknowledges that as a result of the over-preparation of R.S.'s teeth, R.S.'s teeth 12,

21, and 22 broke at the gumline within six years of placement of the crowns.

19. By removing and shaping R.S.'s teeth more than was necessary, and in a manner that weakened the teeth and made them susceptible to breakage., Dr. Mascarin admits that his conduct contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 in the Notice of Hearing.

ii. Failure to obtain informed consent

20. Dr. Mascarin admits that he failed to inform R.S. of his conclusion that R.S. was not a good candidate for veneers or of the specific treatment he recommended (crowns), in a manner which would ensure that R.S. understood the treatment recommendations and consented to them. Dr. Mascarin acknowledges that he failed to fully explain the benefits, risks and side effects of his recommended treatment of crowns over veneers. Dr. Mascarin also acknowledges that he did not take the necessary steps to ensure that R.S. agreed to the treatment he had proposed, and that R.S. did not in fact consent to the treatment he had proposed.

21. Dr. Mascarin admits that his written communication with R.S., being the treatment plans and financial statements, did not make clear that Dr. Mascarin recommended and intended to place crowns instead of veneers. Dr. Mascarin acknowledges that his written communications, in which he references veneers and crowns, left R.S. with the reasonable conclusion that Dr. Mascarin intended to and had placed veneers in R.S.'s mouth. Dr. Mascarin admits that he was careless in providing written communications that did not accurately confirm for R.S. the nature of the treatment provided.

22. Therefore, Dr. Mascarin admits that he treated R.S. by providing crowns without consent, contrary to paragraph 7 of section 2 of the Dentistry Act Regulation, as set out in Allegation 2 in the Notice of Hearing.

iii. Charging Excessive Fees

23. Dr. Mascarin charged R.S. $795 per crown, in excess of the ODA suggested fee. He acknowledges that he did not discuss the recommended fee with R.S., nor discuss the reasons his fees were higher than the recommended rates. Dr. Mascarin acknowledges that the treatment he provided was not clinically complex to the extent to warrant fees over the ODA suggested fees.

24. Therefore, Dr. Mascarin admits that he charged excessive fees when he charged R.S. $795 per crown, contrary to paragraph 31 of section 2 of the Dentistry Act Regulation, as set out in Allegation 3 in the Notice of Hearing.

iv. Disgraceful, Dishonourable, Unprofessional and Unethical

25. During the course of the College's investigation, Dr. Mascarin admits that he was not honest and forthcoming with the College.

26. First, at the request of the College, Dr. Mascarin provided his handwritten treatment notes and a transcription of these notes to the College.

27. Dr. Mascarin's handwritten notes state: "Patient appears to be a good candidate for PVs". Dr. Mascarin's typed transcription which he provided to the College states: "Patient appears to be a good candidate for crowns".

28. If he were to testify, Dr. Mascarin would state that his inaccurate transcription was inadvertent and the result of the stress of the College's investigation. However, Dr. Mascarin acknowledges that he prepared a transcription that contained inaccuracies. Dr. Mascarin further acknowledges that he had a professional obligation to ensure that all transcriptions, including the transcriptions regarding R.S.'s candidacy for veneers as opposed to crowns, were wholly and completely accurate. Dr. Mascarin admits that he was careless in his transcription, and erred by failing to record his handwritten notes accurately.

29. Second, Dr. Mascarin advised the College that references to veneers in R.S.'s financial statements was a staff error, of which he was not aware. Dr. Mascarin advised the College that his staff used a billing code for veneers instead of ¾ crowns. Dr. Mascarin admits that this explanation does not reflect that he provided full

crowns to R.S. and that there was no reasonable basis for the staff to use the billing code for veneers. He acknowledges that he is responsible to ensure that his office provides accurate financial reporting to clients and admits that he failed to do so.

30. Dr. Mascarin acknowledges that he had a professional obligation to provide truthful and accurate information to the College, an obligation of which he was well aware. Dr. Mascarin admits he acted disgracefully, dishonourably, unprofessionally and unethically contrary to paragraph 59 of section 2 of the Dentistry Act Regulation, as set out in Allegation 4 in the Notice of Hearing.

DECISION

Having considered the evidence and submissions of the parties, the Panel found that the Member committed professional misconduct as alleged in the Notice of Hearing.

REASONS FOR DECISION

The Member pled guilty to the allegations as set out in the Notice of Hearing and did not dispute the facts presented in the Agreed Statement of Facts.

The Panel accepted Dr. Mascarin's plea of guilty to allegations 1, 2, 3 and 4 as set out in the Notice of Hearing. The Member admitted that the facts contained in the Agreement Statement of Facts were true and that his actions constitute professional misconduct. The Panel was of the view that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations of professional misconduct.

Dr. Mascarin met with the patient, R.S., to discuss cosmetic restoration of his upper smile. His records confirm that R.S. attended at the office to discuss porcelain veneers. After the initial consultation R.S. agreed to a treatment plan for the placement of veneers. R.S. executed several documents including a financial agreement, a financial statement, a proposed treatment plan, a major restorative work consent and an invoice, all of which referenced veneers, and crowns for teeth 21 and 25. Despite those documents, Dr. Mascarin in fact completed a porcelain fused to metal bridge for teeth 16 to 14 and a full coverage crown preparation for teeth 13 to 25. Dr. Mascarin acknowledged that he did not provide information to R.S. in such a manner that R.S. understood he would be receiving a crown and bridge. Dr. Mascarin further acknowledged that

his discussions with R.S. and his subsequent written treatment plans and financial documents left R.S. with the reasonable conclusion that R.S. was receiving veneers for his upper smile. In September 2011, R.S. returned to Dr. Mascarin's office because the crown over tooth 12 broke at the gumline and was not able to be restored. Tooth 22 also broke at the gumline while R.S. was on vacation. The dentist who provided him with a temporary bridge advised R.S. that he had crowns, not veneers, and noted concerns about over preparation of the teeth. R.S. returned to see Dr. Mascarin who recommended a bone graft and implant for tooth 22 or to complete a 5 tooth bridge. Dr. Mascarin agreed to cover all costs but R.S. had lost confidence in Dr. Mascarin, and elected not to return to him for treatment.

Dr. Mascarin admitted, and the Panel finds, that he failed to meet the standards of practice expected of a general dentist in the provision of crowns to R.S. He acknowledged that, contrary to the standards of practice, he over-prepared teeth 13-25 in that he removed and shaped the teeth more than was necessary and in a manner that weakened the teeth and made them susceptible to breakage. As a result, teeth 12, 21 and 22 all broke at the gumline within 6 years of the initial placement of the crowns.

Dr. Mascarin also admitted that he failed to obtain informed consent. He failed to fully explain the benefits, risks and side effects of his recommended treatment of crowns over veneers and did not take the necessary steps to ensure that R.S. agreed to the treatment he had proposed. Dr. Mascarin admitted that R.S. did not in fact consent to the treatment. The numerous references to veneers and crowns in the treatment plan and financial documents left R.S. with the reasonable conclusion that Dr. Mascarin intended to and did place veneers.

Paragraph 7 of section 2 of the *Dentistry Act Regulation* makes it an act of professional misconduct for a dentist to treat "a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent." Subsection 10(1) of the *Health Care Consent Act*, SO 1996, c 2, Sch A sets out the relevant circumstances in which consent is required by law. It provides:

> 10.(1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
>
> (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
>
> (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute

> decision-maker has given consent on the person's behalf in accordance with this Act.

The Panel finds that Dr. Mascarin treated R.S. by providing crowns and was required by law to obtain R.S.'s consent to the treatment. Dr. Mascarin failed to obtain such consent, contrary to paragraph 7 of section 2 of the *Dentistry Act Regulation*.

Dr. Mascarin also acknowledged that he charged fees in excess of the ODA recommended fee for crowns and that this was not discussed with R.S. Dr. Mascarin acknowledged that the treatment provided was not clinically complex to the extent to warrant fees over the ODA suggested rate. The Panel finds that, in the circumstances, by charging $795 per crown, in excess of the ODA suggested, Dr. Mascarin charged fees that were excessive in relation to the service performed.

Dr. Mascarin admitted he was not honest and forthcoming with the College. There was a discrepancy between his handwritten notes, which referenced veneers, and the transcription he provided to the College, which only referenced crowns. As Dr. Mascarin has acknowledged, he had a professional obligation to provide truthful and accurate information to the College. The Panel finds that his failure to do so amounts to disgraceful, dishonourable, unprofessional and unethical behavior.

PENALTY SUBMISSIONS

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

1. The Royal College of Dental Surgeons of Ontario ("College") and Dr. Steven Joseph Mascarin ("the Member") jointly submit that this panel of the Discipline Committee impose the following penalty on the Member as a result of the panel's finding that the Member is guilty of professional misconduct, namely, that it make an order:

    (a) requiring the Member to appear before the panel of the Discipline Committee to be reprimanded within sixty (60) days of this Order becoming final or on a date fixed by the Registrar;

    (b) directing the Registrar to suspend the Member's certificate of registration for a period of eighteen (18) consecutive months, such suspension to commence effective immediately;

(c) directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration ("conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in clause 1(b) above has been fully served, namely:

(i) while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;

(ii) while the Member's certificate of registration is under suspension, the Member is not permitted to profit, directly or indirectly, from the practice of dentistry during that period. The Member is entitled to arrange for another dentist to take over his practice during the suspension. In this event, all of the billings of the practice during the suspension period belong to the substitute dentist. The Member may be reimbursed by substitute dentist for actual out of pocket expenses incurred in respect of the practice during that period.

(iii) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

(iii) during the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do anything that would suggest to

patients that the Member is entitled to engage in the practice of dentistry during the suspension;

(iv) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in the connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry or profited from his practice during the suspension; and

(v) the Conditions imposed in clauses 1(c)(i)-(iv) above shall be removed at the end of the period the Member's certificate of registration is suspended;

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

(i) the Member shall successfully complete at his expense, within twelve (12) months of this Order becoming final, the ProBE Program for Professional/Problem-Based Ethics (successful completion meaning that he must obtain an unconditional pass);

(ii) the Member shall successfully complete at his expense, within twelve (12) months of this Order becoming final, a one-on-one course, approved by the College, in Informed Consent;

(iii) upon the Member's return to practice after serving the period of suspension reference in clause 1(b) above, the Member shall not provide any prosthodontic treatment, including crowns, bridges and veneers;

(iv) the restriction on the Member's certificate of registration referred to in clause (d)(iii) above shall remain in place until such time as:

a. the College is satisfied that the Member has taken and successfully completed at his expense, a one-on-one, hands-on course in prosthodontics approved by the College; and

b. the Member has completed the Prosthodontics Mentoring Program, in that he has retained a mentor who is a specialist in the area of prosthodontics approved by the College, at his expense, to review and assess the adequacy of the member's crown and bridge treatment and to provide reports to the College every two (2) months until such time as the College is satisfied that mentoring is no longer required and advises the Member of this in writing;

(v) the Member's practice shall be monitored by the College by means of office visit(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the successful completion of the courses and mentoring program referenced in clauses (d)(i)(ii) and (iv) above and ending sixty (60) months thereafter;

(vi) that the Member shall cooperate with the College during the visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1000.00 per monitoring visit, such amount to be paid immediately after completion of each of the visits, provided that the overall cost of monitoring paid by the member shall not exceed $2,400.00, regardless of the number of visits;

(e) that the member pay costs to the College in the amount of $22,000.00 in respect of this discipline hearing, $5,000 of which will be paid on May 1, 2018, $7,000 of which will be paid within 30 days of this Order becoming final, and $10,000 in installments of $2,000 will be paid monthly by the 30th of the month for the following five months, commencing June 30, 2018.

2. The College and the Member further submit that pursuant to the Regulated Health Professions Act, 1991, as amended, the results of these proceedings must be recorded on the Register of the College and the publication of the Decision of the panel would therefore occur with the name and address of the Member included.

PENALTY DECISION

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

(a) The Member is to appear before the panel of the Discipline Committee to be reprimanded within sixty (60) days of this Order becoming final or on a date fixed by the Registrar;

(b) The Registrar is directed to suspend the Member's certificate of registration for a period of eighteen (18) consecutive months, such suspension to commence effective immediately;

(c) The Registrar is directed to impose the following terms, conditions and limitations on the Member's certificate of registration ("conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in clause (b) above has been fully served, namely:

(i) while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;

(ii) while the Member's certificate of registration is under suspension, the Member is not permitted to profit, directly or indirectly, from the practice of dentistry during that period. The Member is entitled to arrange for another dentist to take over his practice during the suspension. In this event, all of

the billings of the practice during the suspension period belong to the substitute dentist. The Member may be reimbursed by substitute dentist for actual out of pocket expenses incurred in respect of the practice during that period.

(iii) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

(iv) during the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry during the suspension;

(v) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in the connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry or profited from his practice during the suspension; and

(vi) the Conditions imposed in clauses (c)(i)-(v) above shall be removed at the end of the period the Member's certificate of registration is suspended;

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

(i) the Member shall successfully complete at his expense, within twelve (12) months of this Order becoming final, the ProBE Program for Professional/Problem-Based Ethics (successful

completion meaning that he must obtain an unconditional pass);

(ii) the Member shall successfully complete at his expense, within twelve (12) months of this Order becoming final, a one-on-one course, approved by the College, in Informed Consent;

(iii) upon the Member's return to practice after serving the period of suspension reference in clause (b) above, the Member shall not provide any prosthodontic treatment, including crowns, bridges and veneers;

(iv) the restriction on the Member's certificate of registration referred to in clause (d)(iii) above shall remain in place until such time as:

a. the College is satisfied that the Member has taken and successfully completed at his expense, a one-on-one, hands-on course in prosthodontics approved by the College; and

b. the Member has completed the Prosthodontics Mentoring Program, in that he has retained a mentor who is a specialist in the area of prosthodontics approved by the College, at his expense, to review and assess the adequacy of the member's crown and bridge treatment and to provide reports to the College every two (2) months until such time as the College is satisfied that mentoring is no longer required and advises the Member of this in writing;

(v) the Member's practice shall be monitored by the College by means of office visit(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the successful completion of the courses and mentoring program referenced in clauses (d)(i)(ii) and (iv) above and ending sixty (60) months thereafter;

(vi) that the Member shall cooperate with the College during the visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1000.00 per monitoring visit, such amount to be paid immediately after completion of each of the visits, provided that the overall cost of monitoring paid by the member shall not exceed $2,400.00, regardless of the number of visits;

(e) The Member shall pay costs to the College in the amount of $22,000.00 in respect of this discipline hearing, $5,000 of which will be paid on May 1, 2018, $7,000 of which will be paid within 30 days of this Order becoming final, and $10,000 in installments of $2,000 will be paid monthly by the 30th of the month for the following five months, commencing June 30, 2018.

REASONS FOR PENALTY DECISION

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

During the penalty phase of the hearing, the parties provided to the Panel a number of past relevant complaints, reports and/or discipline matters involving Dr. Mascarin.

The Panel was satisfied that all goals of penalty orders have been met and that the ultimate goal of public protection is met. The Joint Submission in this case is a relatively complex and carefully negotiated agreement that protects the public, is fair to the Member, and does not bring the administration of justice into disrepute.

The Joint Submission meets the penalty goals of general and specific deterrence. The reprimand and the lengthy suspension provide specific deterrence to the Member and signal more generally to the profession as a whole that the conduct that occurred in this case will not be tolerated by the College or the profession as a whole. The Joint Submission contains significant remediation provisions, which include a careful selection of courses to address the issues raised in the Notice of Hearing, and it also deals with existing practice restrictions and monitoring requirements that are already in place for Dr. Mascarin, arising from other complaints/reports/discipline matters.

The Panel considered the aggravating and mitigating circumstances in this case. Dr. Mascarin cooperated and entered into agreements with the College that avoided the need for a lengthy, contested hearing. This is a significant mitigating factor. The aggravating factors included the fact that the conduct involved serious clinical and standards of practice issues. The lack of informed consent is extremely important, as it is imperative that patients understand the specific treatment proposed by a dentist. Dr. Mascarin's acknowledgment of his failure to communicate accurately with the College is also of great concern to the Panel. The College expects its members to understand the importance of clear and accurate communication with their regulating body. The Panel also considered Dr. Mascarin's prior complaints, reports and discipline history. That history is relevant because the prior matters related to issues that are similar to the current allegations. The penalty jointly proposed in this case reflects the fact that this is not the first time the Member has engaged in behavior of concern to the College. Dr. Mascarin has been the subject of Inquiries, Complaints and Reports Committee cautions, practice restrictions and undertakings, along with two prior Discipline Committee orders concerning informed consent that resulted in suspensions.

The College expects a member against whom a finding of professional misconduct is made to learn from the experience and govern him or herself in a different way. A member's failure to do so requires a significant response by the College. The 18-month suspension ordered is very significant. The Panel feels that Dr. Mascarin needs a significant time away from practice to engage in rehabilitation and education. College counsel advised the Panel that the conduct of Dr. Mascarin was so serious that the College considered seeking revocation of Dr. Mascarin's certificate of registration. However, the College felt that Dr Mascarin demonstrated that he is a willing and governable member of the profession, and agreed to a lengthy suspension instead of seeking revocation. The Panel accepted Dr Mascarin's voluntary withdrawal from practice in June 2017 as evidence of his governability, and agreed to impose the penalty sought in the Joint Submission.

I, Susan Davis, sign these Reasons for Decision as Chairperson of this Discipline Panel.

Susan Davis
Chairperson

May 30, 2018
Date

RCDSO v. Dr. Mascarin

Oral Reprimand Delivered May 31, 2018

Dr. Mascarin, 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 an act of professional misconduct. The misconduct related to your failure to maintain the standard of care, your failure to obtain informed consent, the excessive fees you charged for crowns without justification and without the consent of your patient, and your failure to honestly and accurately communicate with the College.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged involved a serious failure to provide appropriate treatment that resulted in real harm to your patient. Your failure to adequately and accurately explain your treatment plan to your patient and to obtain informed consent for such treatment is also of great concern. It is imperative that the

public have trust and confidence in the dental profession. The Panel is also concerned about your carelessness in your communications with the College. The College must be able to expect honest and accurate communication from its members. Finally, your lengthy history of complaints, reports and discipline matters with the College is extremely disappointing to this Panel. We trust that the seriousness of our order will encourage you to make the changes necessary for you to return to being a productive member of the dental profession.