H180001

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. JULIAN JAMES D'SOUZA,** of the City of Richmond Hill, in the Province of Ontario;

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

Members in Attendance: Dr. Richard Hunter, Chair
Manohar Kanagamany
Ram Chopra
Dr. Carol Janik
Dr. William Coyne

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. Megan Shortreed
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. JULIAN JAMES D'SOUZA	)	Mr. Neil Abramson
	)	For Dr. Julian James D'Souza

Hearing held July 31, 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 July 31, 2018.

PUBLICATION BAN

On the request of the College and on the consent of the Member, the Panel made an order that no person shall publish, broadcast or in any manner disclose the identities of, or any facts or information that could identify, the patients referred to orally at the hearing or in the exhibits filed at the hearing.

THE ALLEGATIONS

The allegations against Dr. Julian D'Souza (the "Member") were set out in a Notice of Hearing dated February 28, 2018, which contains the following allegations against the Member.

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 2006 - 2014, you recommended and/or provided an unnecessary dental service relative to the following patients, contrary to paragraph 6 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Patients
   [A.D.]
   [O.L.]
   [F.S.]
   [N.S.]

   Particulars:

- You prescribed or took the following x-rays for the following patients that were unnecessary as there was no apparent or documented indication/justification for taking them.

  Patients:

[F.S.]	May 24, 2006; February 24, 2014
[N.S.]	March 14, 2007; September 14, 2007; November 21, 2008; August 27, 2014

- The necessity of the "touch ups" cannot be determined from the chart entry for [O.L.] on January 21, 2011.
- For patient [A.D.], instead of extracting tooth 48 as you planned, on May 13, 2010, you placed a temporary restoration on this tooth which was unnecessary.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2006 - 2014, you charged a fee that was excessive or unreasonable in relation to the service performed relative to the following patients, contrary to paragraph 31 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Patients

   [A.D.]
   [O.L.]
   [F.S.]
   [N.S.]

   Particulars:

   - You prescribed or took x-rays for the following patients that were unnecessary, and therefore charging for them was excessive or unreasonable:

     Patients:

[F.S.]	May 24, 2006; February 24, 2014

[N.S.] March 14, 2007; September 14, 2007; November 21, 2008; August 27, 2014

- The necessity of the "touch ups" cannot be determined from the chart entry for [O.L.] on January 21, 2011 and therefore charging for them was excessive and unreasonable.
- For patient [A.D.], instead of extracting tooth 48 as you planned, on May 13, 2010, you placed a temporary restoration on this tooth which was unnecessary, and therefore the charge for the temporary restoration was excessive or unreasonable.

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 years 2001-2014, you failed to keep records as required by the Regulations relative to the following patients, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patients

[B.A.]
[A.D.]
[O.L.]
[P.M.]
[D.M.]
[J.O.]
[T.R.]
[F.S.]
[N.S.]
[D.S.]
[T.V.]
[J.Y.]

Particulars:

- You did not provide the patient chart for [D.M.] that included entries prior to April 5, 2008 to the College.

- Patient charts prior to April 5, 2008 for [D.M.] were not provided to the College.
- You did not provide the patient chart for [B.A.].
- You created double chart entries for September 10, 2014 for patient [N.S.]. The first September 10, 2014 chart entry is incomplete and notes only "consult" but the second September 10, 2014 chart entry is a full and detailed chart entry. A chart entry dated September 26, 2014 follows the first September 10, 2014 chart entry and another September 26, 2016 chart entry was created to follow the more fulsome, second September 10, 2014 chart entry.
- You did not record a rationale for placement of a ZOE on tooth 25 for [O.L.] on July 25, 2011. Further there is no record of what the definitive treatment was to be for tooth 25.
- For patient [J.O.] on January 4, 2011, you placed a glass ionomer on tooth 15, and did not provide a rationale for the treatment.
- You did not record an adequate/any rationale for the number of units of scaling performed for each of the following 3 patients.

Patients	
[A.D.]	May 20, 2010
[J.O.]	July 13, 2011; November 2, 2011; November 14, 2011; November 5, 2012; November 22, 2012;
[D.S.]	March 11, 2009, April 6, 2011; April 11, 2011; March 7, 2012; March 21, 2012; March 6, 2013

- You did not record an adequate/any rationale for scaling again shortly after polishing was performed for the following patients.

Patients	
[A.D.]	May 13, 2010
[J.O.]	June 22, 2011; November 2, 2011; November 5, 2012
[D.S.]	March 4, 2009; April 6, 2011; March 7, 2012; February 20, 2013

- With respect to your 26 hygiene chart entries:
  - You did not note that scaling was performed in 3 of the 26 cases, in the body of your chart entries.

Patients	
[J.O.]	January 16, 2012
[D.S.]	September 16, 2009; December 4, 2013

  - You did not note the number of units of scaling (or time spent scaling) is not noted in 20 of the 26 cases, in the body of your chart entries.

Patients	
[A.D.]	May 13, 2010; October 7, 2010
[J.O.]	January 4, 2011; June 22, 2011; February 17, 2012; May 25, 2012; November 22, 2012
[D.S.]	March 11, 2009; June 3, 2009; October 7, 2009; March 7, 2012; June 20, 2012; September 19, 2012; March 6, 2013; March 20, 2013; May 1, 2013; November 13, 2013; January 15, 2014; February 12, 2014; February 26, 2014

- You did not clearly document what material was used as the chart entries indicate only "GC" for the following patients:

Patients	
[A.D.]	September 24, 2009; May 13, 2010; December 23, 2010;
[O.L.]	January 21, 2011
[P.M.]	April 9, 2011
[J.O.]	January 4, 2011; August 3, 2011
[D.S.]	June 3, 2009; November 13, 2013
[J.Y.]	December 14, 2013

- You did not document diagnoses for the following patients on the following dates:

Patient	
[A.D.]	May 13, 2010; December 23, 2010;
[O.L.]	July 25, 2011
[J.O.]	January 4, 2011
[J.Y.]	December 14, 2013

- For patient [D.S.], more than a year after treatment planning endodontic treatment and a crown for tooth 26, on September 19, 2012 you placed a temporary filling, ZOE and did not record a rationale.
- For [A.D.], on September 24, 2009, you incorrectly charted a restoration for tooth 27 when you treated tooth 28.
- For [F.S.], on May 16, 2005, you charted and claimed an OL restoration for tooth 16 when you placed an MO restoration.
- You did not make a chart entry corresponding to procedures you claimed for patient [D.S.] on March 5, 2014.
- For patient [O.L.] for February 13, 2009, you did not record the retrograde filling you placed after you performed an apicoectomy for tooth 14.
- For [J.O.], on August 9, 2006, although your progress notes indicate you administered local anesthetic, recommended an antiseptic rinse for post-operative care, and codes and fees for two surgeries are noted in the right-hand margin of the chart entry, there is no other documentation of either a 'gingivectomy' or a 'flap with curettage of osseous defect' surgery.
- For [D.S.], on October 19, 2009, your progress notes make reference to performing a gingivectomy, but other than the code and fee for a flap surgery that is noted in the right-hand margin of the chart entry, there is no documentation of the flap surgery.
- For [F.S.], on May 3, 2004, although your progress notes indicate you administered local anesthetic and the code and fee for the 'flap with curettage of osseous defect' surgery is noted in the right-hand margin of the chart entry, the only reference to the surgery is "Mx R Req perio surg."
- For [J.O.], your records indicate you performed a gingivectomy on May 12, 2010 and a flap surgery on June 9, 2010 on the same sextant.

- Although the chart entries indicate gingivectomies were performed, no details of the surgical procedures were noted for the following patients.

Patients	
[O.L.]	November 30, 2007
[F.S.]	September 19, 2001; March 15, 2002; October 12, 2011
[D.S.]	September 7, 2011

- Justification for the occlusal adjustments/equilibration procedures/claims was not found for the following patients.

Patients	
[O.L.]	October 1, 2006; January 21, 2011; July 25, 2011
[J.O.]	February 11, 2008
[T.R.]	June 19, 2013
[F.S.]	January 14, 2008; February 17, 2010
[T.V.]	June 2, 2011; November 21, 2013

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 years 2000-2014, you submitted an account or charge for dental services that the member knows or ought to know was false or misleading relative to the following patients, contrary to paragraph 33 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patients:
[G.D.]
[A.D.]
[R.K.]
[O.L.]
[P.M.]
[J.M.]
[D.M.]
[R.M.]

[J.O.]
[A.P.]
[T.R.]
[F.S.]
[N.S.]
[D.S.]
[T.V.]

Particulars:

- You inappropriately claimed a complete examination for [D.M.] on June 26, 2013 when there were insufficient changes to her dentition since the previous complete examination less than 2 years prior and you did not complete the periodontal charting, which is part of a complete examination.
- You claimed a complete examination for [D.M.], on August 28, 2006, for which there is no corresponding charting or chart entry.
- You claimed complete examinations for the following patients and dates for which there was no corresponding complete examination charting and for which there were no corresponding chart entries, other than a code and a fee in the margin of the chart entries.

Patients	
[R.K.]	December 10, 2013
[D.M.]	April 6, 2011
[J.O.]	October 22, 2008
[F.S.]	May 25, 2011
[N.S.]	April 23, 2008

- You claimed complete examinations for the following patients and dates when you performed only recall examinations.

Patients	
[A.D.]	June 12, 2008
[O.L.]	May 26, 2008
[R.M.]	February 18, 2006
[J.O.]	February 25, 2013
[N.S.]	March 14, 2007

[D.S.]	February 27, 2008

- You claimed complete examinations for the following patients, however the progress notes do not indicate what type of examination was performed and the charting is more consistent with a recall examinations.

Patients	
[A.D.]	November 8, 2011
[R.K.]	September 21, 2010
[O.L.]	September 22, 2004
[D.M.]	September 26, 2009
[R.M.]	September 26, 2009; June 12, 2013
[F.S.]	September 11, 2002; October 26, 2005; May 9, 2008
[N.S.]	December 13, 2003; October 26, 2011
[D.S.]	May 12, 2004; April 6, 2011; February 20, 2013

- A specific examination was performed on September 10, 2014 for [N.S.], but claimed with a service date of September 26, 2014.
- You prematurely billed for treatment for the following patients as the treatment was not yet complete at the time of billing.

Patients	
[J.M.]	December 4, 2013; January 16, 2013
[A.D.]	September 24, 2009
[P.M.]	April 9, 2001
[J.O.]	November 2, 1011

- You inappropriately claimed code 20111 in conjunction with endodontic treatment, as the placement of temporary restorations is included in endodontic procedures for the following patients.

Patients	
[A.D.]	September 24, 2009
[P.M.]	April 9, 2011

[J.O.]	November 14, 2011

- For the following three claims, the surgical procedures appear to have been performed in association with restorative procedures, the fee for which includes soft tissue management.

Patients	
[F.S.]	July 12, 2000; February 4, 2004
[D.S.]	February 12, 2014

- For the following seven cases, both a 'gingivectomy' and a 'flap with curettage of osseous defect' were claimed for the same sextant, on the same day, which was not an appropriate claim. In addition, it is not clear from your records why both surgeries were performed.

Patients	
[O.L.]	July 19, 2006; March 14, 2007
[J.O.]	October 12, 2005; July 12, 2006; April 18, 2012
[A.P.]	June or July 2012
[F.S.]	February 17, 2010

- For [T.R.], you claimed an occlusal adjustment though no reference to an occlusal adjustment was found on the corresponding chart entry dated March 31, 2014.
- No notations were found in the body of the chart entries indicating that the occlusal adjustments were performed for the following patients.

Patients	
[G.D.]	February 9, 2014
[A.D.]	December 23, 2010
[O.L.]	March 14, 2007
[J.O.]	May 31, 2010; January 4, 2011; July 13, 2011; November 2, 2011
[T.R.]	December 14, 2011
[F.S.]	June 4, 2008; March 14, 2009; October 15, 2011; October 12, 2011

[D.S.]	June 3, 2009
[T.V.]	October 30, 2008; November 25, 2008; April 20, 2010; July 6, 2010; July 27, 2010; October 13, 2011

- You inappropriately claimed occlusal adjustments in conjunction with restorative or fixed prosthodontic treatment.

Patients	
[G.D.]	December 19, 2013
[A.D.]	December 22, 2009
[O.L.]	May 23, 2007
[T.R.]	March 4, 2013
[F.S.]	April 4, 2007

- You inappropriately claimed for removal of an "impacted" tooth for the following patients, as the tooth was erupted.

Patients	
[A.D.]	May 13, 2010 (tooth 16)
[O.L.]	February 18, 2011 (tooth 45)
[J.O.]	January 4, 2011 (tooth 24)

- You inappropriately claimed an extraction of an "impacted" tooth on April 1, 2009 for [F.S.], as the tooth was not impacted.

5. *Withdrawn*

THE MEMBER'S PLEA

The College sought leave to withdraw allegation 5 in the Notice of Hearing and the Panel granted leave. The Member admitted the remaining allegations of professional misconduct in the Notice of Hearing. The Member also made admissions in writing in an Agreed Statement of Facts, which he signed.

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 (the attachments and references to them have been omitted).

Background

1. Dr. Julian James D'Souza (or the "Member") has been registered with the College as a general dentist since 1988.

2. His practice consists of two dental offices, located in Richmond Hill (224 Hwy 7 E, #103) and Whitby (185 Brock Street North).

The Notice of Hearing

3. The allegations of professional misconduct against the Member are set out in the Notice of Hearing dated February 28, 2018[.]

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

Withdrawal

5. The College is not proceeding with respect to Allegation 5 in the Notice of Hearing.

6. Accordingly, with leave of the Discipline Committee, the College withdraws Allegation 5.

Facts and Admissions

7. The facts giving rise to the allegations of professional misconduct in the current matter came to the attention of the College from a complaint filed by a representative of Manulife Financial ("Manulife").

8. In particular, Manulife expressed concerns with respect to Dr. D'Souza's submission of examination procedure codes,

exceptional use of procedure code 20111, placement of sedative dressing, exceptional charges for occlusal adjustment/ equilibration, concurrent periodontal surgeries submitted for the same region, predeterminations submitted in excess, accuracy of procedure codes submitted for surgical extractions, exceptional scaling time submitted, and uncontested claims not reimbursed. Manulife stated that, due to the lack of sufficient supporting information provided with Dr. D'Souza's billing submissions, Manulife was often unable to make a thorough and complete assessment, and had declined benefits for some services as a result.

9. The College's investigator, Dr. Helene Goldberg, attended at Dr. D'Souza's Whitby office on November 25, 2014. During this visit, Dr. Goldberg requested five patient charts. Dr. D'Souza was only able to provide one of these charts (for patient M.T.). He indicated that the other patient charts may be at his other office, at his home, or he may not have retained a copy for himself when the patient moved and requested their original file.

10. Dr. Goldberg arranged with Dr. D'Souza to visit his Richmond Hill office the next day (November 26, 2014), and requested him to have all the available files at that time. At that visit, Dr. D'Souza provided 18 additional patient files. Five patient files were still missing, and Dr. Goldberg requested these to be provided to the College. Additional records were received at the College from Dr. D'Souza throughout the course of December 2014, January 2015, and also in March, May and July 2015.

A. Allegations 1 and 2 – Unnecessary Dental Services and Excessive or Unreasonable Fee in Relation to Services Performed without Justification

11. The College's investigation identified several instances in which Dr. D'Souza performed unnecessary dental services. As the services were unnecessary, the fees charged were excessive and unreasonable.

12. Specifically, Dr. D'Souza admits that he performed

unnecessary dental services and charged an excessive or unreasonable fee without justification, as follows:

a. radiographs prescribed or taken which were unnecessary as there was no apparent or documented indication/justification for taking them with respect to patients F.S. (May 24, 2006 and February 24, 2014), and N.S. (March 14, 2007, September 14, 2007, November 21, 2008 and August 27, 2014);

b. "touch ups" were performed which were unnecessary as there was no diagnosis or documentation explaining why this was a necessary interim measure prior to providing a permanent restoration one month later for patient O.L. (January 21, 2011); and

c. a temporary restoration performed was unnecessary as extraction was planned with respect to patient A.D. (May 13, 2010).

14. Therefore, Dr. D'Souza admits that he:

a. recommended and/or provided an unnecessary dental service, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing; and

b. charged a fee that was excessive or unreasonable in relation to the service performed, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing.

Allegation 3 – Failure to Keep Records as Required

15. The College's investigation identified recordkeeping violations with respect to 12 of the patient files it reviewed. In particular, Dr. D'Souza admits that he failed to keep records as required in the following manner:

a. not providing the patient chart for D.M. that included entries prior to April 5, 2008 to the College;

b. not providing the patient chart for B.A.;

c. creating double chart entries for September 10, 2014 for patient N.S.;

d. not recording a rationale for placement of a ZOE on tooth 25 and not recording what the definitive treatment was to be for tooth 25 with respect to patient O.L. (July 25, 2011);

e. placing a glass ionomer on tooth 15 without any rationale for the treatment for patient J.O. (January 4, 2011;

f. not recording an adequate/any rationale for the number of units of scaling performed for patients A.D. (May 20, 2010), J.O. (July 13, 2011, November 2, 2011, November 14, 2011, November 5, 2012, November 22, 2012), and D.S. (March 11, 2009, April 6, 2011, April 11, 2011, March 7, 2012, March 21, 2012, March 6, 2013);

g. not recording an adequate or any rational for scaling again shortly after polishing was performed for patients A.D. (May 13, 2010), J.O. (June 22, 2011, November 2, 2011, November 5, 2012), and D.S. (March 4, 2009, April 6, 2011, March 7, 2012, February 20, 2013);

h. not documenting that scaling was performed in the body of hygiene chart entries for patients J.O. (January 16, 2012), and D.S. (September 16, 2009 and December 4, 2013);

i. not noting the number of units of scaling (or time spent scaling) in the body of hygiene chart entries for patients A.D. (May 13, 2010 and October 7, 2010), J.O. (January 4, 2011, June 22, 2011, February 17, 2012, May 25, 2012 and November 22, 2012), and D.S. (March 11, 2009, June 3, 2009, October 7, 2009, March 7, 2012, June 20, 2012, September 19, 2012, March 6, 2013, March 20, 2013, May 1, 2013, November 13, 2013, January 15, 2014, February 12, 2014 and February 26, 2014);

j. not clearly documenting what material was used (chart entries indicated only "GC", which may refer to a dental company that manufactures various materials but not to the material itself) for patients A.D. (September 24, 2009, May 13, 2010 and December 23, 2010), O.L. (January 21, 2011), P.M. (April 9, 2011), J.O. (January 4, 2011 and August 3, 2011), D.S. (June 3, 2009 and November 13, 2013), and J.Y. (December 14, 2013);

k. not documenting diagnoses for patients A.D. (May 13, 2010 and December 23, 2010), O.L. (July 25, 2011), J.O. (January 4, 2011), and J.Y. (December 14, 2013);

l. placing a temporary filling (26 MO ZOE), and not recording a rationale, a year after treatment planning endodontic treatment and a crown for the same tooth 26 for patient D.S. (September 19, 2012);

m. incorrectly charting a restoration for tooth 27 while treating tooth 28 for patient A.D. (September 24, 2009);

n. charting and claiming an OL restoration for tooth 16 when an MO restoration was placed for patient F.S. (May 16, 2005);

o. not charting procedures claimed for patient D.S. (March 5, 2014);

p. not recording the retrograde filling placed after performing an apicoectomy for tooth 14 for patient O.L. (February 13, 2009);

q. not documenting a gingevectomy or a flap with curettage of osseous defect surgery despite noting codes and fees for the two surgeries in the margin of the chart entry for patient J.O. (August 9, 2006);

r. not documenting a flap surgery except for noting a code and fee for the surgery in the margin of the chart entry for patient D.S. (October 19, 2009);

s. noting only "Mx R Req perio surg." with respect to a flap with curettage of osseous defect surgery despite noting the code and fee for the surgery in the margin of the chart entry for patient F.S. (May 3, 2004);

t. documenting a gingivectomy performed on May 12, 2010 and a flap surgery on June 9, 2010 on the same sextant for patient J.O.;

u. not documenting details of gingivectomies performed for patients O.L. (November 30, 2007), F.S. (September 19, 2011, March 15, 2002, October 12, 2011), and D.S. (September 7, 2011); and

v. not documenting justification for occlusal adjustments/equilibration procedures/claims for patients O.L. (October 1, 2006, January 21, 2011, July 25, 2011), J.O. (February 11, 2008), T.R. (June 19, 2013), F.S. (January 14, 2008, February 17, 2010), and T.V. (June 2, 2011 and November 21, 2013).

16. Dr. D'Souza acknowledges that he breached his professional, ethical and legal responsibilities that required him to maintain a complete record documenting all aspects of each patient's dental care, per the College's *Dental Recordkeeping Guidelines*, and s. 38 of Regulation 547.

17. Therefore, Dr. D'Souza admits that he failed to keep records as required by the Regulations relative to the patients listed, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

Allegation 4 – Insurance Claim Issues

18. The College's investigation identified inappropriate insurance claims by Dr. D'Souza involving 15 patients. In particular, Dr. D'Souza admits that the following insurance claims made on behalf of patients in the identified circumstances were inappropriate:

a. claiming a complete examination and not completing the periodontal charting for patient D.M. (June 26, 2013);

b. claiming a complete examination with no corresponding chart record for patient D.M. (August 28, 2006);

c. claiming a complete examination with only a code and fee in the margin of the chart for patients R.K. (December 10, 2013), D.M. (April 6, 2011), J.O. (October 22, 2008), F.S. (May 25, 2011), and N.S. (April 23, 2008);

d. claiming a complete examination but performing only a recall examination for patients: A.D. (June 12, 2008), O.L. (May 26, 2008), R.M. (February 18, 2006), J.O. (February 25, 2013), N.S. (March 14, 2007), and D.S. (February 27, 2008);

e. claiming a complete examination when the progress notes do not indicate the type of examination and the charting is more consistent with a recall examination for patients A.D. (November 8, 2011), R.K. (September 21, 2010), O.L. (September 22, 2004), D.M. (September 26, 2009), R.M. (September 26, 2009 and June 12, 2013), F.S. (September 11, 2002, October 26, 2005, and May 9, 2008), N.S. (December 13, 2003 and October 26, 2011), and D.S. (May 12, 2004, April 6, 2011 and February 20, 2013);

f. claiming a specific examination for N.S. with a service date of September 26, 2014, when the examination was performed on September 10, 2014;

g. prematurely billing for treatment before the treatment was complete for patients J.M. (December 4, 2013 and January 16, 2013), A.D. (September 24, 2009), P.M. (April 9, 2001), and J.O. (November 2, 2011);

h. inappropriately claiming code 20111 in conjunction with endodontic treatment (the placement of temporary restorations is included in endodontic procedures) for

patients: A.D. (September 24, 2009), P.M. (April 9, 2011), and J.O. (November 14, 2011);

i. claiming for surgical procedures performed in association with restorative procedures (the fee for which includes soft tissue management) for patients F.S. (July 12, 2000 and February 4, 2004), and D.S. (February 12, 2014); claiming for both a gingivectomy and a flap with curettage of osseous defect for the same sextent, and without indication in the patient record of why both surgeries were performed, for patients O.L. (July 19, 2006 and March 14, 2007), J.O. (October 12, 2005, July 12, 2006, and April 18, 2012), A.P. (June or July 2012), and F.S. (February 17, 2010);

j. claiming an occlusal adjustment without reference to an occlusal adjustment in the corresponding chart entry for patient T.R. (March 31, 2014);

k. claiming an occlusal adjustment without reference to an occlusal adjustment in the corresponding chart entry except for a note indicating the code and fee for patients G.D. (February 9, 2014), A.D. (December 23, 2010), O.L. (March 14, 2007), J.O. (May 31, 2010, January 4, 2011, July 13, 2011 and November 2, 2011), T.R. (December 14, 2011), F.S. (June 4, 2008, March 14, 2009, October 15, 2011 and October 21, 2011), D.S. (June 3, 2009), and T.V. (October 30, 2008, November 25, 2008, April 20, 2010, July 6, 2010, July 27, 2010 and October 13, 2011);

l. claiming occlusal adjustments in conjunction with restorative or fixed prosthodontics treatment for patients G.D. (December 19, 2013), A.D. (December 22, 2009), O.L. (May 23, 2007), T.R. (March 4, 2013), and F.S. (April 4, 2007); and

m. claiming for removal of an impacted tooth when the tooth was erupted for patients A.D. (May 13, 2010, tooth 16), O.L. (February 18, 2011, tooth 45), J.O.

(January 4, 2011, tooth 24), and when the tooth was not impacted for patient F.S. (April 1, 2009).

19. If he were to testify, Dr. D'Souza would say that his billing in some of the cases set out above was based on his understanding of what was proper at the time. In particular, with respect to claiming code 20111 in conjunction with endodontic treatment, Dr. D'Souza did not at the time appreciate that a separate claim could not be submitted if a temporary restoration needed to be inserted in advance of endodontic and/or restorative treatment. Regarding claiming for removal of an impacted tooth when the tooth was erupted and/or not impacted, Dr. D'Souza would say that he had interpreted the ODA codes as being applicable to an extraction which involved raising a flap and removing bone, regardless of whether or not the tooth was impacted. However, Dr. D'Souza now understands that his use of codes in billing as set out above was inappropriate.

20. Therefore, Dr. D'Souza admits that he signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement, contrary to paragraph 28 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 of the Notice of Hearing.

Past History

36. Dr. D'Souza has one previous finding by the Discipline Committee of the College.

37. On December 17, 1992, the Discipline Committee made a finding that Dr. D'Souza failed to maintain the standards of practice of the profession, failed to keep records as required, improperly used his authority to prescribe, sell or dispense a drug, falsified a record in respect of a prescription of the sale of a drug, used a non-approved assumed name in connection with his practice, and engaged in conduct that would reasonably be considered by members of the profession as dishonourable, disgraceful, unprofessional and/or unethical. In relation to recordkeeping in particular, the Discipline

Committee noted concerns about the standard of recordkeeping, the failure to record treatments provided, and the dates of treatments rendered. The Discipline Committee imposed a penalty of a reprimand, 6 month suspension (4 months to be remitted upon completion of courses), courses in endodontics, periodontics, oral diagnosis and oral radiology, and pharmacology, practice monitoring for 2 years, a 2 year prohibition on prescribing any narcotics or controlled drugs, and a fine of $5000.

38. Additionally, on November 4, 1997, as a result of a section 75(1)(a) investigation, Dr. D'Souza signed an Undertaking/Agreement with the College where he would fully comply with the College's Guidelines Respecting Infection Control in the Dental office and have his practice monitored for a period of two years.

39. [Reference to documents appended to Agreed Statement of Facts omitted.]

General

40. Dr. D'Souza admits that the acts described above constitute professional misconduct and he now accepts responsibility for his actions and the resulting consequences.

41. Dr. D'Souza has had the opportunity to take independent legal advice with respect to his admissions.

DECISION

Having considered the evidence and submissions of the parties, the Panel found that the Member committed professional misconduct as alleged in allegations 1 through 4 of the Notice of Hearing.

REASONS FOR DECISION

The Member admitted to allegations 1 through 4 as set out in the Notice of Hearing (allegation 5 having been withdrawn by the College) and arrived at an Agreed Statement of Facts with the College.

The Panel accepts through the Member's own admission and on the basis of the facts set out in the Agreed Statement of Facts that the Member provided unnecessary services, charged excessive or unreasonable fees in relation to services performed without justification, he failed to keep records as required by Regulation 547, and submitted improper insurance claims for a number of patients. The Panel concluded that the member committed professional misconduct as set out in allegations 1 through 4 of the Notice of Hearing.

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. Julian James D'Souza ("Member") jointly submit that this panel of the Discipline Committee impose the following penalty on the Member as a result of the panel's finding that the Member is guilty of professional misconduct, namely, that it make an order:

    (a) requiring the Member to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

    (b) directing the Registrar to suspend the Member's certificate of registration for a period of two (2) months, to be served consecutively, such suspension to commence on August 1, 2018;

    (c) that the Registrar impose the following terms, conditions and limitations on the Member's certificate

of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 1(b) above has been fully served, namely:

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

(ii) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office(s) 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 during the suspension; and

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

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

(i) requiring that the Member successfully complete, at his own expense, a course in recordkeeping and billing, including the use of billing codes, approved by the College, and provide proof of successful completion in writing to the Registrar within twelve (12) months of this Order becoming final;

(ii) the Member's practice shall be monitored by the College by means of office visit(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the date of this Order and ending twenty-four (24) months from the College receiving proof of the Member's successful completion of the course(s) referred to above, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(iii) that the Member shall cooperate with the College during the office visit(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $1,000.00 per office visit, such

amount to be paid immediately after completion of each of the office visit(s);

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

(v) the Practice Conditions imposed by virtue of subparagraph (1)(d)(i) above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses described in subparagraph (1)(d)(i) above have been completed successfully;

(vi) the Practice Condition imposed by virtue of subparagraph (1)(d)(ii) above shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in subparagraph (1)(d)(i) above has been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

(e) that the member pay costs to the College in the amount of $5,000 in respect of this discipline hearing, such costs to be paid in full within 120 days of this Order becoming final.

3. The College and the Member further submit that pursuant to the Code, as amended, the results of these proceedings must be recorded on the Register of the College and any

publication of the Decision of the panel would therefore occur with the name and address of the Member included.

4. This joint submission on penalty and costs was reached as a result of a pre-hearing conference held with respect to these matters and it received the endorsement of the pre-hearing conference presider.

Both parties submitted that the Panel should accept the proposed penalty.

Counsel for the Member and for the College both argued that the Joint Submission with respect to Penalty and Costs meets the goals of penalty. Specific and general deterrence were accomplished by the suspension and reprimand components of the penalty, and by the requirement that the results of the proceedings be recorded in the public register on the College's website. Remediation and the ultimate goal of public protection are met by the continuing education course that the Member must complete, as well as the requirement that his practice be monitored for a two (2) year period.

College counsel argued that this case is predominantly about documentation problems. She further argued that while providing unnecessary services, deficient recordkeeping and improper billing are all serious, they are not the most serious kinds of misconduct that come before the Discipline Committee. Though improper, the College believes that the Member's conduct can be remedied with remediation.

In terms of aggravating factors, College counsel argued that the number of charts with recordkeeping deficiencies and the number of years over which the deficiencies occurred are aggravating. With respect to the Member's past discipline history as reflected in paragraphs 36 to 38 of the Agreed Statement of Facts, College counsel noted that there is some overlap between the 1992 matter and this case, as the 1992 matter involved recordkeeping problems along with other kinds of misconduct. However, the finding was from 1992 and therefore should be given little weight as an aggravating factor. College counsel noted by way of mitigation that the Member has cooperated with the College, admitted his misconduct, and expressed remorse. He undertook a voluntary program of education in an attempt at remediation.

College counsel submitted that penalties ordered by this Committee in prior cases in which findings of misconduct have been made based on recordkeeping

problems typically involve suspensions of two to six months. Although the Joint Submission in this case falls at the lower end of that range, it is reasonable and falls within the range of reasonable outcomes.

The Member's counsel provided the Panel with a list of continuing education courses (Exhibit 5) in which the Member has voluntarily participated since 2017. The courses began after the complaint was made but before the referral to the Discipline Committee in this case. The courses were not required by the College and the Member's counsel argued that it provides context for the Joint Submission, as it demonstrates that the Member has accepted responsibility and has engaged in extensive retraining.

Regarding the 1992 discipline finding against the Member, his counsel argued that it happened so long ago that it is not relevant and is not an aggravating factor. He submitted that there are no aggravating factors in this case but that there are three mitigating factors: the Member has been cooperative throughout; he has engaged in a high degree of voluntary education and retraining; and he has admitted his misconduct.

After hearing the parties' submissions on penalty, the Panel retired to deliberate. During its deliberations, the Panel identified three concerns with respect to the Joint Submission on Penalty. In accordance with the process outlined in *R v Anthony-Cook*, 2016 SCC 43, the Panel reconvened the hearing to advise the parties of its concerns and to receive further submissions from the parties before making a final decision.

The Panel's concerns were as follows.

First, the earliest evidence of misconduct in the Agreed Statement of Facts occurred in the year 2000. The Discipline Committee's 1992 order in the prior discipline matter included as a term that the Member undergo practice monitoring for two (2) years. Thus, the monitoring ended in 1994. The Panel reasoned that the present misconduct started only 6 years after the practice monitoring arising from the first discipline matter had ended. The Panel was concerned that the recent allegations exhibited a disturbing pattern of continued professional misconduct and should not be considered in isolation from the 1992 misconduct.

The Panel's second concern related to the list of twelve continuing education courses (Exhibit 5) that the Member's counsel presented as a mitigating factor.

The list consisted of two (2) courses that were pertinent to the Member's professional misconduct in this case: a record keeping course and an ethics course. The other courses were didactic courses presumably related to the Member's fulfilment of the continuing educational requirement that the College mandates for all members.

The third concern pertained to the proposed two (2) month suspension. It would be identical in length to the suspension imposed by the Discipline Committee in the 1992 matter. The Panel was concerned that imposing the same length of suspension a second time would not meet the goals of specific and general deterrence and maintain public confidence in the College's ability to regulate its members.

Both counsel made further submissions to address the Panel's concerns. They argued that only one of the problematic patient records dated back to the year 2000, whereas the bulk of the records were made in 2010 or later. The continuing education courses that the Member had completed prior to the hearing showed the Member's remorse and a willingness to improve, but in terms of the goal of remediation, the most important course is the one the parties jointly sought to have included in the Panel's order, namely: a course in recordkeeping and billing, including the use of billing codes, approved by the College, which would have an evaluative component as reflected in the need for the Member to provide proof of successful completion. Both counsel emphasized that the main focus of the misconduct findings in 1992 related to prescribing narcotics. This is a far more serious form of misconduct than the findings in the present case, which primarily relate to record keeping and billing. College counsel noted that progressive discipline is not required in this case because the findings in the 1992 case were materially different from the findings in this case, but in any event, the Joint Submission reflects progressive discipline because it imposes the same length of suspension for less serious misconduct.

The Member's counsel gave the Panel an excerpt from Richard Steinecke *et al*, *A Complete Guide to the Regulated Health Professions Act*, loose-leaf (consulted on July 31, 2018), (Toronto, ON: Thomson Reuters Canada Limited, 2017), ch 6 at 140, which states "undue weight should not be put on a prior finding, particularly if it did not constitute similar misconduct or was made long before the proceeding at hand."

Finally, in their additional submissions, counsel for both parties highlighted certain aspects of the *Anthony-Cook* case and provided the Panel with prior

cases of the Discipline Committee in which suspensions of 2-3 months were imposed for findings of professional misconduct based on recordkeeping deficiencies.

PENALTY DECISION

After deliberating on the submissions presented by the Member's counsel and the College counsel, including the additional submissions made after the parties were informed of the Panel's concerns, the Panel accepted the Joint Submission with respect to Penalty and Costs and ordered that:

1. The Member is required to appear before the Panel of the Discipline Committee to be reprimanded, within ninety (90) days of this Order becoming final or on a date fixed by the Registrar.

2. The Registrar is directed to suspend the Member's certificate of registration for a period of two (2) months, to be served consecutively, such suspension to commence on August 1, 2018.

3. The Registrar is directed to 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:

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

    (ii) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any

other dentist in the office(s) 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 that connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

(v) the Suspension Conditions imposed by virtue of subparagraphs 3(i)-(iv) above shall be removed at the end of the period the Member's certificate of registration is suspended.

4. The Registrar is directed to impose the following additional terms, conditions and limitations on the Member's Certificate of Registration (the "Practice Conditions"), namely

(i) the Member shall successfully complete, at his own expense, a course in recordkeeping and billing, including the use of billing codes, approved by the College, and provide proof of successful completion in writing to the Registrar within twelve (12) months of this Order becoming final;

(ii) the Member's practice shall be monitored by the College by means of office visit(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the date of this Order and ending twenty-four (24) months from the College receiving proof of the Member's successful completion of the course(s) referred to above, or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

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

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

(v) the Practice Conditions imposed by virtue of subparagraph 4(i) above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses described in subparagraph 4(i) above have been completed successfully;

(vi) the Practice Condition imposed by virtue of subparagraph 4(ii) above shall be removed from the Member's certificate of registration twenty-four (24) months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in subparagraph 4(ii) above

has been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

5. The Member shall pay costs to the College in the amount of $5,000 in respect of this discipline hearing, such costs to be paid in full within 120 days of this Order becoming final.

REASONS FOR PENALTY DECISION

The Panel is aware that joint submissions should be respected unless they fall so far outside the range of an appropriate sanction that they would bring the administration of justice at the College into disrepute or are otherwise contrary to the public interest. The Panel concluded that the jointly proposed penalty was appropriate in all circumstances of this case. It therefore accepted the Joint Submission and made an order in accordance with its terms.

The Panel concluded that the jointly proposed penalty was within the appropriate range for misconduct of this nature and meets the objectives of penalty, including public protection, general and specific deterrence, and rehabilitation. In arriving at this conclusion, the Panel considered the summaries of three previous decisions of this Discipline Committee in which suspensions of two and three months were ordered in cases involving similar allegations and circumstances.

The Panel was satisfied that the reprimand, suspension and the recording of the results of these proceedings on the College register will deter the Member from engaging in similar misconduct in the future and will also send a clear message to the profession that these matters will not be taken lightly by the College.

The terms, conditions and limitations set out in the penalty serve to protect the public as well as to rehabilitate the Member. Office monitoring at the Member's expense will serve to remediate the Member and to protect the public.

The aggravating factors considered by the Panel were the number of patients involved in the allegations and the Member's delay in sending complete records to the College. The Panel placed little weight on the Member's previous disciplinary history because the misconduct found in 1992 was not similar in

nature to the misconduct in this case, and there was a long interval (26 years) between the two hearings.

The Member's completion of continuing education courses prior to the hearing was a mitigating factor. In addition, the Member's admission of guilt and willingness to cooperate with the College through the Joint Submission with respect to Penalty and Costs demonstrated remorse and avoided a lengthy and more costly contested hearing.

In summary, the Panel was satisfied that the Joint submission meets the goals of penalty and falls within the reasonable range of penalties, and that its acceptance would not bring the administration of justice at the College into disrepute or otherwise be contrary to the public interest.

At the conclusion of the discipline hearing on July 31, 2018, the Panel administered a public, oral reprimand to the Member in accordance with paragraph 1 of the Panel's order. A copy of the reprimand is attached to these Reasons for Decision.

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

R. Hunter

Chairperson

Aug 14, 2018

Date

RCDSO v Dr. Julian D'Souza

Oral Reprimand delivered July 31, 2018

Dr. Julian D'Souza, 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 acts of professional misconduct. The misconduct related to four allegations as listed in the Notice of Hearing, exhibit 1.

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

Of special concern to us is the fact that the professional misconduct in which you engaged has involved providing unnecessary dental services and charging excessive fees that were excessive or unreasonable. You failed to keep records as required by the Regulations. You submitted an account or charge for dental services that you knew or ought to have known was improper.

A previous Discipline panel had hoped you would not appear before a panel again, but that has not been the case. This panel also is optimistic that this will be your last appearance before the Discipline Committee.

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

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

[*None stated.*]