H200003
H200004

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. JAMES MAO**, of the City of Thunder Bay, in the Province of Ontario;

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

AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

NOTICE OF PUBLICATION BAN

This is formal notice that on May 4, 2021, the panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario made an Order directing that no person shall publish or broadcast the identity of any patients of the Member, or any information that could disclose the identity of any patients who are named in the Notice of Hearing and/or the Agreed Statement of Facts in this matter.

This Order is made pursuant to subsection 45(3) of the *Code*.

Subsection 93(1) of the *Code* reads:

93(1) Every person who contravenes an order made under subsection 7(3) or Section 45 or 47, or who contravenes subsection 76(3), 82(2) or (3), 85.2(1), 85.5(1) or (2) or 85.14(2) or Section 92.1 is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than $50,000 for a first office and not more than $200,000 for a second or subsequent offence.

Dr. Richard Hunter, Chair
Discipline Panel

May 4, 2021
Date

H200003
H200004

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. JAMES MAO** of the City of **THUNDER BAY**, 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
Dr. Osama Soliman
Mr. Brian Smith

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Andrea Gonsalves
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Megan Shortreed
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. JAMES MAO	)	Michael Hargadon
	)	For Dr. James Mao

Hearing held by way of videoconference

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on May 4, 2021. This matter was heard electronically.

At the outset of the hearing, the College sought an order banning the publication of the names of patients, or any information that could be used to identify the patients, referred to in this matter. The Member consented to the request. The Panel granted the order, which extends to the exhibits filed, as well as to these reasons for decision.

THE ALLEGATIONS

The allegations against the Member were contained in two notices of hearing, both dated February 12, 2020.

The allegations set out in the first Notice of Hearing, H200003 (Exhibit 1), are as follows:

1. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015 to 2018, you contravened a federal, provincial or territorial law, municipal by-law or rule of a public hospital within the meaning of the *Public Hospitals Act*, relevant to the provision of dental care to the public, contrary to paragraph 50 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:
   - On May 18, 2018, in the Superior Court of Justice in Thunder Bay, Ontario, you pleaded guilty and were found guilty of one count of assault with a weapon, contrary to section 267(a) of the *Criminal Code of Canada*.
   - You committed the assault with a weapon on August 12, 2015, when you threatened [Person A], a staff member and patient, with a hypodermic needle.

2. You committed an act or acts of professional misconduct as provided by s. 51(1)(a) 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 2018, you were found guilty of an offence that is relevant to your suitability to practise.

Particulars:

- On May 18, 2018, you were found guilty of one count of assault with a weapon, contrary to section 267(a) of the *Criminal Code of Canada*, which is relevant to your suitability to practise in that you threatened [Person A], a staff member and patient, with a hypodermic needle at your dental office on August 12, 2015.

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 2015, you abused a patient, namely [Person A], contrary to paragraph 8 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On August 12, 2015, you threatened [Person A], a staff member and patient, with a hypodermic needle loaded with lidocaine solution when you felt that she had not performed her dental assisting duties correctly.
   - You caused [Person A] additional physical and emotional harm after you threatened her with a needle as she had to undergo treatment for exposure to possible HIV infection, the side effects of which are extremely physically unpleasant, because she did not know whether the needle had touched her and she did not know whether it was sterile.

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 2016, you failed to take reasonable steps to ensure that any information provided by you or on your behalf to the College was accurate, contrary to paragraph 57 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You knowingly provided inaccurate information to the College in a letter dated May 26, 2016, in which you denied threatening [Person A] with a hypodermic needle. However, on May 18, 2018, you admitted to having threatened [Person A] with a needle when you pleaded guilty to assault with a weapon in court.

5. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2015, 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 [Person A], contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars

   - On August 12, 2015, you threatened [Person A] with a hypodermic needle loaded with lidocaine solution.
   - You threatened to harm and/or yelled at [Person A], your staff member and patient, when you felt that she did not perform her dental assisting duties correctly.
   - You were untruthful in your communications with your regulator when you knowingly provided inaccurate information to the College in a letter dated May 26, 2016, in which you denied that you had threatened [Person A] with a hypodermic needle. However, on May 18, 2018, you admitted to having threatened Person A with a needle when you pleaded guilty to assault with a weapon in court.

The allegations set out in the second Notice of Hearing, H200004 (Exhibit 2), are as follows:

1. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015 to 2018, you contravened a federal, provincial or

territorial law, municipal by-law or rule of a public hospital within the meaning of the *Public Hospitals Act*, relevant to the provision of dental care to the public, contrary to paragraph 50 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- On May 18, 2018, in the Superior Court of Justice in Thunder Bay, Ontario, you pleaded guilty and were found guilty of two counts of assault with a weapon, contrary to section 267(a) of the *Criminal Code of Canada*, in relation to the following incidents:
  - On August 12, 2015, you threatened [Person A], a staff member and patient, with a hypodermic needle.
  - In or about the summer of 2014, you threatened [Person B], a staff member at your dental practice, with a hypodermic needle.

2. You committed an act or acts of professional misconduct as provided by s. 51(1)(a) 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 2018, you were found guilty of an offence that is relevant to your suitability to practise.

   Particulars

   - On May 18, 2018, you were found guilty of two counts of assault with a weapon, contrary to section 267(a) of the *Criminal Code of Canada*, which is relevant to your suitability to practise in that you threatened two persons, one of whom was a patient:
     - On August 12, 2015, at your dental office, you threatened [Person A], a staff member and patient, with a hypodermic needle.
     - In our about the summer of 2014, at your dental office, you threatened [Person B], a staff member at your dental practice, with a hypodermic needle.

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 2015, you abused a patient, namely [Person A], contrary to paragraph 8 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- On August 12, 2015, you abused a patient, [Person A], when you threatened her with a hypodermic needle loaded with lidocaine solution when you felt that she had not performed her dental assisting duties correctly.
- You caused [Person A] additional physical and emotional harm after you threatened her with a needle as she had to undergo treatment for exposure to possible HIV infection, the side effects of which are extremely physically unpleasant, because she did not know whether the needle had touched her and she did not know whether it was sterile.

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 2015, 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 [Person A], contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On August 12, 2015, you threatened [Person A], your staff member and patient, with a hypodermic needle loaded with lidocaine solution.
- In or about the summer of 2014, you threatened [Person B], your staff member, with a hypodermic needle.
- You threatened and/or were verbally abusive towards staff members, one of whom was also a patient:
    - You threatened to harm and/or yelled at [Person A], your staff member and patient, when you felt that she did not perform her dental duties correctly.
- You called [Person B], your staff member, inappropriate and offensive names such as “monkey” and “idiot.”

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct contained in the Notices of Hearing. The Member signed a written plea inquiry, which was entered into evidence at the hearing (Exhibit 3), and confirmed at the hearing that he understood the contents of the document. The Panel was satisfied that Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 4). Certain supporting documents were appended to the Agreed Statement of Facts. The Agreed Statement of Facts provides as follows (with references to the supporting documents omitted):

Background

1. Dr. James Mao (the "Member") has been registered with the College as a general dentist since 1996.

2. At the material times, Dr. Mao practised at his clinic, ABA Dental Clinic. The clinic had two locations in Thunder Bay, Ontario. He has since declared bankruptcy, and now practices there as an employee.

The Notices of Hearing

3. The allegations of professional misconduct against the Member are set out in two Notices of Hearing dated February 12, 2020.

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

Facts and Admissions

A. Overview

5. The alleged misconduct in both Notices of Hearing relates Dr. Mao's interactions with two staff members, [Person A] and [Person B], which led to a criminal finding of guilt on two counts of assault with a weapon. [Person A] was also a patient

of Dr. Mao, although the conduct occurred when she was acting as an employee.

6. In the summer of 2014, Dr. Mao threatened [Person B] with a hypodermic needle loaded with lidocaine solution when he felt that she had not performed her dental assisting duties correctly. On August 12, 2015, Dr. Mao threatened [Person A] with a hypodermic needle loaded with lidocaine solution when he felt that she had not performed her dental assisting duties correctly. He also threatened harm to these staff members and called them names during the course of their employment.

7. On May 26, 2016, Dr. Mao denied that he had threatened [Person A] in correspondence to the College. However, on May 18, 2018, Dr. Mao pled guilty and was found guilty of assault with a weapon for this conduct.

B. Complaint, Report and Investigation

8. The facts giving rise to the allegations of professional misconduct came to the attention of the College when it received a complaint from [Person A] in April 2016.

9. She alleged that on August 12, 2015, Dr. Mao had yelled at her and threatened her with a hypodermic needle with lidocaine in it, after he felt she had not suctioned a patient sufficiently. Dr. Mao then fired her. She did not know if the needle was sterile or if it had touched her, and she underwent HIV-preventative treatment. She also contacted the police.

10. At the time, [Person A] did not mention that she was also a patient of Dr. Mao. She had received some cleanings and check-ups from him.

11. Dr. Mao provided a response to the complaint to the College dated May 26, 2016. In it, he stated that he terminated [Person A] from her position as a dental assistant after she failed to rinse the mouth of a patient after he had administered local anesthetic to the patient. He denied threatening her with a needle or raising his voice to her. He submitted that he had not breached any standards of practice and that the ICRC did not

have jurisdiction to hear the complaint because it involved labour relations and not patient care.

12. The police investigated [Person A]'s allegation. In the course of that investigation, the police located [Person B]. The College obtained the Crown Brief disclosed in the criminal proceedings. It includes a witness statement of [Person B] prepared by the Thunder Bay police, in which [Person B] described a similar incident with a hypodermic needle during her employment with Dr. Mao. She also stated that Dr. Mao called her names like "monkey" and "idiot".

13. The College investigated [Person A]'s complaint and also initiated a s. 75(1)(a) investigation.

14. In addition to his letter of May 26, 2016, Dr. Mao responded to the allegations for both the complaint and report, by letter to the ICRC dated August 20, 2019. In response, Dr. Mao stated that he had pled guilty, had received counselling, was remediated, and sought a caution or other regulatory response short of referral.

15. In December 2019, the ICRC formed the intention to refer allegations. Dr. Mao made no further submissions.

16. On January 23, 2020, the ICRC referred the allegations set out in H200003 and H200004.

C. Criminal Convictions

17. On June 30, 2016, Dr. Mao was charged with four criminal charges. He was charged with two counts of assault with a weapon (in respect of his interactions with [Person A] and [Person B] respectively) and two counts of administration of a destructive or noxious substance with an intent to annoy. He was later indicted on these charges.

18. On May 18, 2018, Dr. Mao pled guilty to the two counts of assault with a weapon. The other charges were withdrawn.

19. As part of the guilty plea, Dr. Mao and the Crown agreed to an agreed statement of facts which was read into the record. Dr. Mao subsequently provided a copy of the agreed statement of facts to the College.

20. The agreed statement of facts sets out the incident with [Person A], as follows:

> 4. [Person A], whose date of birth is [...], commenced working at ABA in June of 2015. She was hired to be a receptionist. She soon began working as a dental assistant to Doctor Mao. She had no employment background as a dental assistant prior to working with Doctor Mao.
>
> 5. On August 12, 2015 [...] [w]hile in the course of injecting the patient with local anaesthetic, Doctor Mao requested that [Person A] provide suction to remove any excess anaesthetic. This is because the anaesthetic used, lidocaine, tastes bitter and causes the tongue to tingle.
>
> 6. [Person A] did not do so to Doctor Mao's satisfaction and he became angry with her. She was asked to leave the procedure and was replaced by another assistant.
>
> 7. [Doctor Mao] directed her to leave the examination room and go with him to the employee break room in the back of the facility.
>
> 8. He told her that because she did not seem to understand why suctioning the anaesthetic was important, she would have to taste it herself.
>
> 9. He directed her to sit in a chair and open her mouth. She did so. She closed her eyes.
>
> 10. He approached her with a hypodermic needle that had been loaded with lidocaine solution. His intention was to deposit some of the solution on her tongue.
>
> 11. As he approached her mouth with the needle, [Person A] opened her eyes. She realized that he was in fact serious about administering this anaesthetic to her. She became alarmed, she

believed he was going to inject her with the anaesthetic. She told Doctor Mao to stop, and immediately got up from the chair.

12. In response, Doctor Mao advised her that her employment was terminated. She left the clinic immediately.

13. She spoke with her parents, who contacted police. She then attended the hospital, as she was unsure if she had been touched with the needle and if the needle was clean.

14. She had not been touched with the needle. The needle and solution were both clean and sterile. However, [Person A] was not aware of whether the needle was the same one that had been used on the patient or not, as Doctor Mao had left her for a moment.

15. As she did not know whether she had in fact been touched by the needle or whether or not the needle was sterile, she underwent prophylactic measures for HIV [...].

21. The agreed statement of facts includes the following in respect of [Person B]:

19. [Person B], whose date of birth is [...], was an employee of Doctor Mao at ABA Dental from June, 2014 to May, 2015. She was hired as a receptionist at the Memorial Avenue location after applying to a Kijiji ad. She was also required to do work outside of her hired duties such as construction and renovation work at the Red River location, which was being prepared for opening. She was also put in the role of dental assistant to Doctor Mao.

20. In the summer of 2014, [Person B] assisted Doctor Mao as he performed a procedure on a patient. This involved the administration of local anaesthetic by Doctor Mao. [Person B] was directed by Doctor Mao to suction up the excess anaesthetic. [Person B] did not do this to Doctor Mao's satisfaction.

21. Once the procedure was complete, Doctor Mao directed [Person B] to join him in the break room at the clinic.

22. He told her that the anaesthetic was bitter, and that she had not suctioned it property and that she would have to taste it to understand why proper suctioning was important.

23. He produced a loaded syringe, he directed her to open her mouth. She refused. He told her that if she continued to refuse she would lose her job, so she complied.

24. He deposited a small quantity of local anaesthetic on her tongue by squirting it into her mouth. There was no physical contact between her and the needle.

25. The needle was sterile, but [Person B] was not aware of this.

22. In the course of his guilty plea, Dr. Mao read a letter of apology to [Person A] and [Person B]. He acknowledged that his methods of training employees were inappropriate and amounted to a criminal act. His counsel also advised the court that Dr. Mao has had discussions with an employment lawyer on appropriate training and that Dr. Mao was receiving psychological counselling and completing a workplace violence training program.

23. Based on a joint submission, Dr. Mao received a conditional discharge and probation for 12 months and other statutory conditions, including: no contact with the staff members, keeping the peace, attending counselling as required by probation officer, firearms prohibition, victim surcharge fine, and providing a DNA sample.

D. Professional Misconduct

24. The Member admits that he pleaded guilty to and was found guilty of two counts of assault with a weapon, contrary to section 267(a) of the *Criminal Code of Canada*. He acknowledges that this criminal conduct directed towards staff members and a patient of his dental clinic was relevant to the provision of dental care to the public as well as his suitability to practise dentistry.

25. As such, he admits that he contravened a federal, provincial or territorial law relevant to the provision of dental care to the

public, contrary to paragraph 50 of Section 2 of the Dentistry Act Regulation, and therefore, engaged in professional misconduct as set out in Allegation 1 in both Notices of Hearing.

26. Further, the Member admits that he was found guilty of two criminal offences relevant to his suitability to practise, contrary to s. 51(1)(a) of the Code, and therefore, engaged in professional misconduct as set out in Allegation 2 in both Notices of Hearing.

27. The Member's conduct toward [Person A] not only threatened her with a needle, he also caused her physical and emotional harm as she had to undergo treatment for exposure to possible HIV infection, the side effects of which are extremely physically unpleasant, because she did not know whether the needle had touched her and she did not know whether it was sterile. As such, the Member admits that he abused a patient, contrary to paragraph 8 of Section 2 of the Dentistry Act Regulation, and therefore, engaged in professional misconduct as set out in Allegation 3 in both Notices of Hearing.

28. When the Member knowingly provided inaccurate information to the College in May 2016, specifically denying that he threatened [Person A] with a needle, he admits that he failed to take reasonable steps to ensure that any information provided by him to the College was accurate, contrary to paragraph 57 of Section 2 of the Dentistry Act Regulation, and therefore, engaged in professional misconduct as set out in Allegation 4 in Notice of Hearing H200003.

29. The Member admits that he threatened two staff members with a needle, was verbally abusive toward them, and provided untruthful information to the College. In doing so, he engaged in conduct or performed acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonorable, unprofessional or unethical, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, and therefore, engaged in professional misconduct as set out in Allegation 5 of Notice of Hearing H200003 and Allegation 4 of Notice of Hearing H200004.

Past History

30. Dr. Mao has had several complaints against him. The ICRC has ordered Dr. Mao to complete two SCERPs, provided three letters of caution or advice, and one suggestion as part of a decision to take no action, as summarized below.

1. C09025E dated December 14, 2009. Complaint filed January 2009.

Complaint from the First Canadian Health Management, the claims processor for Health Canada's Non-Insured Health Benefits Program raising concerns with the accuracy of claims submitted by Dr. Mao between October 3, 2006 and October 2, 2008 for 82 patients.

No further action was taken. However, "The panel members suggest that Dr. Mao ensure that the procedure codes used accurately reflect the treatment provided and that the chart entries be noted in greater detail."

2. C120067A dated July 11, 2013. Complaint filed April 30, 2012.

Patient alleged that Dr. Mao failed to provide her with her full set of dental records despite repeated requests; damaged her gums in the upper right following root canal therapy; created a gap between the root canal treated tooth and the adjacent tooth; and informed her that the root canal treated tooth had a cracked root and needed to be extracted.

The panel offered to accept an undertaking from Dr. Mao to complete a course in endodontics, which Dr. Mao declined to provide.

The panel ordered a SCERP with a course in endodontics, retaining a mentor (for an unspecified period of time), and 24 months of monitoring. The panel was concerned that the member failed to adequately consider the complainant's poor periodontal condition and its effect on the possibility for successful restoration of tooth 16 prior to embarking on root canal therapy, and failed to adequately consider the need for a temporary

protection of the tooth following the root canal. It was also concerned that he recommended extraction when a re-treatment was an option.

The panel also reminded Dr. Mao to provide patient records within a reasonable timeframe of a patient's request for records.

3. G150077S dated August 15, 2017. Registrar's investigation commenced in November 2015.

A former staff member (not [Person A] or [Person B]) called the College and disclosed concerns with the cleaning and sterilization of implant equipment, particularly around cleaning instruments used to drill bone for the placement of implants. The caller stated that the office has had a number of implants fail and Dr. Mao had the office re-evaluate and re-clean the implant equipment. The implants are now all packaged separately and there is a specialized implant kit with drills. The caller stated that the implant kit contains roughly twenty different bits and that the staff members were putting the bits back in the kit to be sterilized without cleaning the bits that were used. The kit was then wrapped and sterilized.

The panel issued a letter of caution in respect of daily spore testing.

4. C160465S dated April 16, 2019. Complaint filed on August 15, 2016.

The Non-Insured Health Benefits Program filed a complaint about the accuracy of the claims Dr. Mao submitted, including but not limited to the date of service, the appropriateness of the procedure code used to reflect the service rendered, and appropriate documentation supporting and reflecting the service rendered. Proceed by way of a Registrar's investigation.

The panel ordered a SCERP with a recordkeeping course and 24 months of monitoring. The panel noted that in 2009, a panel had advised him to ensure procedure codes were accurately used, but Dr. Mao's records regarding extractions were inadequate.

5. C170026U dated May 2, 2019. Complaint filed on January 16, 2017.

Patient complained that Dr. Mao refused to continue with the extraction of her tooth after half of the work had been completed; was unfriendly, short-tempered and rude to her and his employees; told her that she obviously had been "traumatized as a child"; and caused her to experience throbbing cheek pain for at least three weeks following the extraction.

Dr. Mao denied the allegations and provided a statement from an employee that corroborated his position.

The panel issued a letter of caution: Before initiating treatment, Dr. Mao must ensure that he has obtained the patient's informed consent to treatment. As part of that process, the patient must be provided with all of the sedation options. Dr. Mao should keep a detailed record of the nature of the conversation, the information provided, and the patient's decision.

6. C180118F dated October 10, 2019. Complaint filed February 12, 2018.

Patient complained that Dr. Mao increased his fees at the start of a new year and would not honour his previous year’s fees, Dr. Mao did not answer his questions about IV sedation, Dr. Mao sought predeterminations without prior discussion with patient, and Dr. Mao was unprofessional, rude and a "crook".

Dr. Mao denied the allegations. He said the patient was making false and defamatory reviews online, which the patient denied.

The panel concluded that raising fees was not inappropriate, it was unable to determine the divergent issues around the IV sedation discussion, and Dr. Mao should make a diagnosis before sending predeterminations to the insurer.

On October 10, 2019, the panel issued advice and recommendations to Dr. Mao. Dr. Mao applied to HPARB for a review and HPARB ordered the panel to reconsider its decision. The panel did so, and again issued advice and recommendations to Dr. Mao on November 16, 2020, as follows: that if Dr. Mao

intends to recommend to a patient that the patient pursue orthodontic treatment including Invisalign, and if Dr. Mao intends to submit insurance pre-determinations for such services, it would be prudent for Dr. Mao to first do a thorough orthodontic workup and to have a detailed discussion with the patient about his diagnosis and recommendations, and to record these details in the patient's chart, so that the patient understands the rationale for the insurance predetermination.

General

31. Dr. Mao admits that the acts described above at paragraphs 1 through to 29 constitute professional misconduct and he now accepts responsibility for his actions and the resulting consequences.

32. Dr. Mao has had the opportunity to take independent legal advice with respect to his admissions, and was represented in these proceedings by Scott Fenton until the termination of Mr. Fenton's retainer on January 8, 2021 and by Michael Hargadon from and after March 2021.

DECISION

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

REASONS FOR DECISION

The Member admitted to the allegations set out in the Notices of Hearing and he accepted the facts presented in the Agreed Statement of Facts.

The Member pleaded guilty. He did not dispute the allegations, particulars or the facts presented in the Agreed Statement of Facts submitted by College counsel.

The Panel concluded that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations and demonstrates the Member's lack of sensitivity to his office staff and patients.

In particular, Dr. Mao admits to:

- Abusing two staff members—one whom was a patient—by threatening them with a weapon and calling them names.
- Having been found guilty in criminal court on two counts of assault with a weapon.
- Knowingly providing inaccurate information to the ICRC in the course of its investigation when he denied that he had threatened Person A with a needle and denied that he had breached the standards of practice.
- Contravening a federal, provincial or territorial law relevant to the provision of dental care to the public.

In light of Dr. Mao's admissions and the clear misconduct described in the Agreed Statement of Facts, the Panel unanimously found Dr. Mao guilty of professional misconduct as set out in the nine allegations contained within the two Notices of Hearing. With respect to allegation #5 in Notice of Hearing H200003 and allegation #4 in Notice of Hearing H200004, the Panel found that the Member's conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional and unethical.

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission on Penalty and Costs (Exhibit 5), which requested that the Panel make an order as follows.

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

2. Directing the Registrar to suspend the Member's certificate of registration for a period of five (5) months. The suspension shall commence on the date of this Order becoming final, and shall run without interruption.

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

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

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

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

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

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

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

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

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

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

ii. giving orders or standing orders to dental hygienists

iii. supervising work performed by others

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

v. acting as a clinical instructor;

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

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

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

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

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

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

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

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

a. the Member shall successfully complete, at his own expense, the ProBE Program for Professional/Problem-Based Ethics, to be completed with "unconditional pass" grade within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

b. the Member's practice shall be monitored by the College by means of periodic inspection(s) by a representative or representatives of the College at such time or times and in such manner as the College may determine, during the twenty-four (24) months following the date he returns to practice following the suspension in paragraph 2 above. The inspection(s) will focus on the Member's anger management issues and staff training, to ensure safety of staff and patients, and may include interviews staff;

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

d. the representative or representatives of the College shall report the results of the inspections 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;

e. the Practice Conditions imposed by virtue of clause (a) of paragraph 4 shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the course has been completed successfully; and

f. the Practice Conditions imposed by virtue of clauses (b)-(d) of paragraph 4 shall be removed from the Member's certificate of registration 24 months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clauses (b)-(d) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports

Committee that the Member has successfully completed the monitoring program, whichever date is later.

5. The Member shall pay costs to the College in the amount of $15,000.00, within 30 days of the Order becoming final.

PENALTY DECISION

The Panel accepted the Joint Submission on Penalty and Costs, and ordered that:

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

2. The Registrar is directed to suspend the Member's certificate of registration for a period of five (5) months. The suspension shall commence on the date of this Order becoming final, and shall run without interruption.

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:

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

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

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

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

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

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

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

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

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

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

   ii. giving orders or standing orders to dental hygienists

   iii. supervising work performed by others

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

   v. acting as a clinical instructor;

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

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

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

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

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

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

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

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

a. the Member shall successfully complete, at his own expense, the ProBE Program for Professional/Problem-Based Ethics, to be completed with "unconditional pass" grade within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

b. the Member's practice shall be monitored by the College by means of periodic inspection(s) by a representative or representatives of the College at such time or times and in such manner as the College may determine, during the twenty-four (24) months following the date he returns to practice following the suspension in paragraph 2 above. The inspection(s) will focus on the Member's anger management issues and staff training, to ensure safety of staff and patients, and may include interviews staff;

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

d. the representative or representatives of the College shall report the results of the inspections 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;

e. the Practice Conditions imposed by virtue of clause (a) of paragraph 4 shall be removed from the Member's certificate of registration upon

receipt by the College of confirmation in writing acceptable to the Registrar that the course has been completed successfully; and

f. the Practice Conditions imposed by virtue of clauses (b)-(d) of paragraph 4 shall be removed from the Member's certificate of registration 24 months following receipt by the College of confirmation in writing acceptable to the Registrar that the requirements set out in clauses (b)-(d) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

5. The Member shall pay costs to the College in the amount of $15,000.00, within 30 days of the Order becoming final.

REASONS FOR PENALTY DECISION

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

The Panel was satisfied that the reprimand and five-month suspension, the fact of which will be made public on the College's register, will act as both a specific deterrent for the Member and as a general deterrent for the membership at large. These terms send a clear message to the profession that rude, abusive and threatening behaviour towards office staff and patients will not be tolerated by the College.

The imposition on the Member's certification of registration of the specified terms, conditions and limitations also serve to protect the public. While under suspension, Dr Mao must not engage in the practice of dentistry. Prior to or within one month of his return to the practice, he is required to take and successfully complete a course in ethics (ProBE). In addition, once he returns to practice, the Member's office will be monitored for 24 months to ensure that he is meeting professional standards, in particular for his anger management issues and staff training. These terms serve the objective of rehabilitation of the Member.

When considering the appropriateness of the penalty, the Panel considered both aggravating and mitigating factors. The Panel was satisfied that the Joint Submission on Penalty and Costs is fair and reasonable.

The aggravating factors in this case include the seriousness of the misconduct affecting the two staff members, one of which was also Dr. Mao's patient. These victims were young, vulnerable women and Dr. Mao was in a position of power as their employer and, in the case of Person A, her dentist. The Member's conduct has caused them physical and emotional harm.

As mitigating factors, the Panel notes that the Member admitted to the allegations of misconduct and entered into an Agreed Statement of Facts with the College, which eliminated the need for a more drawn out and costly hearing. The Panel also considered as a mitigating factor that Dr. Mao completed "Anger Management" therapy in advance of this hearing.

The Panel accepted the costs as appropriate in this case.

THE REPRIMAND

At the conclusion of the discipline hearing, the panel delivered the reprimand to the Member. A copy of the reprimand is attached as Appendix "A" to these Reasons.

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

May 10, 2021

Dr. Richard Hunter — Date

Appendix “A”

RCDSO v. DR. JAMES MAO

Dr. Mao, as you know, this Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the seriousness of your misconduct.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found that you have engaged in multiple acts of professional misconduct. The misconduct related to threatening and abusive behaviour towards two employees, one of whom was also a patient. These individuals were vulnerable young women and you were in a position of authority over them, creating a power imbalance. Your conduct resulted in emotional trauma to both of these individuals. You also misled the College by providing inaccurate information about what had occurred with one of the individuals.

The cumulative effect of your conduct would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

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

Of special concern to us is the fact that the professional misconduct in which you engaged has involved a pattern of unacceptable treatment of your staff, and rude and unbecoming behaviour relating to your patient.

We trust the suspension will give you time to reflect on your conduct as a professional. We expect that when you return to practice you will maintain the high standards that the public and the College expect of members of the profession.