DISCIPLINE COMMITTEE
OF THE COLLEGE OF DENTURISTS OF ONTARIO

PANEL: Hanno Weinberger, Chairperson
Anita Kiriakou, Public Member
Patrick McCabe, Professional Member
Bruce Selinger, Professional Member
Eugene Cohen, Professional Member

BETWEEN:

COLLEGE OF DENTURISTS OF ONTARIO	)	MARK SPECTOR for College of Denturists of Ontario
- and -	)	PIERRE CHAMPAGNE for Yasong Chen
YASONG CHEN	)	
	)	LUISA RITACCA Independent Legal Counsel
	)	Heard: February 1 & 2, 2016

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on February 1 & 2, 2016 at Victory Verbatim in Toronto, Ontario.

The Allegations

The allegations against Yasong Chen (the "Member") as stated in the Notice of Hearing dated July 17, 2015 are as follows.

IT IS ALLEGED THAT:

1. Yasong Chen is a registered denturist in Ontario.

2. At the material times, Mr. Chen practised denturism at two clinics he operated in Markham, Ontario and in Scarborough, Ontario.

Unlawfully Holding Himself Out as a **"Doctor" and a "Dentist"**

3. Mr. Chen is not a member of a regulated health profession in Ontario that is allowed to use the title, "doctor", in the course of providing or offering to provide health care to individuals.

4. Mr. Chen is also not and, at all material times, was not a member of the Royal College of Dental Surgeons of Ontario.

5. Mr. Chen displayed certificates in his clinics for courses in dentistry identifying Mr. Chen as "doctor" described himself to the College's investigator as an "international dentist"; and allowed many of his patients and staff to refer to him as "doctor".

6. In order to solicit new patients, Mr. Chen also advised Helen C in approximately August 2012 that he was a specialist in dentistry and that he could perform any dental treatments her family required.

7. By holding him self out as a "doctor"' or a person qualified to practice dentistry, Mr. Chen engaged in professional misconduct pursuant to paragraph 2 (failing to maintain a standard of practice); paragraph 10 (making a misrepresentation to a patient) ; paragraph 18 (using an unauthorized term, title or designation); paragraph 33 (contravening the *Denturism Ac*t; 1991, the *Regulated Health Professions Act*, 1991 or the regulations under either of them); and/or paragraph 47 (disgraceful, dishonourable or unprofessional conduct); of section 1 of Ontario Regulation 854/93, as amended, under the *Denturism Act*, 1991.

Performing Unauthorized Controlled Acts

8. Mr. Chen performed numerous controlled acts that he was not authorized to perform. In particular, Mr. Chen:

   a) replaced a bridge, scaled teeth, applied or ordered x-rays and repaired a cavity after injecting approximately five needles into a patient's gums, Helen C., between approximately December 20 12 and approximately February 2013;

   b) extracted a wisdom tooth, applied or ordered x-rays, performed a bone graft and sutured the wound after injecting approximately three needles into a patient's gums, Kenny C, between approximately December 2012 and January 2013;

   c) repaired a cavity after injecting needles into a patient's gums, Daniel C, in approximately August 2012;

   d) repaired a cavity after injecting needles into a patient's gums, Eric C, in approximately November 2012;

e) extracted two wisdom teeth, sutured the wounds and repaired cavities after injecting needles into a patient's gums, Kun T, between approximately August 2012 and October 2012;

f) extracted a tooth, performed a bone graft and sutured the would after injecting need les into a patient's gums, Jian W, in approximately March 2013;

g) extracted teeth and sutured the wounds after injecting needles into a patient's gums, Yan X, between approximately January 2013 and February 2013; and/or

h) Performed similar procedures involving, among other things, extracting wisdom teeth, applying or ordering x-rays, injecting needles into gums, bone grafting, repairing cavities, scaling and suturing on other patients.

9. As a result of the procedures Mr. Chen had performed, many of his patients suffered from excessive bleeding, pain, inflammation discoloured gums, infection and were unable to eat properly. They had to consult with properly registered dentists to correct Mr. Chen's work and/or alleviate their symptoms.

10. By performing controlled acts that he was not allowed to perform on patients, and injuring those patients, Mr. Chen engaged in professional misconduct pursuant to paragraph 2 (failing to maintain a standard of practice); paragraph 4 (abusing a patient physically); paragraph 10 (making a misrepresentation to a patient); paragraph 14 (failing to refer to a dental surgeon or a physician a patient who has a condition outside the scope of denturism); paragraph 33 (contravening the Denturism Act, 1991, the Regulated Health Professions Act, 1991 or the regulations under either of them) and/or paragraph 47 (disgraceful, dishonourable or unprofessional conduct)*; of section 1 of Ontario Regulation 854/93, as amended, under the Denturism Act, 1991.

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*Paragraph 47 of section 1 of *Ontario Regulation 854/93* provides in part that it is professional misconduct for a Member to engage in conduct or performing an act, relevant to the practice of denturism that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unethical or unprofessional. The parties confirmed through Independent Legal Counsel that allegations against the Member regarding paragraph 47 included an allegation of "unethical" conduct, although that is not specifically mentioned in the parenthesis at paragraph 10 and 12 of the *Notice of Hearing*.

False or Misleading Billing Practices

11. Between approximately October 2010 to approximately July 2013, Mr. Chen issued and/or ordered his staff to invoice or bill on his behalf at least 967 false or misleading charges totalling at least approximately $96,979.49:

a) including at least 185 charges totalling approximately $15,988.10 showing that patients had received dental treatments from Dr. Huai-Chen (Jenny) Hsu, a registered dentist,

after she had left Mr. Chen's clinic on approximately October 17, 2012, as set out in Schedule "A; and

b) including at least 782 charges totalling approximately $80, 991.39 showing that patients had received dental treatments from Dr. Saina Aliakbarrad, a registered dentist, even though she did not do so, as set out in Schedule "B".

12. For each of these reasons, Mr. Chen engaged in professional misconduct pursuant to paragraph 2 (failing to maintain a standard of practice); paragraph 20 (falsifying a record); paragraph 22 (signing or issuing a false or misleading document); paragraph 24 (submitting an account or charge for services that is false or misleading) ; paragraph 33 (contravening the *Denturism Act*, 1991, the *Regulated Health Professions Act*, 1991 or the regulations under either of them); and/or paragraph 47 (disgraceful, dishonourable or unprofessional conduct); of section 1 of Ontario Regulation 854/93i as amended, under the *Denturism Act*, 1991.

Misleading the College and Failing to Cooperate with its Investigation

13. Mr. Chen misled the College when he advised the College's investigator in approximately September 2013 that:

a) he had only performed work related to dentures;

b) he had not performed or billed for dental work on Helen C or Kenny C;

c) he could not locate the dental records for Kenny C because Mr. Chen did not treat him;

d) Helen C or Kenny C may have mistaken him for a registered dentist by the name of "Dr. Shan"; and

e) he had not prepared false and/or misleading receipts/invoices showing work performed by Dr. Hsu or Dr. Aliakbarrad.

14. Further, in approximately October 2013 the College's investigator asked Mr. Chen to provide him with information and documents regarding:

a) deposits made into Mr. Chen's bank accounts for dental work Dr. Hsu purportedly performed on Helen C. and Kenny C. amongst others; and

b) exchanges between Mr. Chen and Helen C.'s and Kenny C.'s insurance company relating to any cheques/payments that had been payable to Dr. Hsu for the work Dr. Hsu had purportedly performed on them.

15. Mr. Chen has failed or refused to do so.

16. By misleading the College and failing to provide the College with information and documents it had requested, Mr. Chen obstructed the College's investigator contrary to sub-

section 76(3) of the *Code*, and failed to cooperate fully with the College contrary to subsection 76(3.l) of the *Code*.

17. For each of these reasons, Mr. Chen thereby engaged in professional misconduct pursuant to paragraph 2 (failing to maintain a standard of practice); paragraph 33 (contravening the *Denturism Act,* 1991, the *Regulated Health Professions Act,* 1991 or the regulations under either of them); paragraph 43 (failing to ensure that information provided to the College is accurate); paragraph 44 (failing to reply appropriately within thirty days to written communication from the College requesting a response) and/or paragraph 47 (disgraceful, dishonourable or unprofessional conduct); of section 1 of Ontario Regulation 854/93, as amended, under the *Denturism Act, 1991.*

Counsel for the College advised the panel that it would be seeking to withdraw two (2) of the allegations contained in paragraph 17 of the Notice of Hearing (*Exhibit #1*), specifically paragraph 43 (failing to ensure that information provided to the College is accurate) and paragraph 44 (failing to reply appropriately within thirty days to written communication from the College requesting a response). The Member consented to the request to withdraw these allegations.

Member's Plea

The Member acknowledged that he had engaged in professional misconduct as set out in the allegations contained in the Notice of Hearing and as refined by the Agreed Statement of Facts (*Exhibit #2*). A plea inquiry was conducted to confirm that the Member's admission was voluntary, informed and unequivocal. The panel was satisfied that the Member's plea was voluntary, informed and unequivocal.

Overview

The panel was provided with an Agreed Statement of Facts (*Exhibit #2*), which contained the details of the Member's misconduct. The panel has not reproduced the Agreed Statement of Facts in its entirety in these reasons. In brief, Yasong Chen became a member of the College in 2009. Approximately one year after graduating from George Brown College and for a period of approximately 2 1/2 years, the Member provided services to patients outside his scope of practice. During that period of time, the Member practised acts of dentistry on multiple patients. The Member admitted that some of the dental procedures he performed included extracting wisdom teeth, injecting needles into gums, bone grafting, repairing cavities and suturing. Two of the patients he treated, one adult and one child, suffered harm and pain after developing infections that the Member failed to recognize and/or deal with in a timely and appropriate manner.

The Member held himself out to patients, staff and colleagues as a "doctor" or a person qualified to practise dentistry. For example, Mr. Chen displayed certificates in his clinics identifying himself as "Dr. Chen".

While providing these dental services during the above time period, the Member submitted 911 false or misleading claims to insurance companies. These 911 false or misleading claims totalled approximately $91,831.49 and represented numerous patients. Further, in order to be reimbursed for these false or misleading claims, the Member used the identity of two (2) dentists who were working or had previously worked in his clinic.

The panel accepted the facts as outlined in the Agreed Statement of Facts and made a finding that the Member had conducted acts of professional misconduct.

Decision

Having considered the evidence admitted, the onus and standard of proof, the panel finds that the Member committed acts of professional misconduct. In particular, the panel finds that Mr. Chen is guilty of professional misconduct pursuant to paragraph 2 (failing to maintain a standard of practice); paragraph 10 (making a misrepresentation to a patient); paragraph 14 (failing to refer to a dental surgeon or a physician a patient who has a condition outside the scope of denturism); paragraph 18 (using an unauthorized term, title or designation); paragraph 22 (signing or issuing a false or misleading document); paragraph 24 (submitting an account or charge for services that is false or misleading); paragraph 33 (contravening the *Denturism Act, 1991,* the *Regulated Health Professions Act, 1991* or the regulations under either of them); and, paragraph 47 (disgraceful, dishonourable, unethical or unprofessional conduct); of section 1 of Ontario Regulation 854/93, as amended, under the *Denturism Act*, 1991, S.O.1991, c.25.

Specifically, the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable, unethical and unprofessional by: misrepresenting himself to patients, staff and colleagues as a dentist; practising outside his scope of practice for a period of approximately 2 1/2 years; causing physical harm to two (2) patients, in the form of prolonged infection; and, using the identity of two (2) dentists in order to submit 911 false or misleading claims to insurance companies.

Reasons for Decision

The Member acknowledged that he engaged in acts of professional misconduct by: failing to maintain a standard of practice; making a misrepresentation to a patient, failing to refer to a dental surgeon or a physician a patient who has a condition outside the scope of denturism; using an unauthorized term, title or designation; signing or issuing a false or misleading document; submitting an account or charge for services that is false or misleading; contravening the *Denturism Act, 1991,* the *Regulated Health Professions Act, 1991* or the regulations under either of them; and, disgraceful, dishonourable, unethical or unprofessional conduct.

The panel found that approximately one year after graduating from George Brown College and for a period of approximately 2 1/2 years, the Member practised outside his scope of practice. During that period of time, the Member practised acts of dentistry on multiple patients (*Exhibit #2*, paragraphs 16, 37, 38 and 42). The dental procedures performed by the Member consisted of extracting wisdom teeth, applying or ordering x-rays, injecting needles into gums, bone grafting, repairing cavities, scaling, suturing and providing pills for pain. Two (2) of the patients he treated, one adult and one child developed infections that the Member failed to recognize and/or deal with in a timely and appropriate manner. Ultimately, the Member consulted with and brought the adult and child patients to a registered dentist and a paediatric dentist respectively in order to alleviate the situation.

The Member held himself out as a "doctor" or a person qualified to practise dentistry. Mr. Chen displayed certificates in his clinics identifying himself as "Dr. Chen" (*Exhibit #2,* Tab C) and issued cheques to colleagues with the header "Dr. Yasong Chen and Associates Toronto Dental Services" (*Exhibit #2,* Tab B).

While providing these dental services, the Member submitted 911 false or misleading claims to insurance companies. These 911 false or misleading claims totalled approximately $91,831.49 and represented numerous patients (*Exhibit #2*, paragraph 44 and Tabs AA and BB). Further, the Member used the identity of two dentists who had worked or were working in his clinic in order to receive payment for these false or misleading claims.

For the panel, the sheer numbers associated with the Member's professional misconduct were staggering. The panel was gravely concerned by the number of dental services provided, all outside of the Member's scope of practice, to multiple patients, including vulnerable children, for a period of approximately 2 1/2 years. By providing dental services, outside of a denturist's scope of practice, and within approximately one (1) year after graduating from George Brown College, the Member displayed a blatant disregard for the well-being of his patients. The panel noted, that in at least two (2) cases, complications, in the form of prolonged infections, did in fact occur.

Of further concern to the panel was the numbers associated with the false or misleading claims submitted to the insurance companies. Without their knowledge, the Member used the identity of two (2) dentists to submit 911 false or misleading claims, representing numerous patients and totalling approximately $91,831.49.

For the panel, these acts of professional misconduct, and the attendant numbers, are egregious.

Penalty

At the penalty phase of the hearing, the panel received one affidavit from the College and heard from the Member and two witnesses, called on his behalf.

Witness #1 - the Member.

During the examination in chief, the panel heard from the Member that he was born and raised in China. He explained that Mandarin was his first language and that he arrived in Canada in 2000.

The Member informed the panel that he had graduated from a five year dental program in China in 1992 and had worked as a dentist for three years before taking specialized training in oral surgery in 1995. The Member stated that he worked on surgical cases in China from 1997 to 2000, prior to moving to Canada.

In 2009, he graduated as a denturist from George Brown College and was employed as an instructor (at George Brown) for one (1) year following his graduation. Since that time, the Member has been practising denturism in three (3) different clinics across the GTA.

With respect to the misconduct in this case, the Member offered his apologies to the panel, the College and the profession.

The Member told the panel that he had tried to make amends to the two (2) families who were harmed by his conduct.

In the case of HC and her family, the Member informed the panel that he had apologized to HC and offered to pay to have her teeth fixed. He testified that he gave HC two (2) cash payments, totalling $5,000.

In the WC and family matter, the Member told the panel that he had apologized to WC in her driveway and gave her $1,000 in cash. As well, the Member brought WC and her son to a paediatric dentist and paid for the services that were provided to WC's son.

The Member also filed two (2) draft apology letters he wrote to HC, WC and their families (*Exhibit #4,* Tabs 10 and 11). The Member assured the panel that both letters would be mailed at the conclusion of this hearing.

The Member also testified that since October 2013, he has only been working as a denturist. He told the panel that he has taken steps to change the misleading letterhead on his cheques and to remove the certificates in his office referring to himself as "Dr. Chen".

Further, Member's Counsel presented the panel with a draft mentoring and monitoring agreement (*Exhibit #4,* Tab 12) the Member would be prepared to undertake with Evie Jesin (RRDH, B.Sc., Educator) at the conclusion of this matter. This draft agreement was presented to assure the panel and the College that the Member had seen the error of his ways and was taking the appropriate steps toward his remediation.

Member's Counsel also presented a draft of a sworn undertaking, with the College of Denturists of Ontario (*Exhibit #6*), that the Member was prepared to sign at the conclusion of this hearing and informed the panel that a similar sworn undertaking had already been signed and sent to the Royal College of Dental Surgeons of Ontario.

Under cross examination, the Member could recall ethics and jurisprudence being taught during his denturism program at George Brown College, but could not specifically recall what he was taught with respect to a denturist's scope of practice.

College Counsel drew the Member's attention to *Exhibit #4,* (Tab 6, paragraph 5), a letter dated October 22, 2013 and written by the Member's previous Counsel to the College investigator. In this letter, Member's Counsel wrote that the Member "will be refunding the monies which he was not entitled to receive". When asked by College Counsel whether this refund of monies had occurred, the Member responded that it had not.

The Member reaffirmed that the two (2) letters of apology (*Exhibit #4,* Tabs 10 and 11) would be sent at the conclusion of this matter. In response to a question posed by College Counsel, the Member stated that he would be prepared to apologize to other patients when he saw them.

At the conclusion of the cross examination, the Member admitted that he had been practising dentistry illegally. He further admitted that in order to address the issues of infection that arose with HC and WC's son, he had taken those patients to see legitimate dentists.

Witness #2 - Jiping (Jacqueline) Wang.

During examination in chief, the panel heard that Ms. Wang had been referred to the Member by a friend. This friend had told Ms. Wang that the Member had done very good work on her father. Ms. Wang presented to the Member with a broken tooth. The Member referred her that same day to a dentist who could fix her tooth. Ms. Wang faced the same problem at a later date. She contacted Mr. Chen's office once more, as he had been instrumental in solving her problem the first time.

During cross examination, Ms. Wang admitted that she had not seen the Notice of Hearing and was not really sure why she was in attendance. She told the panel that she had come to tell her story.

Witness #3 - Jamie Abanador.

In response to questions asked during the examination in chief, Mr. Abanador stated that he had first met the Member when he attended at the Member's clinic in September 2009 to inquire about having his dentures replaced. Mr. Abanador was very pleased with the work done by the Member and felt that his new dentures were better than his previous ones. Mr. Abanador returned to the Member once again in March 2015 to have a new set of dentures made. Mr. Abanador was satisfied with the work done by the Member. He stated that he knew the Member was a denturist but understood that the Member also had a dentist's background.

During cross examination, Mr. Abanador testified that he had not previously seen the Notice of Hearing and that he was only "kind of" aware that something was going on.

Neither Ms. Wang nor Mr. Abanador were aware of the admissions made by the Member or of the nature or extent of the misconduct found by this panel.

Penalty Submissions

The College advised the panel that it was seeking revocation of the Member's certificate of registration. According to College Counsel, Mr. Chen wanted to be a dentist and had used his denturist credentials to lure patients into his clinic to provide dental services. The Member had operated clinics that offered both dental and denturist services and had referred to himself as "Dr. Chen" to his patients, staff and colleagues.

The College submitted that the Member preyed on his own ethnic community, and in some instances preyed on his own neighbours. Mr. Chen's patients trusted him and felt lucky to find a professional from within their own community to service their dental needs. The Member assured his patients that he could provide any dental services they required, including fixing bridg-

es, extracting wisdom teeth and filling cavities. In fact, the Member himself felt he possessed the necessary skills to safely offer dental services to his patients.

However, in the matter of HC, the Member later admitted to her that her bridge work was in fact the first he had done. For HC, that work resulted in what she described as a "terrible experience". She had to return to the Member four (4) times in an attempt to address the constant pain she was experiencing before she insisted on seeing a legitimate dentist. During these repeated visits, the Member did not seem to notice that the site of her bridgework had become infected. Mr. Chen also admitted that HC's husband's wisdom tooth extraction had been dangerous due to the tooth's proximity to the jaw.

In the matter of WC's son, a vulnerable patient, the Member also failed to notice the infection at the site of the cavity he had filled. Once again it was only at the insistence of the child's mother that the Member relented and took the child to a paediatric dentist. The paediatric dentist had initially wanted to extract the baby tooth to deal with the infection, but at the insistence of the boy's mother, did not do so.

The College reminded the panel of the facts in this matter. Mr. Chen had been, for a period of 2 1/2 years providing dental services that were all outside his scope of practice as a registered denturist. During that period of time, the Member practised acts of dentistry on multiple patients. The dental procedures performed by the Member consisted of extracting wisdom teeth, applying or ordering x-rays, injecting needles into gums, bone grafting, repairing cavities, scaling, suturing and providing pills for pain. Two (2) of the patients he treated, one adult and one child developed infections and had to consult a registered dentist and a paediatric dentist respectively in order to alleviate the situation.

The Member held himself out to be a "doctor" or a person qualified to practise dentistry. He referred to himself as "Dr. Chen" to patients, staff and colleagues. The Member displayed certificates in his clinics identifying himself as "Dr. Chen".

While providing these dental services, the Member submitted 911 false or misleading claims to insurance companies. These 911 false or misleading claims totalled approximately $91,831.49 and represented numerous patients. Further, the Member used the identity of two (2) dentists who had worked or were working in his clinic in order to submit these false or misleading claims.

The College submitted that Mr. Chen had used his membership with the College of Denturists of Ontario as a cloak in order to perform unlawful dental services.

The College provided the panel with a penalty brief highlighting a variety of cases from other Colleges where similarly found allegations resulted in revocation. The College argued that if the panel were to choose to suspend the Member's certificate of registration, once the suspension was served, the Member could return to his practice. In the event that the Member's certificate was revoked, the Member could apply for reinstatement once a year had transpired. In that event however, the onus would be on Mr. Chen to convince a panel of the Discipline Committee that he had been remediated, was remorseful and had grown both personally and professionally. For

those reasons, the College submitted that in this matter revocation was the only reasonable and appropriate penalty.

Member's Counsel reminded the panel that its role in sanctioning was not to react in anger but to determine a just and appropriate penalty, even given the serious nature of this matter.

Member's Counsel provided the panel with its penalty brief and spoke in depth about the *Abdelrahman* decision, a previous decision of this College's Discipline Committee. According to Member's Counsel, the allegations and findings in both matters were the same and therefore it would be reasonable and appropriate to treat similar acts of misconduct in similar ways. Accordingly, Member's Counsel argued that the panel should only be considering a suspension in this matter. Member's Counsel submitted that revocation should only be applied to uncontrollable and/or ungovernable members. Mr. Chen was neither. Member's Counsel argued that penalties ordered by panels should be escalating; revocation should not be the starting point.

Member's Counsel reminded the panel that it needed to consider mitigating factors when determining an appropriate penalty. The mitigating factors in this case were that: the Member had no prior discipline matters before the College; Mr. Chen had shown remorse, accepted responsibility for his actions, apologized to the two (2) families identified in the Agreed Statement of Facts, and had given both an amount of cash; Mr. Chen had basically cooperated with the College; and, by entering into an Agreed Statement of Facts, truncated the length of the hearing and the need for numerous witnesses to appear before the panel.

According to Member's Counsel, and taking into account the penalty ordered in the *Abdelrahman* decision, the proposed penalty of a six month suspension, appropriate course work in ethics, written apologies to both the HC and WC families (*Exhibit #4,* **Tab 10 and 11**), sworn undertaking with the College (*Exhibit #6*) and entering into a mentoring/monitoring agreement with Evie Jesin (*Exhibit #4,* **Tab 12**) would be both fair and appropriate. Member's Counsel argued that this proposed penalty would address the principles of specific deterrence, general deterrence and remediation.

Member's Counsel concluded by reminding the panel that the Member has been practising without incident for the past 2 1/2 years. Given all that, Member's Counsel argued that revocation would in no way be a reasonable or appropriate penalty.

In reply, the College directed the panel to look at the facts of the matter at hand. While admitting that there were similarities in this case and the previous A*bdelrahman* case, the College argued that there were significant differences as to the facts, making the previous case distinguishable.

In the *Abdelrahman* case, three (3) adult patients were impacted. These patients were led to believe that the Member was a dentist. Mr. Abdelrahman performed dental services on these three (3) patients by filling a cavity, taking x-rays and placing crowns on top of implants. While assisting one (1) patient in filling out her insurance forms, Mr. Abdelrahman switched the dental codes to suggest that the work performed had been dental hygiene. The false claim submitted reflected the costs associated with filling a cavity and taking x-rays.

In the present case, the Member provided dental services to multiple patients over the course of 2 1/2 years. The dental procedures performed consisted of extracting wisdom teeth, applying or ordering x-rays, injecting needles into gums, bone grafting, repairing cavities, scaling, suturing and providing pills for pain. Two (2) of the patients treated, one adult and one child, developed infections that required the assistance of other professionals in order to resolve.

The Member referred to himself as "Dr. Chen" to patients, staff and colleagues and displayed certificates in his clinics identifying himself as "Dr. Chen".

The Member submitted 911 false or misleading claims to insurance companies totalling approximately $91,831.49 and representing numerous patients. And finally, the Member used the identity of two (2) dentists who had worked or were working in his clinic in order to submit these false or misleading claims.

The College argued that in these circumstances the penalty imposed in the *Abdelrahman* case would not be appropriate. Mr. Chen's misconduct was of a significantly more extreme nature than that of Mr. Abdelrahman.

Penalty and Costs Decision

The Discipline Committee orders the following penalty:

1. The Discipline Committee directs the Registrar to revoke Mr. Chen's certificate of registration effective immediately.

2. Mr. Chen shall pay costs to the College in the amount of $70,000.00. The initial instalment of $5,800.00 is due three (3) months from the date the order becomes final. $5,800.00 is due on a monthly basis thereafter, on the 15th day of each month, until the twelfth (12th) and final month at which time the balance of $6,200.00 is due.

Reasons for Penalty Decision

The panel is satisfied that the penalty is fair, considered and serves to promote public confidence in the profession. In its deliberations, the panel considered the four principles of sanctioning in reaching its decision. Those principles are general deterrence, specific deterrence, remediation and protecting the public interest and maintaining public confidence in the profession. The panel also considered the mitigating and aggravating factors as presented in this matter.

In its deliberations, the panel returned to the facts of the matter as outlined in the Agreed Statement of Facts (*Exhibit #2*), submissions by counsel and in particular, to the *Abdelrahman* decision (Member's Book of Authorities, Tab 3).

By his own admission and as found by this panel, the Member engaged in acts of professional misconduct by: failing to maintain a standard of practice; making a misrepresentation to a patient, failing to refer to a dental surgeon or a physician a patient who has a condition outside the

scope of denturism; using an unauthorized term, title or designation; signing or issuing a false or misleading document; submitting an account or charge for services that is false or misleading; contravening the *Denturism Act, 1991,* the *Regualted Health Professions Act, 1991* or the regulations under either of them; and, disgraceful, dishonourable, unethical or unprofessional conduct.

The findings of professional misconduct are egregious. Over a period of approximately 2 1/2 years, the Member performed acts of dentistry, which were all outside the scope of his practice on multiple patients. Two (2) of these patients were vulnerable children (aged 4 and 9). These acts included, but were not limited to, extracting wisdom teeth, applying or ordering x-rays, injecting needles into gums, bone grafting, repairing cavities, scaling and suturing. By performing acts outside his scope of practice, the Member put his patients in harm's way.

Particularly troubling for the panel was the fact that these acts began approximately one (1) year after graduating from George Brown College at which point in his career, the Member should have had a clear understanding of a denturist's scope of practice. During cross examination by College Counsel, Mr. Chen could not recall having been taught scope of practice during his education at George Brown College. The panel viewed these numerous and ongoing transgressions as blatantly disregarding the welfare of his patients. Some of these patients were neighbours of the Member. They trusted him and had initially felt blessed that they were living in proximity to someone who they believed, based on his assurances to them, could provide all the dental care they needed.

In the Agreed Statement of Facts (*Exhibit* #2) the Member stated that he found it difficult to say no to people in need of dental care. Further, he felt confident that in light of his training he could safely perform dentistry. However, specifically in the case of at least two (2) patients, one adult and one vulnerable child, pain and suffering did in fact result from the work done by the Member. Both patients developed infections that went undetected and lasted over a period of months. Ultimately, the Member brought the adult and child patients to a registered dentist and a paediatric dentist respectively in order to alleviate the situation.

The Member presented himself as someone qualified to practise dentistry in Ontario. He used the titles "doctor" or "specialist dentist" when interacting with his neighbours, patients, staff and colleagues. He issued cheques to staff from "Dr. Yasong Chen and Associates" and exhibited two (2) framed certificates in his office identifying himself as "Dr. Yasong Chen".

Over a period of 2 1/2 years, the Member submitted 911 false or misleading charges to insurance companies totalling approximately $91,831.49. These 911 false claims resulted from interactions with numerous patients. Of these 911 false claims, 129 charges, totalling approximately $10,840.10 (*Exhibit #2*, paragraph 44a), indicated that patients had received dental treatment from a Dr. Hsu, a former employee, even after she had already left Mr. Chen's clinic. The remaining 782 charges, totalling approximately $80,991.39 (*Exhibit #2*, paragraph 44b), indicated that patients had received dental treatment from Dr. Aliakbarrad, even though she had not performed or supervised any of the work contained in the claims. By using the names of two (2) dentists, without their knowledge, the panel viewed this as tantamount to identity theft on the part of the Member.

The panel carefully reviewed the matter of *Abdelrahman* which Member's Counsel had presented as a similar case. In its review, the panel recognized that there were some similarities in the facts of the two (2) cases. However, the panel concluded that the differences greatly outweighed the similarities and as such, made the present case a much different case than *Abdelrahman.* For example, the *Abdelrahman* matter involved three (3) adult patients, who were lead to believe they were receiving dental care from a dentist, when in fact Mr. Abdelrahman was not a dentist, but a denturist. Mr. Abdelrahman provided services outside his scope of practice by taking x-rays, filling cavities and putting crowns on top of implants. He assisted one (1) of his patients in completing her insurance claim form and while doing so, switched the dental codes to reflect that he had been providing dental hygiene services instead of dentistry. In this matter, false or misleading claims were submitted to the insurance company regarding one (1) patient and the amount charged reflected the costs of filling a cavity and taking x-rays. Mr. Abdelrahman used his own name in submitting the insurance claim but altered the codes. The *Abdelrahman* matter proceeded by way of a Joint Submission on Penalty with the parties agreeing on the appropriate penalty based on the facts of the finding.

In the present case, while the allegations of performing dentistry were the same, here Mr. Chen did so on multiple patients. And even though all patients can be viewed as vulnerable, three (3) of the patients Mr. Chen practised dentistry on were children and in the view of the panel were especially vulnerable. In providing services outside his scope of practice, Mr. Chen broke up and extracted wisdom teeth, applied or ordered x-rays, injected needles into gums, performed bone grafts, repaired cavities, scaled teeth and sutured wounds.

Further, in the case of two (2) patients, one adult and one child, infections occurred following the services Mr. Chen provided. In both cases the pain and suffering caused by the infections lasted for a prolonged period of time before being resolved by a registered dentist and a paediatric dentist respectively.

Mr. Chen filed 911 false or misleading insurance claims, reflecting services provided to numerous patients. The amount of these claims was approximately $91,831.49. In order to submit these insurance claims, Mr. Chen adopted the identity of two (2) dentists who either had been, or were still employed at one of his clinics.

For the reasons listed above, the panel concluded that the differences identified between the two (2) matters were such that a harsher penalty was warranted in this matter. The panel did not arrive at its decision to revoke lightly. However, the panel determined that in this case, the degree of professional misconduct, the breach of trust exhibited, the length of time the Member practiced dentistry and misrepresented himself as a dentist, and the large sum of money falsely collected from insurance companies warranted revocation. Of special consideration by the panel was the sheer number of patients impacted by the Member. Mr. Chen practised dentistry on multiple patients with the potential of doing harm by providing services outside his scope of practice. The panel is aware that at least two (2) patients did in fact experience pain and suffering by having to endure infections for a prolonged period of time following dental procedures performed by the Member.

The panel's decision to order revocation of the Member's certificate of registration was the result of considered and thorough deliberations. The panel determined it was the appropriate sanction given the facts of this case. In its determination, the panel considered that revocation acts as a specific and general deterrent. To the Member specifically and to the profession in general, revocation sends a very strong and clear message. It is imperative for members of the College to practise professionally and ethically within their scope of practice. Further, in dealing with patients, staff and insurance companies, members of this College must not misrepresent themselves or make false or misleading claims.

Revocation also sends a strong message to the public that the College will not tolerate such acts of professional misconduct and that these acts will be dealt with severely. The public's confidence in the profession is further bolstered by a strong and decisive penalty decision.

Reasons for Costs Decision

The panel received affidavit evidence from the College, setting out the costs of the investigation and costs of the proceedings (*Exhibit* #7).

The panel orders Mr. Chen to pay the College costs in the amount of $70,000.00. Payments will be as follows:

1. the initial instalment of $5,800.00 is due three (3) months after the date the order becomes final;
2. $5,800.00 is due on a monthly basis thereafter, on the fifteenth (15th) day of each month, until the twelfth (12th) and final month at which time the balance of $6,200.00 is due.

In awarding costs, the panel was cognizant that costs are not meant to be punitive, and that they should be reasonable and reflective of the actual work done and the costs associated with the investigation and hearing of a matter. The panel relied heavily on the Affidavit of Dr. Glenn Pettifer (*Exhibit #7*) submitted by College Counsel.

College Counsel submitted that the total cost of this matter was closing in on $135,000.00. This amount was reflective of the length and breadth of the work done and the expenses associated with bringing this matter to a hearing.

The panel understands it has the authority to award costs and that in prior decisions, the courts have indicated that an award of costs representing not more than two thirds of actual costs is appropriate. The panel also recognizes that cost recovery is a necessary strategy in smaller colleges like this College, and while the Member has the right to a thorough investigation and the right to a hearing, he also bears some responsibility for the overall costs. The costs of the investigative and discipline process cannot solely be the onus of the rest of the College's membership. The amount of $70,000.00 ordered by the panel, represents approximately fifty-five (55) percent of the costs incurred by the College. It allows the College to offset a significant chunk of the costs that would otherwise be carried by the relatively small membership of the College of Denturists of Ontario.

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

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

H. K. Weinberger
Hanno Weinberger, Chairperson

Feb. 17/16
Date

Anita Kiriakou, Public Member
Eugene Cohen, Professional Member
Patrick McCabe, Professional Member
Bruce Selinger, Professional Member