Corrigendum released on July 24, 2019. Original judgment has been corrected with text of corrigendum appended.

THE MATTER OF THE COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA

AND

DR. BIN XU, A REGISTRANT

REASONS FOR DECISION

Dr. Karl Denk, (Chair)

Dr. Myrna Halpenny

Mr. Paul Durose

Hearing Date:	November 1-2 & 5-7, 2018
Counsel for CDSBC:	Mr. Thomas Lutes and Mr. David Madani
Dr. Xu:	not in attendance and not represented by counsel
Counsel for the Discipline Panel:	Mr. William L. Roberts and Ms. Amy M. Nathanson

***names of third parties and minors have been redacted in this decision*

I. INTRODUCTION

1. A panel of the Discipline Committee of the College of Dental Surgeons of British Columbia (the "College") was appointed pursuant to s. 38 of the *Health Professions Act* (the "*HPA*") to hear and determine allegations against Dr. Bin Xu, a registrant, set out in a Further Amended Citation issued on September 17, 2018, pursuant to s. 37 of the *HPA*.

2. The hearing took place in Vancouver on November 1-2 & 5-7, 2018. Dr. Xu did not attend and was not represented at the hearing.

3. Dr. Xu practiced as a general dentist in Shenyang City in China before moving to North America. He received his Doctor of Dental Surgery in 2004 from the University of Southern California. Dr. Xu took the National Dental Examining Board (Canada) examination and became a registrant in the College in February 2005.

4. Between 2015 and 2018, 12 patients complained to the College about Dr. Xu. The College investigated these complaints and conducted chart reviews of 19 of Dr. Xu's

patients. Following the College's investigation and direction for citation process, a citation was issued on May 16, 2018. An amended citation was issued on July 31, 2018, followed by a further amended citation (the "Citation") on September 17, 2018.

5. The College has characterized the allegations in the Citation as spanning foundational expectations such as diagnosis, treatment planning, informed consent, substandard care, and billing. The College alleges that through a spectrum of inadequate practices Dr. Xu practiced the profession of dentistry incompetently and that he committed professional misconduct or unprofessional conduct.

II. PRELIMINARY ISSUES

Substituted Service Order and Non-Attendance of Dr. Xu at the Hearing

(a) *Substituted Service Order*

6. The last contact the College had with Dr. Xu was in January 2017.

7. The College attempted to serve the original citation on Dr. Xu in May 2018, by sending it to his last known physical address by regular mail and courier, and emailing it to his last known email address. The materials the College mailed and couriered to Dr. Xu were returned to the College "unclaimed, but there was no "bounce back" with respect to the email. The College used a similar process and had a similar result when it attempted to serve the amended citation on Dr. Xu in July 2018.

8. At the College's request, a pre-hearing conference was held on August 8, 2018. At the conference, the College sought an order for substituted service, an order regarding inspection of the College's documents prior to the hearing, and an adjournment of the hearing that was scheduled to commence on September 17, 2018.

9. At the pre-hearing conference the College outlined the efforts it had made to locate and serve Dr. Xu. These attempts included the College retaining a private investigating firm, but the firm was unable to locate Dr. Xu.

10. The Panel issued written reasons on August 30, 2018, and made the following orders :

(a) For the purposes of the hearing, the CDSBC may serve Dr. Xu with the amended citation, any further amended citations and the summaries of witnesses' evidence by the following means: (1) emailing them to Dr. Xu's last known email address; (2) delivery by regular mail to Dr. Xu's last known address; and (3) posting notice of the hearing on the College's website as soon as possible;

(b) the hearing be adjourned to November 2018; and

(c) the Panel directs that the College may meet the requirements in s. 38(4.1) of the *HPA* as follows: (1) preparing a hard copy of all materials it intends to rely on at the hearing for Dr. Xu; (2) provide Dr. Xu with notice that he may personally review the materials or receive them electronically by a pass-word protected drop-box mechanism. This notice must be sent to Dr. Xu's last know email address, and by letter sent by regular mail to Dr. Xu's last known address no later than 21 days prior to the commencement of the hearing; and (3) in the event that Dr. Xu's whereabouts become known to the CDSBC prior to the new hearing date, the College must make additional efforts to serve materials on Dr. Xu by personal service or registered mail.

(collectively, the "August Orders")

11. The College posted the Citation on its website in early October 2018, with names redacted.

(b) *Dr. Xu's Non-Attendance at the Hearing*

12. Dr. Xu did not attend the hearing on November 1, 2018, and was not represented by counsel. Pursuant to s. 38(5)(a) & (b) of the *HPA*, a panel may "proceed with a hearing in the respondent's absence on proof of receipt of the citation on the respondent, and without further notice to the respondent, take any action it is authorized to take under this Act."

13. The College's evidence was that it made numerous attempts to contact Dr. Xu by both regular mail, delivered to his last known address, and by email to his last known email address. [1] A second private investigator hired by the College in October 2018 was also unable to locate Dr. Xu.

[1] Affidavit #2 of RG [redacted], sworn October 31, 2018.

14. In addition, the College activated a drop-box with all of the College's disclosure material and sent a letter by email and regular mail to Dr. Xu regarding his access to the drop-box. The College also delivered its Summary of Expert Witness Evidence and Outline of Anticipated Witness Evidence to Dr. Xu by email and regular mail.

15. The Panel was satisfied that the College met the service requirements set out in the August Orders. The Panel was also not aware of any valid reason to explain Dr. Xu's failure to attend the hearing. Accordingly, the Panel permitted the hearing to proceed in Dr. Xu's absence.

Withdrawal of Charges in the Citation

16. At the outset of the hearing, counsel for the College advised that the College was withdrawing some of the charges set out in the Citation and the following paragraphs of the Citation were struck: 18, 20(a) & (b), 23, 26(c), (e) & (i) and 27.

17. A copy of the Citation with these paragraphs struck out is attached as Schedule "A".

III. HISTORY OF THE CITATION

18. The College received the first complaint about Dr. Xu in August 2015. At that time, Dr. S [redacted] was assigned as the Complaint Investigator for the College. In or around April 2016, Dr. Sigrid Coil took over as Complaint Investigator for Dr. Xu's file.

19. The details of the initial complaint itself will be dealt with later in this decision.

20. As part of the College's investigation, on June 29, 2016, Dr. Coil and Dr. P [redacted] met with Dr. Xu to review the complaint and Dr. Xu's chart and to provide Dr. Xu with an opportunity to explain or clarify anything from his response to the complaint.

21. Subsequently, Dr. Coil and Ms. W [redacted], who was then Deputy Registrar for the College, met with Dr. Xu on July 11, 2016, to discuss the College's concerns arising from its investigation to date and the potential outcomes of the investigation.

22. In July 2016, the College also initiated a chart review of ten of Dr. Xu's patients. Seven of the patients were randomly chosen by the College and the remaining three patients were chosen by Dr. Xu.

23. A chart review may be undertaken when there are serious concerns about whether a dentist is practicing to the appropriate standard expected of a dentist in British Columbia, and to determine whether areas of concern arising from a complaint are isolated incidences or amount to a pattern. Dr. Coil explained that "chart" is shorthand for patient records, which include handwritten and digital treatment notes, radiographs, photographs, referral letters from specialists and billing information.

24. Dr. Coil drafted a memo summarizing her findings from the chart review, which the College provided to Dr. Xu on September 13, 2016. Dr. Coil and Ms. W met with Dr. Xu again on September 26, 2016, to discuss the chart review and to determine a course of action to address the issue with Dr. Xu's practice they had identified.

25. Dr. Coil submitted a memo (the "Memo"), to a panel of the Inquiry Committee (the "Inquiry Committee Panel") setting out a summary of the initial complaint, her findings from the chart review and a draft Memorandum of Understanding ("MOU") outlining a possible remediation course for Dr. Xu. On October 12, 2016, after considering the Memo, the Inquiry Committee Panel directed that the College conduct an inspection of Dr. Xu's office and undertake a second chart review.

26. On October 17, 2016, Dr. Coil and Dr. P attended Dr. Xu's office at 100-6133 Buswell Street in Richmond, B.C. to inspect Dr. Xu's office. Dr. Coil used Dr. Xu's day sheets to randomly choose nine patients for the second chart review and requested that Dr. Xu provide copies of these charts, which he did.

27. Dr. Coil summarized her findings from the second chart review in an addendum to the Memo and provided a copy to the Inquiry Committee Panel. On December 6, 2016, Dr. Coil sent a copy of the updated Memo to Dr. Xu along with a Voluntary Withdrawal from Practice Agreement (the "Voluntary Withdrawal") for his signature.

28. On January 20, 2017, Dr. Xu signed the Voluntary Withdrawal.

29. After Dr. Xu signed the Voluntary Withdrawal, the College continued to receive and investigate complaints about him. On February 15, 2017, Dr. Coil sent a letter to Dr. Xu enclosing a memorandum of agreement and understanding (the "MAU"). The MAU set out various conditions, including the requirement that Dr. Xu complete the last two years of dental school, and pass the national dental examining board examination and that Dr. Xu was not to practice until the complaint was resolved.

30. Dr. Xu did not respond to Dr. Coil's letter and ceased contact with the College. The matter was referred to the Inquiry Committee who directed that a citation be issued.

IV. REVIEW OF THE EVIDENCE AND PANEL'S FINDINGS OF FACT

Onus and Standard of Proof

31. The College has the burden of proving the charges in the Citation on the civil standard of proof on a balance of probabilities. As set out in *F (H) v. McDougall* 2008 SCC 53, this means that the evidence must be "sufficiently clear, cogent and convincing" to satisfy the balance of probabilities.

32. The Panel applied this standard in its assessment of the evidence and its findings.

Witnesses

33. The College called nine witnesses to give evidence at the hearing, eight of whom were either Dr. Xu's former patients or their family members.

34. The College's primary witness, Dr. Sigrid Coil, was the College's Complaint Investigator for the 12 complaints included in the Citation and she conducted the two chart reviews.

35. Relying on *Yazdanfar v. College of Physicians and Surgeons of Ontario*, [2013] O.J. No. 4787, the College also sought to have Dr. Coil qualified as an expert witness, which is a not uncommon practice in disciplinary proceedings involving medical professionals.

36. The Panel accepted Dr. Coil as an expert in general dentistry to provide her opinion on the standards of general dentistry. Dr. Coil has been registered as a general dentist in British Columbia since 1991, and completed her residency at the University of Washington in 1992. She has clinical experience with pediatric and geriatric patients, and patients with significant medical and dental issues, and has performed the full scope of general dentistry (including endodontics, prosthodontics, oral surgery and orthodontics). As in *Yazdanfar*, the Panel found that there was no issue with Dr. Coil providing evidence in her capacity as Complaint Investigator and as an expert witness.

37. The Panel found Dr. Coil to be a credible and professional witness who provided her evidence in a fair and measured manner. Dr. Coil considered questions from the Panel thoughtfully and was able to admit when alternative explanations were plausible and when the evidence available to the College limited her ability to make certain findings.

38. With one exception, the portions of the Citation arising from the chart reviews include the allegation that Dr. Xu failed to create and/or maintain adequate dental records. At the outset, the Panel will summarize Dr. Coil's evidence about the standard for maintaining dental records.

39. The College has issued the Dental Record Keeping Guidelines (the "Guidelines") which are provided to all registrants. The Guidelines set out the College's expectations regarding recording keeping, including the types of records that must be kept, maintenance of records and information that should be included in the records.

40. As set out in the Guidelines, the purpose of patient records is to provide a picture of a patient's general health, dental status and any patient concerns and requests. Records should include the proposed treatment plan and record any treatment performed. Outcome of treatment should be documented and any deviations from expected outcomes should be recorded in the chart and patients should be advised of compromised results as soon as the dentist is aware of the situation. All relevant information provided to the patient should be documented.

41. Patient records should include: a description of the presenting condition, a record of significant findings, clinical diagnosis and treatment options, a record that treatment

options were discussed with the patient, the proposed treatment plan, a notation that informed consent was obtained, a description of the treatment performed and an accurate financial record.

42. Dr. Coil said that as a Complaint Investigator, she does not expect to see perfection in a dentist's records and that when she was providing her opinion on record-keeping she was describing a level of reasonable record keeping based on the Guidelines.

Evidence Adduced by the College and the Panel's Findings

Allegation 1

With respect to your patient [redacted] *("WSK"), between April 2015 to June 2015, you did one or more of the following:*

(a) failed to properly diagnose the patient's presenting condition, particularly by failing to diagnose the patient's periodontal condition, extensive caries and failing restorations;

(b) failed to obtain and/or document informed consent for the treatment provided, particularly in relation to the patient's failing dentition and teeth 1.2 and 3.5;

(c) failed to develop an appropriate treatment plan;

(d) failed to create and/or maintain adequate dental records;

(e) provided substandard endodontic and prosthondontic treatment of teeth 1.2 and 3.5;

(f) billed and received payment for restorations on teeth 3.3 and 3.7 when you did not provide such treatment; and

(g) misled the College when you stated in communication to the College that you provided restorations for teeth 3.3 and/or 3.7, when you did not provide such treatment.

Facts and Evidence

43. On August 24, 2015, [redacted] ("KC") submitted a complaint about Dr. Xu to the College on behalf of his mother, WSK. The essence of the complaint was that Dr. Xu provided substandard treatment and did not complete WSK's treatment.

44. Dr. Coil investigated WSK's complaint and gave evidence as the College's Complaint Investigator regarding her dealings with Dr. Xu during her investigation. This is the only time that Dr. Xu co-operated with the College's investigation into a complaint against him. Dr. Xu provided the College with a response to the complaint, WSK's chart, and attended several meetings at the College during the course of the investigation.

(a) Dr. Coil's Evidence

45. Dr. Coil testified that in her review of WSK's complaint and chart she identified issues relating to diagnosis and treatment planning, informed consent and record keeping.

46. During her investigation Dr. Coil also relied on information and images from Dr. C [redacted], who WSK saw approximately two months after her last visit with Dr. Xu.

47. Dr. Coil's first critique was that Dr. Xu's treatment notes from WSK's new patient examination were not sufficient. Dr. Coil said that a new patient examination should include an indication that the dentist had examined the patient, identified the chief complaint in sufficient detail, conducted intra-oral and extra-oral examinations, identified the dentition, and noted any concerns with the teeth (such as periodontal disease). Dr. Coil testified that there should also be an indication that the dentist had relayed this information to their patient.

48. With respect to diagnosis, Dr. Coil testified that Dr. Xu failed to identify some of WSK's presenting conditions such as periodontal disease, failing restorations and ill-fitting dentures.

49. Dr. Coil identified several issues with Dr. Xu's treatment planning for WSK. First, Dr. Coil questioned Dr. Xu's choice to restore teeth 3.3 and 3.7 when WSK had other teeth with significant decay and failing restorations. Dr. Coil explained that when a patient has multiple issues that need to be addressed, it is reasonable for a dentist to identify a priority list for treatment and the patient can then determine how they want to proceed. Dr. Xu did not record a priority treatment list for WSK.

50. Dr. Coil also questioned Dr. Xu's treatment recommendation to provide fillings for teeth 1.2 and 3.5 after the root canals. Dr. Coil's view was that there was insufficient tooth structure left in either of these teeth for anything but a crown.

51. With respect to informed consent, Dr. Coil said that it did not appear that Dr. Xu had adequately informed WSK about her failing dentition or discussed treatment options with her. Dr. Coil also testified that Dr. Xu should have had a treatment plan in place for all WSK's dental issues before proceeding with treatment.

52. Dr. Coil had concerns with the conduct of the root canal treatment itself. Dr. Coil's opinion was that the root canal treatment Dr. Xu provided for tooth 3.5 was under-filled and of minimal density. Dr. Coil explained that if a filling is not to length, the dentist should inform their patient of this and advise them of potential issues that could arise in the future if the tooth becomes symptomatic. There is no indication in the chart that Dr. Xu discussed this with WSK.

53. Dr. Coil also pointed out that the Dr. Xu had made a very large access cavity and that the filling he provided was not acceptable because there was a large gap below the filling that was open to the oral cavity. Finally, Dr. Coil pointed out that although Dr. Xu billed for a two canal root canal treatment, the post-operative radiographs show a single gutta percha point in the root.

54. Dr. Coil testified that the standard for a reasonable dentist treating tooth 3.5 should have included a discussion with WSK about the restorability of the tooth and whether any treatment should even be attempted. Dr. Coil noted that according to Dr. C's records, his treatment plan includes extracting tooth 3.5.

55. With respect to tooth 1.2, Dr. Coil explained that based on her review of the post-treatment radiographs the post and crown Dr. Xu provided did not meet the standard of care because the crown lacked marginal integrity and the post was not adequately retentive.

56. Dr. Coil testified that the standard of treatment for tooth 1.2 should have involved Dr. Xu giving WSK information about the tooth's restorability and other treatment options and

that Dr. Xu should have recorded these discussions. Dr. Coil's view was that Dr. Xu had not provided WSK with sufficient information to make an informed choice on treatment for tooth 1.2.

57. Finally, Dr. Coil testified that while Dr. Xu recorded in his treatment notes that he provided fillings for teeth 3.3. and 3.7 (and he billed WSK for this treatment), in her view, the post-treatment radiographs do not show that these fillings were actually provided.

(b) WSK and KC's evidence

58. Both WSK and KC gave evidence at the hearing. WSK gave her evidence in Cantonese through a certified interpreter.

59. WSK saw Dr. Xu on April 9, 2015, because she had been experiencing pain in two of her teeth. She testified that Dr. Xu examined her and told her that one tooth needed a filling and another tooth needed a root canal. When asked if Dr. Xu gave her the option of extracting these teeth, WSK was adamant that he had not given her this option.

60. Dr. Xu asked WSK to pay for her treatment in advance. Although she could not recall how much she paid Dr. Xu on her first visit, WSK was sure that she paid in cash because Dr. Xu told her it would be less expensive if she did.

61. WSK recalled that sometimes when she went for an appointment Dr. Xu was not there and the office was closed. WSK said that when she followed up about these missed appointments she was told that Dr. Xu was busy and not available.

62. WSK testified that Dr. Xu told her that another two of her teeth required fillings and she agreed to allow him to treat these teeth. Once again, she paid him in advance. WSK said when more than a month had gone by and Dr. Xu still had not treated these teeth she decided not to have them treated and asked Dr. Xu for a refund. WSK's evidence was that Dr. Xu promised her a refund, but when she went to collect it, Dr. Xu told her he had done work on these teeth and refused to give her a refund.

63. WSK went to Dr. Xu's clinic several times to try and obtain a refund. She testified that after she threatened to call the police Dr. Xu's receptionist got Dr. Xu on the phone and Dr. Xu agreed to repay WSK $200. WSK confirmed that she received this refund but said she was not satisfied with it because she had paid Dr. Xu much more than that.

64. The majority of KC's evidence was him relaying what his mother had told him about her experience with Dr. Xu. KC was directly involved in helping his mother obtain a refund and gave evidence about the various attempts they made to obtain a refund from Dr. Xu. KC's evidence about the final visit to Dr. Xu's office when his mother received the refund was consistent with WSK's account. KC said that the visit was very unpleasant and that Dr. Xu's receptionist scolded him and his mother.

(c) Dr. Xu's Evidence

65. As set out above, this was the only complaint where Dr. Xu responded to the College. By letter dated October 10, 2015, Dr. Xu responded to WSK's complaint as follows:

- WSK presented with issues relating to teeth 3.5 and 1.2. He diagnosed a deep cavity and multiple carious lesions and offered two treatment options: root canal followed by crown and post or extraction. He also suggested removing the decay on teeth 3.3 and 3.7.
- WSK asked for a discount and he gave her a 20% discount. She agreed to proceed with the root canal treatment without the crowns for teeth 1.2 and 3.5 and she agreed to restorations on teeth 3.3 and 3.7.
- He performed the root canal treatment on teeth 1.2 and 3.5 and the restorations on teeth 3.3 and 3.7 on April 16, 2015. There was a serious infection on teeth 1.2 and 3.5 and he told her it would take time to cure and prescribed antibiotics. WSK came back three more times to complete the root canal.
- There was extensive decay on tooth 1.2 and the crown was broken. He explained to WSK the importance of fixing the crown and she agreed to proceed. He did the post on May 30, 2015, and the crown cementation on June 21, 2015.
- On June 22, 2015, WSK came to the office and complained that her teeth 3.3 and 3.7 were not restored and that he had broken tooth 1.2 during treatment. She asked for a refund. He showed her radiographs to point out his treatment of these teeth but WSK continued to insist that he did not perform treatment. He agreed to refund her $200 because she was a senior.

66. The College submitted into evidence a recording of Dr. Xu's meeting on June 29, 2016, with Dr. Coil and Dr. P and played a portion of it during the hearing. This was the only opportunity the Panel had to "hear" from Dr. Xu.

67. In response to Dr. Coil pointing out that he had not diagnosed several teeth with significant caries, Dr. Xu's response was that he had focused on treatment teeth 1.2 and 3.5 because WSK only wanted him to treat these teeth.

68. Dr. Coil asked Dr. Xu to explain why he recommended fillings for teeth 1.2 and 3.5 when there was insufficient tooth structure left for proper restoration other than a crown. Dr. Xu said that he had given WSK the option of extraction or root canal treatment. Dr. Xu said that WSK told him that she wanted to save her tooth and so he told her that he would try a root canal with a filling or crown. Dr. Xu agreed with Dr. Coil that providing a filling was not a good option. Dr. Xu said that he told WSK that the filling would not last, but she had insisted that he try to save her tooth.

69. Dr. Xu agreed that the crown and filling he provided did not meet acceptable treatment standards. Dr. Xu could not explain why he billed for two root canals for tooth 3.5.

70. Dr. Coil asked Dr. Xu about his treatment of teeth 3.3 and 3.7, and pointed out that the post-treatment radiographs do not show any fillings. Dr. Xu admitted that he had not actually provided fillings for these teeth. Dr. Xu said he had recorded this treatment in the chart but probably had run out of time to do the fillings at that appointment. Dr. Xu said he was going to treat these teeth at WSK's next appointment.

Analysis and Findings

71. The Panel finds that Dr. Xu failed to properly diagnose WSK's periodontal disease, caries and failing restorations and failed to develop an appropriate treatment plan for these issues.

72. The Panel also finds that Dr. Xu did not obtain informed consent from WSK, particularly with respect to Dr. Xu's treatment of teeth 1.2 and 3.5. While Dr. Xu told Dr. Coil that he gave WSK the option to extract her teeth, he did not record this in the chart, and WSK remained firm in her evidence that the only treatment option Dr. Xu provided her was

restoration. The Panel accepts WSK's evidence that Dr. Xu did not tell her that extraction was an option.

73. The Panel finds that Dr. Xu's treatment of teeth 1.2 and 3.5 was substandard. Even Dr. Xu agreed with Dr. Coil's opinion that his treatment of these teeth had been substandard.

74. When he responded to WSK's complaint, Dr. Xu advised the College that he had treated teeth 3.3 and 3.7. Dr. Xu subsequently admitted that he had not treated these teeth. Accordingly, the Panel finds that Dr. Xu accepted payment for treatment he did not provide and that Dr. Xu misled the College in his response to WSK's complaint where he stated that he had treated these teeth.

75. It is troubling that when WSK attended Dr. Xu's office to ask for a refund, Dr. Xu intentionally deceived her by pointing to radiographs to "show" her he had treated these teeth. In light of this deliberate behaviour, Dr. Xu's explanation to Dr. Coil that he recorded the treatment but ran out of time and was going to complete it at the next appointment is not believable.

76. Finally, the Panel finds that Dr. Xu failed to create adequate dental records. Dr. Xu's records for WSK are missing key information such as diagnosis, confirmation of informed consent discussions and priority of treatment recommendations.

77. The Panel finds that the College has proven the allegations in paragraph 1 of the Citation.

Allegations 2-15 – Chart Reviews

78. The charges set out in paragraphs 2-15 of the Citation arise from the two chart reviews Dr. Coil conducted. Dr. Coil gave evidence both as the College's Complaint Investigator and as an expert. None of the patients whose charts were reviewed appeared as witnesses and Dr. Xu had not responded to the College regarding the concerns arising out of the chart reviews.

Allegation 2

With respect to your patient [redacted] *("YHL"), between 2008 and 2016, you did one or more of the following:*

(a) failed to properly diagnose and develop treatment plan for significant decay and periodontal, prosthodontic and/or endodontic concerns:

(b) failed to obtain and/or document informed consent for the treatment provided;

(c) failed to create and/or maintain adequate dental records;

(d) provided substandard care in the endodontic treatment of teeth 2.2, 2.3, and 2.4; and

(e) billed or allowed to be billed, for three units of time for bridge repair and/or retreatment for tooth 2.4 when the patient records do not indicate this treatment was provided.

Facts and Evidence

79. Dr. Coil conducted her review of YHL's chart as part of the first chart review. Her evidence was that for YHL in particular, she identified significant issues with Dr. Xu's treatment of YHL. Dr. Coil testified that in her view, Dr. Xu's diagnosis and treatment planning, billing, recordkeeping, and informed consent protocols were all below the expected standard.

80. YHL first saw Dr. Xu on January 31, 2008, as a result of tooth pain. Dr. Coil pointed out that the background information Dr. Xu collected included a notation that YHL's medical history includes cancer and thyroid disease. However, there is no information in the records indicating that Dr. Xu reviewed these medical issues with YHL or asked follow up questions. Dr. Coil's expert opinion was that it would be reasonable for a dentist to review medical history their patient and ask pertinent questions about issues that might impact treatment.

81. Dr. Coil identified several concerns regarding treatment planning and diagnosis arising out of YHL's recall examination on June 6, 2015. Dr. Coil reviewed the radiograph showing YHL's presenting condition and pointed out that Dr. Xu failed to identify decay and periodontal concerns.

82. Dr. Xu diagnosed percussion sensitivity with respect to tooth 1.7. Dr. Coil's evidence was that percussion sensitivity could indicate pulpal issues with the tooth, but Dr. Xu only provided antibiotics and did not set out any further recommendation for treatment of tooth 1.7. Dr. Coil testified that this raised concerns for her about diagnosis and treatment planning, record keeping and the standard of endodontic treatment Dr. Xu provided to YHL.

83. Dr. Coil pointed out that Dr. Xu provided root canal treatment of teeth 2.2, 2.3, 2.4 and extracted tooth 2.6, without recording anything in the chart to support this treatment. Dr. Coil testified that a chart should contain information to support the treatment provided, set out a diagnosis and indicate that treatment options were discussed with the patient. Dr. Xu did not record any of this in YHL's chart.

84. Dr. Coil questioned whether providing root canal treatment for these teeth was advisable given the bone loss around them. She also had concerns with how Dr. Xu carried out the root canal treatments. Dr. Coil referred back to the radiograph and testified that she did not think the obturation was providing adequate treatment, that it appeared that Dr. Xu was not within the canal and was short on the obturation. Dr. Coil conceded that it was difficult to confirm her latter observation from the radiograph in YHL's file.

85. Dr. Coil was asked to provide her opinion on how a reasonable dentist would have treated YHL. Dr. Coil explained that the standard of care involves more than the actual treatment of a particular tooth; it includes the entire process leading up to diagnosis, treatment planning and discussing finding and treatment options with a patient.

86. Dr. Coil's opinion was that a reasonable dentist would have discussed the presenting condition with YHL, and advised him of the periodontal status of his teeth, the compromised presenting condition and the prognosis. Dr. Coil reiterated her opinion that the long term prognosis for teeth 2.2, 2.3 and 2.4 was poor and would not warrant retreatment of root canals or any kind of prosthodontic treatment. Dr. Coil also explained that informed consent discussions with patients are vital when the dentition is compromised and that these discussions should be documented.

87. Finally, Dr. Coil noted a billing concern with respect to tooth 2.4. The ledger indicates that on March 10, 2016, a radiograph and bridge cementation took place, but the treatment notes for the same date do not refer to any treatment for tooth 2.4.

Analysis and Findings

88. The Panel finds that Dr. Xu's treatment of YHL did not meet the standard Dr. Coil articulated for a reasonable dentist in terms of diagnosis, treatment planning, informed consent, record keeping and billing.

89. The Panel finds that Dr. Xu failed to diagnose or develop a treatment plan for YHL's periodontal disease and failing restorations.

90. The Panel finds that Dr. Xu did not create adequate dental records. Among other things, Dr. Xu failed to diagnose significant issues, did not follow up on important issues in YHL's medical history, and failed to record treatment rationale and informed consent.

91. The Panel also finds that Dr. Xu provided substandard care in the endodontic treatment of teeth 2.2, 2.3 and 2.4, because he proceeded with root canal treatment when it was not advisable due to the bone loss around these teeth, and in the treatment itself, he was short on the obturation.

92. Finally, the Panel finds that Dr. Xu billed for bridge repair for tooth 2.4, that is not recorded in his treatment notes.

93. The Panel finds that the College has proven the allegations in paragraph 2 of the Citation.

Allegation 3

With respect to your patient [redacted] *("WLQ"), between August 2015 and September 2015, you did one or more of the following:*

(a) failed to properly diagnose the patient's presenting condition and develop an appropriate treatment plan;

(b) provided substandard care in the endodontic re-treatment of tooth 4.6; and

(c) failed to create and/or maintain adequate dental records.

Facts and Evidence

94. As a result of her review of WLQ's chart, Dr. Coil identified concerns with Dr. Xu's treatment of WLQ relating to diagnosis, treatment planning, substandard care and record keeping.

95. With respect to Dr. Xu's treatment notes from WLQ's new patient examination on August 26, 2015, Dr. Coil testified that she would expect to see more detailed treatment notes for a new patient examination, including information about what areas were examined or if there were areas of concern.

96. The Panel sought clarification on whether Dr. Xu's examination of WLQ had been a limited or complete new patient examination and Dr. Coil confirmed that Dr. Xu had conducted a limited examination. Dr. Coil conceded that a limited examination is less extensive and does not need to involve extra-oral and soft tissue. However, Dr. Coil maintained that Dr. Xu still should have included a general statement about WLQ's periodontal condition in the chart. Dr. Coil referred to the Guidelines, which provide that other than for an emergency or single appointment situation, the overall condition of the teeth and supporting structures should be reviewed and documented regularly.

97. With reference to the panorex, Dr. Coil pointed out that Dr. Xu had not identified all the areas of concern such as tooth 2.5, which appears to be rotated 90 degrees. Dr. Coil's evidence was that this degree of rotation is an abnormal finding that should have been noted.

98. Dr. Coil pointed out that while Dr. Xu identified WLQ's impacted wisdom teeth and two teeth with previous root canal treatments, he did not record a treatment plan or indicate that he had a discussion with WLQ about these teeth. Dr. Coil's opinion was that it would have been reasonable for Dr. Xu to take periapical radiographs to assess the previously root canal treated teeth.

99. Finally, Dr. Coil's opinion was that the images show that in his re-treatment of tooth 4.6, Dr. Xu went outside of the root canal anatomy of the mesial root and had taken his filling outside the lower area of the root. Dr. Coil testified that in these circumstances, a dentist

should inform their patient of the less-than-ideal treatment outcome, the possibility of future complications and options for next steps, such as referral to a specialist. Dr. Coil pointed out that there is no indication in WLQ's chart that Dr. Xu did any of this.

Analysis and Findings

100. The Panel does not agree with Dr. Coil that Dr. Xu should have diagnosed WLQ's rotated tooth. However, the Panel does find that Dr. Xu failed to conduct adequate testing or develop a treatment plan for WLQ's root canal treated teeth.

101. The Panel agrees with Dr. Coil's opinion that Dr. Xu's root canal treatment of tooth 4.6 was substandard.

102. Finally, the Panel finds that Dr. Xu did not create or maintain adequate treatment records. The Panel agrees with Dr. Coil that Dr. Xu's notes do not meet the standard set out in the Guidelines for a limited new patient examination and he failed to record informed consent and treatment rationale for his treatment of tooth 4.6.

103. The Panel finds that the College has proven the allegations in paragraph 3 of the Citation.

Allegation 4

With respect to your patient [redacted] *("CHC"), between August 2015 and January 2016, you failed to create and/or maintain adequate dental records, including failing to record informed consent and treatment rationale for the extraction of tooth 1.5.*

Facts and Evidence

104. As a result of her review of CHC's chart, Dr. Coil identified several record keeping concerns.

105. The August 2015 treatment notes indicate that CHC told Dr. Xu that he wanted Dr. Xu to extract an upper tooth and that he would be going to China to get the implant. Dr. Xu surgically extracted CHC's tooth at this appointment.

106. Dr. Coil testified that there is nothing in Dr. Xu's treatment notes indicating why tooth 1.5 needed to be extracted and no indication that he had any discussions with CHC about treatment or that he obtained informed consent.

107. Finally, Dr. Coil noted that the radiographs from August 2015 referred to in the ledger were missing from the chart that Dr. Xu provided to the College.

Analysis and Findings

108. The Panel finds that Dr. Xu's failed to create or maintain adequate dental records for CHC because he failed to record the treatment rationale for extracting tooth 1.5 and he failed to record informed consent discussions with CHC. Radiographs are an important part of a patient's chart and the Panel finds that Dr. Xu's failure to maintain these radiographs in CHC's chart also constitutes inadequate record keeping.

109. The Panel finds that the College has proven the allegation in paragraph 4 of the Citation.

Allegation 5

With respect to your patient [redacted] *("KL"), between December 2014 and February 2016, you did one or more of the following:*

(a) failed to properly diagnose the patient's presenting condition and develop appropriate treatment plans;

(b) failed to obtain and/or document informed consent for the treatment provided; and

(c) failed to create and/or maintain adequate dental records.

Facts and Evidence

110. Dr. Coil's review of KL's chart identified concerns with Dr. Xu's treatment of KL relating to diagnosis, treatment planning, informed consent and record keeping.

111. Dr. Xu conducted a new patient examination of KL in or around December 2014, when KL was approximately eight years old. Dr. Xu identified carious lesions on a number of KL's teeth, but he did not record a treatment plan to restore these teeth. Dr. Coil testified

that she would expect to see a reasonable treatment plan, a note that Dr. Xu discussed the decay with KL's parents, and a plan to move forward recorded in KL's chart.

112. KL saw Dr. Xu approximately six months later for a recall examination. Dr. Coil reviewed the bite-wings from this appointment and pointed out incipient decay between teeth 6.5 and 2.6 and beneath the stainless steel crown margin. Dr. Xu did not record this decay in his treatment notes.

113. Dr. Coil also testified that the large carious lesion on tooth 6.4 appeared to be very close to the pulp of the tooth. Dr. Coil testified that she would expect to see a notation in the chart that Dr. Xu had advised KL's parents that the condition of tooth 6.4 might be compromised and that it might need treatment in the future due to the depth of the decay. Dr. Coil pointed out that there is nothing in the chart indicating that Dr. Xu had these discussions with KL's parents. Dr. Coil explained that making informed consent notations is particularly important when treating minors and dentists must ensure that parents are properly advised.

Analysis and Decision

114. The Panel agrees with Dr. Coil's expert opinion that Dr. Xu failed to identify and diagnose multiple areas of decay on KL's teeth and did not develop a treatment plan to restore these teeth.

115. The Panel also finds that Dr. Xu failed to create adequate dental records. Among other things, Dr. Xu failed to diagnose KL's presenting condition, failed to adequately document his treatment and failed to record informed consent from KL's parents.

116. The Panel finds that the College has proven the allegations in paragraph 5 of the Citation.

Allegation 6

With respect to your patient [redacted] *("DT"), between July 2015 and September 2015, you did one or more of the following:*

(a) failed to properly diagnose the patient's decay on tooth 1.2; and

(b) failed to create and/or maintain adequate dental records, including failing to record informed consent for the treatment provided for tooth 2.1.

Facts and Evidence

117. Dr. Coil's review of DT's chart identified concerns with Dr. Xu's treatment of DT relating to diagnosis and record keeping.

118. DT saw Dr. Xu in July 2015 for an emergency examination of a fractured central incisor. Dr. Coil testified that while Dr. Xu conducted appropriate testing and properly diagnosed tooth 1.2 as requiring restoration, he also identified tooth 2.2 as requiring a restoration without indicating why it required treatment.

119. Dr. Coil reviewed the radiograph from this appointment and pointed out that Dr. Xu also did not identify or develop a treatment plan for the carious lesion in the dentin of tooth 1.2.

120. Dr. Coil identified numerous record-keeping issues with DT's chart. Dr. Xu recommended a crown for tooth 2.1, but there is no indication that Dr. Xu fully advised DT of his treatment options. Dr. Coil also testified that since DT's chart referenced a Workers' Compensation Board ("WCB") claim she would have expected to see more information than what Dr. Xu recorded. Dr. Coil explained that if a patient has a WCB claim, a dentist must gather and record sufficient information from the patient in case the chart is needed in future litigation.

121. Dr. Coil also pointed out that the copy of DT's chart that Dr. Xu initially provided to the College on August 18, 2016, and the original chart that Dr. Xu subsequently provided to the College on November 4, 2016, did not match. For example, the copy of the chart has an August 20, 2015 entry indicating "WCB appr", but this entry is not recorded in the original chart.

122. Dr. Coil testified that if a dentist needs to modify a patient record for any reason, they should make a new chart entry that refers to the date of the original entry that the change or additional information relates to. Dr. Coil stated that it would be inappropriate for a dentist to erase or cross out a previously recorded entry.

Analysis and Findings

123. The Panel agrees with Dr. Coil's finding that there was a carious lesion on tooth 1.2 that Dr. Xu failed to properly diagnose.

124. The Panel also finds that Dr. Xu failed to create and/or maintain adequate dental records. Among other things, Dr. Xu failed to record the treatment rationale for tooth 2.2, failed to diagnose or treatment plan for the caries on tooth 1.2, and failed to record informed consent from DT.

125. The most serious record keeping issue that Dr. Coil identified was the discrepancy between DT's original chart and the "copy" that he provided to the College. A dentist should not have two versions of a patient's chart and the Panel finds it very concerning that the copy of the chart Dr. Xu provided the College does not match the original. However, the Panel was not asked to make a finding that Dr. Xu intentionally altered DT's chart and therefore will make no finding in this regard.

126. The Panel finds that the College has proven the allegations in paragraph 6 of the Citation.

Allegation 7

With respect to your patient [redacted] *("LW"), between September 2015 and October 2015, you did one or more of the following:*

(a) failed to properly diagnose the patient's presenting condition for tooth 2.5;

(b) failed to properly diagnose the open crown margin on tooth 2.6; and

(c) failed to create and/or maintain adequate dental records.

Facts and Evidence

127. Dr. Coil's review of LW's chart identified concerns with Dr. Xu's treatment of LW relating to diagnosis and record keeping.

128. LW saw Dr. Xu on September 27, 2015, for a consultation after a crown come off tooth 2.5. Dr. Xu took an impression for a cast, post and core.

129. Dr. Coil pointed out that Dr. Xu did not record a diagnosis for the presenting condition for tooth 2.5 and that there is no indication that Dr. Xu discussed treatment options with LW or obtained informed consent for his treatment of tooth 2.5.

130. Dr. Coil's opinion was that given the lack of tooth structure, tooth 2.5 might not be able to retain a post and Dr. Xu should have suggested other treatment options to LW, including extraction.

131. Finally, Dr. Coil referred to the radiograph and pointed out the open crown margin on the distal end of tooth 2.6 that Dr. Xu failed to properly diagnose. Dr. Coil explained that a dentist should review an entire radiograph and not just focus on the tooth/area associated with the presenting condition because this could result in the failure to diagnose an issue with another tooth.

Analysis and Findings

132. The Panel agrees with Dr. Coil that Dr. Xu failed to properly diagnose LW's presenting condition for tooth 2.5 and the open crown margin on tooth 2.6.

133. The Panel also finds that Dr. Xu failed to create adequate dental records. Among other things, Dr. Xu failed to provide LW with treatment options, failed to record informed consent and failed to take post-treatment x-rays of the post and crown he placed.

134. The Panel finds that the College has proven the allegations in paragraph 7 of the Citation.

Allegation 8

With respect to your patient [redacted] *("YVX"), since about February 2016 you did one or more of the following:*

(a) failed to provide follow up orthodontic treatment; and

(b) failed to create and/or maintain adequate dental records.

Facts and Evidence

135. Dr. Coil's review of YVX's chart identified concerns with Dr. Xu's treatment of YVX relating to lack of follow up treatment and record keeping.

136. Dr. Coil reviewed the bite-wings from YVX's appointment with Dr. Xu on May 10, 2014, and testified that in her opinion they clearly show decay between teeth 2.5 and 2.6, and incipient decay on 3.5 and 4.5 distal and 1.7 mesial. Dr. Coil pointed out that there is nothing in the chart indicating that Dr. Xu diagnosed the decay, developed a treatment plan or informed YVX's parents about the decay.

137. Dr. Xu subsequently provided orthodontic treatment for YVX. Dr. Coil testified that YVX's file does not include the usual orthodontic records that a reasonable dentist would take prior to providing orthodontic care. Dr. Coil also pointed out that the dates on the radiographs in YVX's chart do not match up with the treatment entries and overall she found YVX's chart confusing and difficult to piece together.

138. Finally, Dr. Coil testified that she was concerned that Dr. Xu had not provided follow up treatment for YVX. First, the decay on YVX's teeth remained untreated and the records show lengthy gaps between YVX's appointments. In addition, the last entry in YVX's chart indicates that Dr. Xu conducted a check-up and changed a wire on YVX's braces. Dr. Coil's opinion was that this entry indicates that YVX's orthodontic treatment was not complete and as a result, there should have been a note in the chart that a follow-up plan was in place. Dr. Coil explained that it is particularly important to have a follow-up plan with orthodontic treatment because the teeth need to be continuously monitored and adjustments may need to be made in short order.

Analysis and Decision

139. The Panel finds that Dr. Xu did not provide follow-up orthodontic treatment for YVX and agrees with Dr. Coil that follow up treatment is particularly important with orthodontic treatment.

140. The Panel also finds that Dr. Xu failed to create or maintain adequate dental records for YVX. Among other things, Dr. Xu failed to diagnose or treatment plan for the decay on YVX's teeth and failed to inform her parents about the decay. Patient records should be well organized and understandable so that if a dentist is unable to continue treating a patient, another dentist should be able to easily understand that chart and carry on with the patient's treatment. Dr. Coil's evidence that she found YVX's chart to be confusing is a clear indication that Dr. Xu's patient records for YVX fell below this standard.

141. The Panel finds that the College has proven the allegations in paragraph 8 of the Citation.

Allegation 9

With respect to your patient [redacted] *("LSL") in or about September 2015, you did one or more of the following:*

(a) provided substandard care in the endodontic treatment of tooth 4.7;

(b) misled the patient about the endodontic treatment provided;

(c) failed to provide options for further endodontic treatment of tooth 4.7; and

(d) failed to create and/or maintain adequate dental records.

Facts and Evidence

142. Dr. Coil's review of LSL's chart identified concerns with Dr. Xu's treatment of LSL relating to substandard care and record keeping.

143. LSL saw Dr. Xu on September 23, 2015, as a result of tooth pain. The treatment notes from this appointment refer to distal decay on tooth 4.7, and indicate that Dr. Xu provided LSL with two treatment options: root canal treatment or extraction and

restorations. Dr. Xu proceeded with the root canal on tooth 4.7, but subsequently told LSL that the roots were calcified and that the tooth should be extracted.

144. Dr. Coil's opinion was that there was no good explanation why this tooth needed to be extracted - she did not think the tooth was as calcified as Dr. Xu had indicated.

145. Dr. Coil testified that in her view, it was questionable whether tooth 4.7 was actually restorable and therefore whether a root canal was an appropriate treatment. Dr. Coil explained that Dr. Xu should have taken a pre-treatment radiograph which would have assisted him in diagnosing whether the tooth was actually restorable.

146. Dr. Coil also stated that she had concerns about the conduct of the root canal treatment Dr. Xu provided. Dr. Coil referred to the radiograph taken during the treatment and gave her opinion that the files are not within the root canal structure. She also pointed out that there was still significant decay on the tooth, indicating that Dr. Xu did not clean all the decay to gain proper access for the root canal. Finally, Dr. Coil testified that she was concerned that Dr. Xu had performed the root canal without a dental rubberdam because none of the images show a rubber dam clamp. Dr. Coil's evidence was that a dental rubberdam should always be used during a root canal treatment to minimize the risk of infection from saliva and bacteria entering the root canal system.

147. Dr. Coil's opinion was that a reasonable dentist treating tooth 4.7 would have taken a pre-treatment radiograph, probed around the tooth to evaluate the extent of the decay and whether the tooth was restorable, recorded their finding and diagnosis and discussed treatment options with LSL. Finally, Dr. Coil's evidence was that if a dentist feels they are unable to complete treatment, they should always give their patient the option of being referred to a specialist. Dr. Coil's view was that it would have been appropriate for Dr. Xu to refer LSL to a specialist.

148. Finally, Dr. Coil was asked to explain the allegation that Dr. Xu misled LSL about the endodontic treatment he provided. Dr. Coil explained that in her opinion, Dr. Xu's failure to provide LSL with all relevant pre-treatment information and his failure to provide her with treatment options (including referral to a specialist) amounted to misleading LSL.

Analysis and Findings

149. The Panel finds that Dr. Xu's endodontic treatment of LSL's tooth 4.7 did not meet the standard of care Dr. Coil articulated for a reasonable dentist treating the tooth. Dr. Xu did not conduct sufficient testing of tooth 4.7 to allow him to properly assess whether it was restorable, he failed to clean the decay to obtain proper access for the root canal and his files were outside the root canal structure. With respect to Dr. Coil's concern that Dr. Xu did not use a dental rubberdam, there is insufficient evidence for the Panel to find that Dr. Xu did not use a dental rubberdam.

150. The Panel agrees with Dr. Coil that Dr. Xu should have referred LSL to a specialist after he was unable to complete the root canal treatment.

151. The Panel finds that Dr. Xu failed to create and/or maintain adequate dental records. Among other things, Dr. Xu did not take a pre-treatment radiograph, and he did not offer or discuss other treatment options with LSL after he was unable to complete the root canal treatment.

152. With respect to the allegation in paragraph 9(b) of the Citation, the Panel does not find that Dr. Xu mislead LSL regarding the endodontic treatment provided. The College's allegation is based on the fact that Dr. Xu did not provide LSL with relevant pre-treatment information or an evaluation of the treatment options available. These failures are captured in the allegations of substandard care and inadequate record keeping (and the Panel has found that the College has proven these allegations). The Panel finds that Dr. Xu's failure to provide sufficient pre-treatment information to LSL was substandard care, not the result of a deliberate intention by Dr. Xu to mislead LSL.

153. The Panel finds that the College has proven the allegations in paragraph 9(a), (c) & (d) of the Citation. The College has not proven the allegation in paragraph 9(b) of the Citation.

Allegation 10

With respect to your patient [redacted] *("YHF"), in or about August 2015 you did one or more of the following:*

(a) provided substandard care in the endodontic treatment of tooth 3.6;

(b) failed to provide options for further endodontic treatment of tooth 3.6; and

(c) received payment for treatment not completed for tooth 3.6 and failed to provide a refund as indicated.

Facts and Evidence

154. Dr. Coil's review of YHF's chart identified concerns with Dr. Xu's treatment of YHF including substandard care and billing.

155. YHF saw Dr. Xu on August 28, 2015, as a result of tooth pain. Dr. Coil pointed out that although Dr. Xu took a radiograph, he did not record any diagnosis as a result of the testing. Dr. Coil also noted that there is no indication that Dr. Xu did any probing of the tooth, which in her opinion should be a routine part of diagnosis with tooth pain.

156. Dr. Xu's treatment notes indicate that he gave YHF the option of a root canal or extraction for tooth 3.6. Dr. Xu began root canal treatment, but he subsequently told YHF that the files could not go through because of bone resorption in the furcation and that the tooth would have to be extracted. Dr. Coil pointed out that there is no indication in the chart that Dr. Xu provided YHF with any treatment options other than extraction or that he referred YHF to a specialist.

157. Dr. Coil also identified several concerns with Dr. Xu's endodontic treatment of tooth 3.6. Dr. Coil questioned whether root canal treatment was appropriate given the bone loss around the tooth clearly evident in the radiograph. Dr. Coil's opinion was that Dr. Xu should have discussed with YHF whether the tooth was actually salvageable before proceeding with the root canal treatment. There is nothing in the chart indicating that Dr. Xu had this discussion with YHF. Dr. Coil also noted that there was no rubber dam clamp visible in the radiograph, which suggests that Dr. Xu did not use a dental rubberdam during the root canal.

158. Finally, Dr. Coil gave evidence about a billing concern. The ledger shows that Dr. Xu charged YHL for the root canal treatment that he did not complete. While the treatment notes provide: "[p]rovide refund to patient" Dr. Coil testified that if Dr. Xu actually provided the refund, it should be recorded in the chart.

Analysis and Findings

159. The Panel agrees with Dr. Coil's opinion that Dr. Xu provided substandard endodontic treatment of tooth 3.6. Dr. Xu's failure to conduct appropriate pre-treatment testing and his failure to discuss with YHF whether the tooth was actually salvageable falls below the standard for a reasonable dentist. Again, the Panel is not able to make a finding as to whether or not Dr. Xu used a dental rubberdam during treatment.

160. The Panel also finds that after Dr. Xu was unable to complete the root canal of tooth 3.6, he failed to discuss other treatment options with YHF, such as a referral to a specialist.

161. Finally, the Panel agrees with Dr. Coil's opinion that if Dr. Xu provided YHF with a refund, he should have recorded this in the chart. However, the Panel does not have sufficient evidence to determine if the lack of notation confirming the refund is because Dr. Xu did not provide the refund, or if Dr. Xu provided the refund but failed to record this in the chart.

162. The Panel finds that the College has proven the allegations in paragraph 10(a) & (b) of the Citation. The College has not proven the allegation in paragraph 10(c) of the Citation.

Allegation 11

With respect to your patient [redacted] *("HCL"), between March 2015 and August 2015, you did one or more of the following:*

(a) failed to properly diagnose the patient's presenting condition;

(b) failed to develop an appropriate treatment plan for the patient's periodontal condition;

(c) provided substandard care in the endodontic treatment of tooth 1.7;

(d) failed to provide options for further endodontic treatment of tooth 1.7; and

(e) failed to create and/or maintain adequate dental records including in relation to the patient's periodontal condition.

Facts and Evidence

163. Dr. Coil's review of HCL's chart identified concerns with Dr. Xu's treatment of HCL relating to diagnosis, treatment planning, substandard care and record keeping.

164. HCL saw Dr. Xu on March 26, 2015, for a new patient examination. Dr. Xu took a panorex, diagnosed periodontal disease and advised HCL that he should see a specialist. HCL said he would see a specialist in China.

165. HCL received three implants in China before seeing Dr. Xu again on May 5, 2015. Dr. Coil testified that save for the implants, HCL's presenting condition (severe decay and abscessed teeth) was identical to HCL's presenting condition at his first appointment. Dr. Coil's opinion was that Dr. Xu should have done a periodontal examination, made a treatment plan, prioritized treatments and reviewed these concerns with HCL. She noted that there is no indication in the chart that Dr. Xu did any of these things.

166. On May 23, 2015, HCL saw Dr. Xu for an emergency examination of tooth 1.7. Dr. Xu began root canal treatment of the tooth but subsequently informed HCL that he could not complete the treatment because the tooth was calcified and needed to be extracted. Dr. Coil pointed out that there is no indication that Dr. Xu provided HCL with any other treatment options or referred him to a specialist to see if the tooth was treatable.

167. In terms of the root canal treatment itself, Dr. Coil's view was that the radiograph shows that the file is outside of the tooth. Dr. Coil's opinion was that this was due to the poor access cavity Dr. Xu created. Dr. Coil also testified that it was questionable whether Dr. Xu had removed all of the decay prior to the root canal treatment.

168. Dr. Coil was asked to describe the standard for a reasonable dentist treating tooth 1.7. Dr. Coil's opinion was that there should have been some discussion with HCL about the extent of the decay, restorability and the prognosis of the tooth prior to treatment. Dr. Coil also testified that a reasonable dentist would have taken a pre-treatment radiograph

to allow for a proper diagnosis and to ensure that HCL had enough information to make an informed decision about treatment. Finally, Dr. Coil testified that a reasonable dentist who encountered difficulty in treating tooth 1.7, should have provided HCL with other treatment options, including a referral to a specialist. Dr. Coil testified that in her opinion, tooth 1.7 could have been saved.

Analysis and Findings

169. The Panel finds that Dr. Xu failed to properly diagnose HCL's presenting condition of severe decay and that he did not develop a treatment plan for HCL's periodontal condition.

170. The Panel also finds that the endodontic treatment Dr. Xu provided for tooth 1.7 fell below the standard articulated by Dr. Coil. After Dr. Xu was unable to complete the root canal, he should have re-assessed his treatment plan and provided HCL with other options for further endodontic treatment of the tooth or referred him to a specialist.

171. Finally, the Panel finds that Dr. Xu did not create or maintain adequate dental records for HCL. Among other things, Dr. Xu failed to properly diagnose and treatment plan for HCL's periodontal condition or discuss further treatment options for tooth 1.7, and the ledger was missing from the chart Dr. Xu provided to the College.

172. The Panel finds that the College has proven the allegations in paragraph 11 of the Citation.

Allegation 12

With respect to your patient [redacted] *("YAZ"), between October 2012 and March 2016, you did one or more of the following:*

(a) *provided substandard care in the endodontic treatment of tooth 2.3;*

(b) *provided substandard prosthodontic care in relation to teeth 2.2, 1.1 and 2.1;*

(c) *failed to properly diagnose and/or develop an appropriate treatment plan in relation to teeth 1.1, 1.2, 2.1 and 2.3; and*

(d) *failed to create and/or maintain adequate dental records.*

Facts and Evidence

173. Dr. Coil's review of YAZ's chart identified concerns with Dr. Xu's treatment of YAZ relating to diagnosis and treatment planning, substandard care and record keeping.

174. YAZ saw Dr. Xu on October 22, 2012, after the crown on her tooth 2.3 had fallen out. Dr. Xu provided a restoration for the tooth.

175. Dr. Coil pointed out that although Dr. Xu took radiographs, the only finding he recorded in the chart regarding tooth 2.3 was that it was positive for percussion. Dr. Coil's opinion was that the standard of care for treating this tooth should have included more than one type of testing, including probing to determine the restorability of the tooth so that a proper diagnosis could be made.

176. Based on her review of the radiograph taken in May 2013, Dr. Coil's opinion on Dr. Xu's root canal treatment on tooth 2.3 was that the obturation was minimal in density and short of the apex. Dr. Coil also questioned whether, given its length, the post Dr. Xu placed was retentive. Dr. Coil noted that it appears that YAZ ended up losing tooth 2.3 approximately eight months later.

177. Dr. Coil was asked to articulate the standard she would expect of a reasonable dentist with respect to the endodontic treatment of tooth 2.3. Dr. Coil's opinion was that there should have been more testing or probing to assess the tooth's restorability and that a diagnosis should have been recorded. Dr. Coil also testified that if the root canal was not done to length, a reasonable dentist should have advised the patient they had been unable to get to the apex, advised the patient about the consequences of leaving the short obturation, and explained the prognosis and that future treatment that could be required.

178. In April 2013, Dr. Xu removed and replaced the crowns on YAZ's teeth 1.1, 1.2 and 2.1. Dr. Coil testified that in her view, the post-treatment radiograph showed open margins on the medial of teeth 1.1 and 2.1. Dr. Coil testified that there might also be an open margin on tooth 1.2, but that it was difficult to tell for certain. Dr. Coil also gave her opinion that

the post for tooth 2.2 appeared to be excessively large for the tooth, and that tooth 1.1 had a small post with a large unfilled post space.

179. Dr. Coil's opinion on the standard of dentistry for the prosthodontic work performed on teeth 2.2, 1.1 and 2.1 was that she would expect to see a post of the appropriate length and intact crown margins.

180. Dr. Coil testified that it was difficult to piece together Dr. Xu's treatment of YAZ due to numerous issues with the chart. For example, the dates on the radiographs do not correspond with chart entries and Dr. Coil said she had to review the ledger to try and determine what treatments were provided on what dates. In addition, some of the radiographs were missing from the chart Dr. Xu provided to the College.

Analysis and Decision

181. The Panel finds that the endodontic treatment Dr. Xu provided for tooth 2.3 fell below the standard articulated by Dr. Coil. Dr. Xu did not conduct sufficient testing, which may have impacted his diagnosis, and the root canal procedure he provided was substandard.

182. The Panel also finds that the prosthodontic care Dr. Xu provided for teeth 2.2, 1.1 and 2.1 fell below the standard articulated by Dr. Coil. Leaving crowns with open margins and using posts of the wrong size is substandard care.

183. Dr. Xu also failed to properly diagnose and treatment plan for teeth 1.1, 1.2, 2.1 and 2.3. Dr. Xu did not conduct sufficient testing, so he was not able to properly assess the restorability of these teeth and develop an appropriate treatment plan. The Panel notes that it appears that tooth 2.3 was lost less than a year after Dr. Xu's root canal treatment.

184. The Panel also finds that Dr. Xu failed to create and maintain adequate dental records. All of the issues with the chart that Dr. Coil identified amount to inadequate record keeping. As set out above, patient records should be in a state that would allow another dentist to step in and continue treatment. The fact that Dr. Coil had to try and piece together details of Dr. Xu's treatment of YAZ using the ledger makes it clear that Dr. Xu's records for YAZ do not meet this standard.

185. The Panel finds that the College has proven the allegations set out in paragraph 12 of the Citation.

Allegation 13

With respect to your patient [redacted] *("JBY"), between or about August 2015 and September 2015, you did one or more of the following:*

(a) failed to properly diagnose and/or develop an appropriate treatment plan in relation to teeth 1.8 and 4.8; and

(b) failed to create and/or maintain adequate dental records.

Facts and Evidence

186. Dr. Coil's review of JBY's chart identified concerns with Dr. Xu's treatment of JBY relating to diagnosis and record keeping.

187. JBY saw Dr. Xu on August 22, 2015, for a new patient examination. Dr. Coil testified that the radiograph clearly shows impacted wisdom teeth (1.8 and 4.8). However, Dr. Xu did not identify these teeth and there is no indication in the chart that he advised JBY about them or developed a treatment plan for them.

188. Dr. Coil stated that JBY's wisdom teeth appeared to be within the bone and very close to the adjacent tooth, and in her opinion there was a possibility of resorption of the roots. Dr. Coil's opinion was that Dr. Xu should have advised JBY of these potential concerns and provided him with options for dealing with these teeth, such as having them extracted or simply monitoring them to ensure no problems developed.

Analysis and Findings

189. The Panel agrees with Dr. Coil's opinion that JBY's impacted wisdom teeth are clearly visible on the radiograph and that Dr. Xu failed to diagnose or develop a treatment plan for them.

190. The Panel also finds that Dr. Xu failed to create or maintain adequate dental records for JBY because he failed to diagnose and treatment plan for his wisdom teeth, and he failed

to record discussions with JBY about treatment options. In addition, the bite-wings taken on August 22, 2015 were missing from the chart Dr. Xu provided to the College.

191. The Panel finds that the College has proven the allegations in paragraph 13 of the Citation.

Allegation 14

With respect to your patient [redacted] *("HLH"), between or about December 2010 and March 2016, you did one or more of the following:*

(a) failed to properly diagnose and/or develop an appropriate treatment plan for tooth 3.6; and

(b) failed to create and/or maintain adequate dental records.

Facts and Evidence

192. Dr. Coil's review of HLH's chart identified concerns with Dr. Xu's treatment of HLH relating to diagnosis, treatment planning and recording keeping.

193. HLH saw Dr. Xu on September 9, 2015 for a recall examination. Dr. Coil's evidence was that although Dr. Xu identified and treated some decay on HLH's teeth, he failed to identify the decay on tooth 3.6. Dr. Coil's opinion was that the size of the caries made it clearly visible in the radiograph and Dr. Xu should have diagnosed this decay and developed a treatment plan for it.

194. In terms of record-keeping, Dr. Coil pointed out that although the ledger shows that Dr. Xu billed HLH for a night guard and lab services on September 9, 2015, there is no corresponding chart entry confirming that HLH needed a night guard or that Dr. Xu actually provided him with a night guard.

Analysis and Findings

195. The Panel agrees with Dr. Coil's opinion that the decay on tooth 3.6 is clearly visible in the radiograph and that Dr. Xu should have diagnosed the decay and developed a treatment plan for it.

196. The Panel also finds that Dr. Xu failed to create adequate dental records for HLH. If Dr. Xu billed for a night guard, this should be recorded in the treatment notes.

197. The Panel finds that the College has proven the allegations in paragraph 14 of the Citation.

Allegation 15

With respect to your patient [redacted] *("EZ"), between October 2009 and March 2016, you did one or more of the following:*

(a) failed to properly diagnose and/or develop an appropriate treatment plans for teeth 7.4, 7.3, 5.5, 5.4, and 8.4;

(b) provided treatment and/or advice that was unnecessary and/or inappropriate given the age of the patient, including scaling, root planning and recommending a night guard; and

(c) failed to create and/or maintain adequate dental records.

Facts and Evidence

198. Dr. Coil's review of EZ's chart identified concerns with Dr. Xu's treatment of EZ relating to diagnosis, unnecessary treatment and record keeping.

199. Dr. Coil testified that in her view, the radiograph from EZ's appointment with Dr. Xu in September 2012, clearly indicates areas of decay on teeth 5.4, 5.5, 7.3, 7.4 and 8.4, but there is nothing in the chart indicating that Dr. Xu identified the decay or developed a treatment plan for it.

200. Dr. Coil was also concerned that some of the treatments Dr. Xu provided to EZ were not age appropriate. First, the ledger records two units of scaling on March 5, 2011, when EZ was only three years old. Dr. Coil's opinion was that scaling is not appropriate for a child of that age and she found it hard to believe that a three year old would tolerate half an hour of scaling. Dr. Coil testified that if Dr. Xu had not actually provided the scaling, the fact that he recorded and billed for it would be a record keeping issue.

201. The ledger also records that Dr. Xu performed root planning on EZ in October 2015, when she was seven years old. Dr. Coil's evidence was that root planning indicates recession, but there is no notation in the chart about recession and no information to support why Dr. Xu provided this treatment. Dr. Coil said that if there was a legitimate reason for the root planing, Dr. Xu should have recorded it.

202. EZ's chart indicates that Dr. Xu provided her with a night guard when she was about seven years old. Dr. Coil's opinion was that it is generally not appropriate to give a child of that age a night guard because their teeth are still falling out and changing. Dr. Coil pointed out that there is nothing in the chart indicating why EZ needed a night guard.

203. Finally, Dr. Coil testified that since EZ was a minor, she would expect to see notes in the chart confirming Dr. Xu had discussed these issues and treatments with EZ's parents.

Analysis and Findings

204. The Panel finds that Dr. Xu failed to diagnose or develop a treatment plan for the decay on EZ's teeth 7.4, 7.3, 5.5, 5.4 and 8.4.

205. The Panel agrees with Dr. Coil's opinion that scaling, root planing and night guards are generally not appropriate for children of EZ's age. There is nothing in the chart indicating that despite her age, these treatments were necessary for EZ. As a result, the Panel finds that Dr. Xu provided treatments to EZ that were not age appropriate.

206. Finally, the Panel finds that Dr. Xu failed to create and maintain adequate dental records. Dr. Xu failed to diagnose or develop a treatment plan for the decay on EZ's teeth, he failed to record a treatment rationale for the scaling, planing and night guard and he failed to obtain or record informed consent from EZ's parents for the treatment he provided.

207. The Panel finds that the College has proven the allegations in paragraph 15 of the Citation.

Citations Arising from Complaints Made to the College

208. The remainder of the Citation deals with patients who filed complaints about Dr. Xu with the College.

209. Dr. Coil confirmed that for all of the complaints set out in the remaining paragraphs of the Citation, the College sent Dr. Xu the complaint materials and asked him to provide a response to the complaint and a copy of the complainant's chart. Dr. Coil confirmed that Dr. Xu did not provide the College with a response to any of these complaints or provide the patient charts to the College.

Allegation 16

With respect to your patient [redacted] *("BML"), you did one or more of the following:*

(a) during and around the period April and October 2016, received payment from the patient for bone graft treatment that was not provided; and

(b) since April 2016, failed to refund monies received for bone grafting treatment not provided.

Facts and Evidence

210. BML made a complaint to the College about Dr. Xu on October 22, 2016. His main complaint was that he paid for bone graft treatment that Dr. Xu only purported to provide, and that he never received a refund.

211. BML attended the hearing to give evidence.

212. BML first saw Dr. Xu on May 16, 2015, because he wanted implants. BML testified that after Dr. Xu reviewed his x-rays Dr. Xu recommended implants and told BML that he would need bone grafting before Dr. Xu could provide an implant and crown.

213. BML said he agreed to this treatment plan and that he was pleased because Dr. Xu said he would give him a discount. BML's evidence was that at this appointment, Dr. Xu extracted one of his molars and provided bone grafting and that he paid Dr. Xu $5,000 in cash for this treatment.

214. Dr. Xu told BML to come back in three months for the crown, but BML said that he was unable to reach Dr. Xu for some time. After many attempts, BML was able to reach Dr. Xu and Dr. Xu placed the crown on May 9, 2016, almost a full year later.

215. BML testified that on July 9, 2016, August 19, 2016 and September 20, 2016, Dr. Xu extracted molars and pretended to provide bone grafts. He said that after each procedure Dr. Xu produced empty bottles to show BML how much bone powder he had put into BML's mouth. BML's evidence was that at these three appointments Dr. Xu "did everything like a real surgery" including providing and removing sutures.

216. After his surgeries were complete, BML went to see another doctor, Dr. Z [redacted], who took x-rays and told him that the bone grafts had not been done. BML testified that for three of his surgeries Dr. Xu only went through the motions and did not actually put bone powder in the surgical areas. He said he felt cheated.

217. BML testified that he paid Dr. Xu approximately $11,900 for the four surgeries. BML produced a handwritten receipt dated September 9, 2015, on Dr. Xu's letterhead acknowledging BML's payment of $3,500. He also produced a handwritten receipt on a piece of paper with no letter-head acknowledging a $4,000 payment. BML's evidence was that Dr. Xu wrote and signed this receipt on May 9, 2016.

218. BML said that after he discovered that Dr. Xu performed fake surgeries he went to Dr. Xu's clinic to demand a refund. BML testified that on October 19, 2016, Dr. Xu wrote and signed a document confirming that he would provide BML with a refund. BML produced a document setting out the total payments BML made to Dr. Xu ($17,400), the services Dr. Xu provided (one extraction and genuine bone graft valued at $5,500) and that Dr. Xu owed BML a refund of $11,900.

219. As part of her investigation into BML's complaint, Dr. Coil sought and received information from Dr. Z, who saw BML on October 14, 2016. The treatment notes Dr. Z provided to the College include the following notation: "PA show low levels sinus floor and higher density bone at site of 17. PA on [quad 2] shows no sign of bone graft. Also sinus floor is very low. Patient says he got bone grafting." Dr. Z also noted that BML would have to see an oral surgeon for a final evaluation, but her first impression was that both sides of BML's mouth would need sinus lifting before implants could be placed.

220. Dr. Coil also sought and obtained information from Dr. B [redacted] who saw BML in November 2016. In the treatment notes Dr. B provided to the College he stated that due

to the position of the maxillary sinus there was minimal bone height available in the maxillary left quadrant to place an implant without a sinus graft procedure. He also stated that there was adequate bone on the upper right side for placement of implants.

221. Dr. Coil testified that based on the materials she received from Dr. Z and Dr. B, it was questionable whether the bone grafts had been done. When asked if it is possible that Dr. Xu had attempted the bone graft procedure but simply did not perform it to an adequate level, Dr. Coil agreed that this was possible. Dr. Coil also testified that if bone grafts had been done, she would be concerned this was not present a few months later when the radiographs were taken.

Analysis and Findings

222. The Panel accepts as documentary evidence the receipts and documents BML provided to the Panel to support his claim that he paid Dr. Xu $17,400 for the four surgeries.

223. The Panel also accepts BML's evidence that Dr. Xu did not provide him with any refund. The Panel was referred to a default judgment BML received in British Columbia Provincial Court (small claims) for the amount he claims he should be refunded. The Panel does not place any weight on the default judgment in terms of assessing whether Dr. Xu provided the bone grafting treatment. However, it accepts that BML has not received a refund and has used other avenues to attempt to recover from Dr. Xu.

224. The more difficult question is whether Dr. Xu actually provided the bone grafting. The Panel has some difficulty accepting that after completing one "real" bone grafting procedure, Dr. Xu performed an additional three surgeries, where he did everything (including extractions) but insert the bone graft material.

225. The Panel considered Dr. Z's report which noted that the PA on quadrant 2 shows no sign of bone graft and that the sinus floor is very low. However, Dr. Z qualified that this was her initial impression and that BML should see an oral surgeon for a final evaluation.

226. The Panel also considered the opinion of the oral surgeon, Dr. B, who found that there was minimal bone height available in the maxillary left quadrant to place an implant

without a sinus graft, but found that there was adequate bone on the upper right side to place implants.

227. The Panel also considered Dr. Coil's opinion was that it was possible that the bone grafts had been done, just not to an adequate standard.

228. The Panel finds, on the balance of probabilities that Dr. Xu provided some bone grafting during the last three surgeries he performed on BML. The Panel accepts Dr. B's assessment that there was adequate bone on the upper right side of BML's mouth to place implants. With respect to the maxillary left quadrant, the Panel finds that the bone grafting Dr. Xu provided was done but not to an adequate standard sufficient for the placement of implants

229. The Panel finds that the College has not proven the allegations in paragraph 16 of the Citation. However, the Panel has finds that the bone graft treatment Dr. Xu provided BML was wholly inadequate and as a result, Dr. Xu should have (but did not) provide BML with a refund for this substandard treatment.

Allegation 17

With respect to your patient [redacted] *("SYSZ"), during or around the period October 2016 and January 2017, you did one or more of the following:*

(a) provided substandard care, including failing to provide adequate or any follow-up care in relation to the orthodontic treatment provided;

(b) failed to schedule and/or attend appointments with the patient; and

(c) failed to refund monies received for orthodontic and implant treatment not provided.

Facts and Evidence

230. In December 2016, SYSZ made a complaint to the College about Dr. Xu in relation to the orthodontic treatment he provided.

231. SYSZ attended the hearing and gave evidence.

232. SYSZ testified that she first saw Dr. Xu on October 15, 2016, for a cleaning and filling. She said that Dr. Xu also provided her with a plan for orthodontic treatment, which included Invisalign for her top teeth and standard braces for her lower teeth, and two implants. Dr. Xu told her that her treatment would be completed in about one year. SYSZ said that Dr. Xu did not take any x-rays or impressions before he provided her with this orthodontic plan.

233. SYSZ testified that Dr. Xu told her that the cost for her cleaning, filling and orthodontic treatment would be $12,375, but that he would give her a $1,000 discount if she paid him in cash. SYSZ's evidence was that she paid Dr. Xu $5,000 in cash at her first appointment. The materials SYSZ submitted to the College with her complaint included a handwritten document dated October 15, 2016, written on a Listerine notepad, and signed by Dr. Xu, acknowledging payment of $5,000.

234. On October 21, 2016, Dr. Xu placed braces on SYSZ's four lower front teeth. He told her that she would have to see him every week to have the wires replaced. SYSZ testified that Dr. Xu asked for payment of $2,000 which she paid with her credit card. SYSZ produced a handwritten document dated October 21, 2016, written on a Listerine notepad and signed by Dr. Xu, acknowledging payment of $2,000.

235. SYSZ said that the braces on her lower teeth cut her mouth to the point that she was only able to eat soft foods. When asked if Dr. Xu had given her any instructions on how to keep her braces clean or use wax for sore spots, SYSZ's evidence was that Dr. Xu did not provide her with any of this information.

236. SYSZ testified that when she arrived at Dr. Xu's clinic the following week for her appointment, the clinic was closed. SYSZ said she attempted to call Dr. Xu multiple times, but he did not return her call until the next day. When he returned her call, Dr. Xu apologized for missing the appointment and told her that he was not feeling well and he would call her to reschedule once he was feeling better. SYSZ said that Dr. Xu did not contact her to re-schedule her appointment and that she had to call him repeatedly to schedule her next appointment.

237. On November 4, 2016, Dr. Xu replaced a wire on SYSZ's braces and took impressions for her Invisalign. Two weeks later Dr. Xu replaced another wire for SYSZ and gave her an Invisalign tray for her upper teeth. SYSZ said that the edges of the tray were very sharp and cut her mouth. SYSZ testified that she called Dr. Xu and told him the pain was unbearable. SYSZ said that Dr. Xu took another impression of her teeth, but he never ended up giving her another tray.

238. SYSZ also testified that after wearing the tray for four days it became loose and would not stay on properly.

239. SYSZ testified that in mid-December 2016, she paid Dr. Xu another $1,000 in cash for her treatment. SYSZ produced an undated handwritten receipt on Dr. Xu's letterhead and signed by Dr. Xu, acknowledging payment of $1,000.

240. She testified that she called Dr. Xu shortly before her implant surgery was scheduled and Dr. Xu told her that he had to cancel the surgery because his assistant was not available. SYSZ said that Dr. Xu told her he would get in touch to re-schedule, but he never called her back. SYSZ said she called Dr. Xu several times and when Dr. Xu finally answered he told her he was in the hospital but he could place her implants that evening.

241. SYSZ testified that she did not feel comfortable going ahead with the surgery because she felt Dr. Xu was unprofessional. Instead, she asked him for a refund and testified that Dr. Xu agreed to provide her with a refund.

242. SYSZ testified that after Dr. Xu agreed to provide her with a refund he stopped returning her calls. SYSZ testified that she went to his office on December 22, 2016, and asked him for a written statement confirming that he would give her a refund. SYSZ produced a handwritten note dated December 22, 2016, on Dr. Xu's letterhead and signed by Dr. Xu, saying that Dr. Xu would give her a refund on December 28, 2016. SYSZ said that Dr. Xu did not provide her with a refund on December 28, 2016.

243. SYSZ was determined and resourceful. She testified that she searched the internet and found numerous references to Dr. Xu and she posted her contact information on various Chinese websites so other patients of Dr. Xu could contact her. SYSZ said she was able

to gather a group of Dr. Xu's patients and that she arranged a meeting between them and Dr. Xu on March 17, 2017. SYSZ's evidence was that at the meeting, Dr. Xu promised to repay everyone, but said that he did not have the money – he suggested they try and make claims on his insurance. SYSZ testified that Dr. Xu has never provided her with a refund.

244. SYSZ has seen other dentists and specialists regarding her orthodontic treatment. SYSZ testified that these dentists told her that there was no space in her mouth for implants and that her Invisalign tray might not be authentic.

245. Dr. Coil also testified about her investigation of SYSZ's complaint, which she summarized and provided to the Inquiry Committee on May 5, 2017. After the Inquiry Committee directed that a citation be issued in relation to SYSZ's complaint, the College wrote to SYSZ to advise that a citation was being issued and that her file was closed. SYSZ subsequently wrote to the College on May 28, 2017, providing information from the other dentists she had seen.

246. Counsel for the College advised the Panel that this additional information was not disclosed to Dr. Xu during the investigation process but that it was provided to him with the materials the College made available to him pursuant to the August Orders. The College submitted that the additional information was relevant and material and asked the Panel to allow questions about the material to proceed, subject to the panel's ultimate decision on their admissibility. The Panel agreed to allow Dr. Coil to provide evidence regarding these supplementary materials and reserved its decision on admissibility.

247. Dr. Coil testified that as she understood it, Dr. Xu's orthodontic plan for SYSZ was that since SYSZ was missing her lower lateral incisors, he was going to move her canines into the position of her laterals to create space to place implants where her canines had been.

248. Dr. Coil testified that she had concerns about the quality of the treatment Dr. Xu provided to SYSZ. First, he developed the treatment plan without adequate imaging and consideration. Dr. Coil testified that the lower canine crowns were tipped without the roots moving, leaving inadequate space for implants. Dr. Coil also testified that she was

concerned that the Invisalign tray Dr. Xu provided SYSZ was not authentic; Dr. Coil said that to her it looked like an Essix retainer.

249. Dr. L [redacted] saw SYSZ on January 28, 2017. Dr. L sent a letter to Dr. Coil on November 26, 2017, summarizing his treatment of SYSZ. In his letter, Dr. L expressed his opinion was that there was insufficient room between SYSZ's teeth to place implants (as per Dr. Xu's treatment plan), that the elastics on SYSZ's lower braces were broken and the arch wire was not fully engaged to the bracket slot.

250. Dr. A.L. [redacted] saw SYSZ on January 4, 2017. Dr. A.L. sent a letter to Dr. Coil on May 7, 2018, summarizing his assessment of SYSZ. Dr. A.L. was also of the opinion that there was insufficient room for implants. Dr. A.L. also commented that SYSZ's Invisalign tray was not a typical tray and to him it looked like it had been made in an in-office vacuum former. Dr. A.L. trimmed the wires on SYSZ's lower teeth because they were irritating her lips.

Analysis and Findings

251. SYSZ was a composed witness who gave her evidence in a direct and forthright manner.

252. As set out above, the Panel allowed the College to lead evidence from other dentists SYSZ has consulted with and reserved its decision on their admissibility. The Panel finds that the documentary evidence from Dr. L and Dr. A.L. is admissible. Their evidence is clearly relevant to the allegations against Dr. Xu with respect to his treatment of SYSZ and although these documents were not included in the initial disclosure, the College served them on Dr. Xu in the manner authorized by the August Orders.

253. The primary allegation regarding Dr. Xu's treatment of SYSZ is that he provided substandard orthodontic care and failed to provide adequate or any follow up care. The Panel agrees with Dr. Coil that Dr. Xu provided substandard orthodontic care to SYSZ. The Panel accepts SYSZ's evidence that Dr. Xu did not take any x-rays or impressions before developing her orthodontic treatment plan. Further, the treatment plan itself was substandard – the essence of Dr. Xu's plan was to create space for implants, but both

Dr. L and Dr. A.L. were of the view that he did not accomplish this and there was not sufficient room for implants.

254. The Panel also finds that Dr. Xu's treatment of SYSZ was substandard. The Panel accepts SYSZ's evidence that Dr. Xu did not take any steps to assist or resolve the discomfort her braces were causing. The Panel accepts SYSZ's evidence that Dr. Xu failed to attend or cancelled several appointments and that he never contacted her to re-schedule. The Panel finds that Dr. Xu failed to provide adequate follow up care.

255. The Panel is unable to make a finding regarding the authenticity of the Invisalign tray provided to SYSZ. SYSZ gave evidence about speaking with an individual at Invisalign, but this evidence was hearsay. Dr. L, Dr. A.L. and Dr. Coil, all expressed doubts about the authenticity of the tray, but none of them equivocally stated that the tray was not authentic. According, the Panel is not able to make a finding about the authenticity of the Invisalign tray SYSZ received from Dr. Xu.

256. The Panel also accepts the documentary evidence produced by SYSZ that she paid Dr. Xu approximately $9,000 for the orthodontic treatment he was supposed to provide, but did not complete. The Panel also finds that despite her significant efforts, SYSZ has not received a refund from Dr. Xu.

257. The Panel finds that the College has proven allegations in paragraph 17 of the Citation.

Allegation 19

With respect to your patient [redacted] *("BWS") since about September 2016, you failed to refund monies you received for prosthodontic treatment not provided.*

Facts and Evidence

258. On February 17, 2017, BWS's granddaughter made a complaint to the College on his behalf, alleging that BWS paid Dr. Xu for treatment that was never provided.

259. BWS attended the hearing and gave evidence in Mandarin through a certified interpreter.

260. BWS first saw Dr. Xu on September 20, 2016, for an infected root canal. He testified that Dr. Xu told him that his teeth would cost him a lot in the future and that for $3,000, Dr. Xu would guarantee treatment of all of BWS's dental care for the next five years.

261. BWS said he paid Dr Xu $640 at this appointment and he produced a handwritten receipt on 'Pacific Dental Conference' stationery, dated September 20, 2016, and signed by Dr. Xu, confirming receipt of $640.

262. BWS testified that he returned to Dr. Xu's clinic the next day and paid Dr. Xu $3,000 in cash. He produced a similar signed handwritten receipt on 'Pacific Dental Conference' stationary and signed by Dr. Xu acknowledging receipt of $3,000.

263. After BWS made his second payment, Dr. Xu told him to come back in ten days to receive his partial denture. However, BWS testified that he has not been able to reach Dr. Xu since September 21, 2016, and that he never received his partial denture or any refund from Dr. Xu. BWS described his extensive efforts to locate Dr. Xu, including calling him and going to Dr. Xu's clinic many times (which he said he was able to do because as a senior he rides the bus for free).

Analysis and Findings

264. BWS testified in a forthright and credible manner, and the Panel accepts his evidence regarding his interactions with Dr. Xu, the promises Dr. Xu made to him, and Dr. Xu's failure to complete his treatment.

265. The Panel accepts the documentary evidence that BWS paid Dr. Xu $3,640 in advance for a partial denture and five years of continued dental treatment. The Panel also accepts BWS's evidence that Dr. Xu did not provide him with a partial denture or a refund.

266. The Panel finds that the College has proven the charges set out in paragraph 19 of the Citation.

Allegation 21

With respect to your patients [redacted] *and* [redacted] *("KZ" and "SZ") you did one or more of the following:*

(a) with respect to KZ, in or about the period December 2012 and September 2016:

(i) provided substandard care in the patient's orthodontic treatment; and

(ii) failed to provide appropriate follow up care.

(b) with respect to SZ, in or about December 2012 and September 2016:

(i) provided substandard care in the patient's orthodontic treatment including by failing to monitor and provide adequate follow up treatment; and

(ii) failed to refund monies you received for orthodontic treatment that was not completed.

Facts and Evidence

267. On April 17, 2017, [redacted] ("QZT") made a complaint to the College claiming that Dr. Xu provided substandard orthodontic treatment for her daughters, KZ and SZ.

268. QZT attended the hearing and gave evidence in Cantonese through a certified interpreter. QZT explained that her daughters did not attend the hearing because they were both in school (KZ is in university and SZ is in high school).

269. QZT testified that she took her daughters to see Dr. Xu in 2012 because they both needed braces. At that time KZ was 12 years old and SZ was nine years old.

270. In addition to the specific concerns relating to each daughter, overall, QZT was not happy with how Dr. Xu treated her and her daughters. QZT testified that sometimes Dr. Xu was not there for KZ and SZ's appointments, or if he was there, he did not treat them. QZT said she got so stressed that she stopped going to appointments and asked KZ and SZ to go by themselves.

271. When asked if Dr. Xu gave her advice on how to clean her daughters' teeth or follow-up care, QZT said that the only thing Dr. Xu did was ask his nurse to give them dental floss on one or two occasions.

272. QZT testified that Dr. Xu placed braces on KZ in 2012 and told her that KZ's treatment would be completed in three years. QZT testified that Dr. Xu removed KZ's braces at his Kingsway clinic. She was unsure of the exact date, but thought this happened in 2016.

273. QZT testified that Dr. Xu told her that SZ was too young for braces and that it would be easier to extract her upper teeth first. QZT's evidence was that Dr. Xu never extracted any of SZ's teeth, but he gave her an apparatus to wear for a while but it was not "good enough." It is unclear what apparatus QZT was referring to. QZT sometimes referred to the braces Dr. Xu placed on SZ in the summer of 2016 as an apparatus.

274. QZT's evidence was that Dr. Xu told her she had to pay $4,500 for KZ's treatment and $1,500 for SZ's treatment. She confirmed that she paid Dr. Xu a lump sum payment of $6,000. QZT was not sure the exact date she made the payment but thought it was after the first few appointments. QZT said it has been so long she has lost the receipt.

275. At the hearing QZT produced two receipts on stationery from Dr. Xu's clinic signed by Dr. Xu. The first receipt acknowledges payment of $3,200 and appears to be dated June or August 8, 2016. The second receipt acknowledges payment of $500 and appears to be dated June 4, 2016, or June 4, 2017. QZT was unable to clarify the dates on the receipts. QZT's evidence was that these payments were deposits for SZ's braces and that Dr. Xu had put on SZ's braces around that time.

276. QZT testified that after Dr. Xu removed KZ's braces, he told QZT that he was not going to do any more work for SZ, so she asked him for a refund. It is not clear when this conversation took place.

277. QZT testified that she attended the March 17, 2017 meeting SYSZ organized. QZT's evidence was that at the meeting Dr. Xu promised to provide refunds to his patients after he went back to China and sold some property. QZT said she has never received a refund from Dr. Xu.

278. QZT testified that she has taken both her daughters to see specialists. She brought a picture and radiograph of both KZ and SZ to the hearing. SZ's images are dated March 18, 2017, and KZ's images are dated April 12, 2017.

279. QZT testified that a specialist (she could not recall their name but the images she provided have the names Dr. K [redacted] and Dr. M [redacted] told her that KZ's orthodontics had been done so badly there was nothing to be done to fix it and it was better to leave her teeth alone. QZT testified that this specialist did not say anything about KZ's jaw, but a previous dentist (she could not recall the name) told her that Dr. Xu's work had been done so badly that KZ's jaw was not aligned. QZT said that KZ has difficulty eating certain foods because it is hard for her to bite and chew.

280. QZT's evidence was that a specialist (again she could not recall their name) told her that SZ needed to have four teeth removed, but they had wait a year or so until SZ's teeth returned to a more normal shape. QZT said that SZ still had her braces on when she saw the specialist in 2017, but had them removed shortly thereafter.

Analysis and Findings

281. The Panel found QZT to be a credible witness. Although QZT was not able to recall some dates or names, the Panel attributes this to the passage of time.

Allegations Relating to KZ

282. The College has alleged that Dr. Xu provided substandard care in KZ's orthodontic treatment and that he failed to provide appropriate follow up care.

283. The College did not establish that the orthodontic care Dr. Xu provided to KZ was substandard. The Panel did not have KZ's chart (because Dr. Xu did not provide it to the College), a report from the specialist who saw KZ and did not hear from KZ herself. The only evidence the Panel had regarding KZ's orthodontic treatment was from QZT.

284. QZT's evidence addressed several issues she had with Dr. Xu's treatment of KZ, including the length of treatment, Dr. Xu's failure to provide care instructions and KZ's

misaligned jaw. Although the Panel found QZT's evidence to be credible, her evidence was not sufficient to establish that Dr. Xu provided substandard orthodontic care to KZ.

285. QZT testified that initially Dr. Xu told her that KZ's treatment would be completed in three years. Based on QZT's evidence, it appears that KZ's braces were on for four or five years.[2] There is insufficient evidence for the Panel to determine why KZ's treatment took longer than Dr. Xu's estimate. The Panel cannot make a finding that the length of KZ's treatment was the result of substandard care.

286. QZT also testified that Dr. Xu did not provide any care information to KZ (except having his assistant provide dental floss). However, QZT also testified that she stopped going to KZ's appointments and there was no evidence from KZ regarding what care instructions, if any, Dr. Xu gave her.

287. Finally, the Panel is unable to find that any issues KZ has with her jaw are the result of Dr. Xu's orthodontic treatment. QZT's evidence that an unnamed dentist told her about KZ's jaw is hearsay and there was no evidence about KZ's jaw from any of the other dentists who have seen her.

288. The College has also alleged that Dr. Xu failed to provide adequate follow up treatment to KZ. The Panel accepts QZT's evidence that Dr. Xu missed appointments and that she had to repeatedly follow up with Dr. Xu to get him to provide treatment to KZ. The Panel finds that Dr. Xu conduct amounts to a failure to provide KZ with adequate follow up care.

289. QZT also testified that Dr. Xu gave KZ a retainer after he removed her braces but that was it was no good. The Panel is not able to assess whether the retainer Dr. Xu gave KZ was appropriate and QZT's evidence did not address whether or not Dr. Xu referred KZ to another dentist or followed up regarding KZ's retainer. However, Dr. Xu should have continued to monitor KZ to ensure her retainer was fitting properly and that KZ was compliant in wearing her retainer. If Dr. Xu was unable to follow up himself, he should

[2] In her evidence QZT said she thought KZ's braces were removed in 2016, but in her complaint to the College she said they were removed in 2017.

have referred KZ to another dentist and made KZ aware of the importance of following up with another dentist.

290. The Panel finds that College has proven the allegation in paragraph 21(a)(ii) of the Citation. The Panel finds that the College has not proven the allegation in paragraph 21(a)(i) of the Citation.

Allegations Relating to SZ

291. The College has alleged that Dr. Xu's treatment of SZ was substandard, including failing to monitor and provide adequate follow up treatment, and that he failed to provide a refund for treatment he did not complete.

292. There was very little specific evidence regarding SZ's orthodontic treatment. It is unclear what treatment Dr. Xu provided to SZ between 2012 and 2016, which QZT testified is when Dr. Xu placed braces on SZ in the summer of 2016. There was also no evidence about the treatment Dr. Xu provided to SZ between the time he put on her braces in the summer of 2016 and when he ceased treating her.

293. Again, the Panel did not have SZ's chart, evidence from the specialist who evaluated SZ or evidence from SZ herself. However, the Panel accepts QZT's evidence that at some time during his treatment of SZ, Dr. Xu missed several appointments and delayed commencing SZ's treatment. The Panel finds that this constitutes a failure to provide adequate follow up treatment to SZ.

294. The College has also alleged that Dr. Xu failed to refund money he received for treatment that was not completed. Based on QZT's evidence and the receipts she produced at the hearing, the Panel accepts that she paid Dr. Xu at $3,700 as a deposit for SZ's orthodontic treatment. The extent of the treatment Dr. Xu provided to SZ is not clear and there was no evidence on the total cost Dr. Xu quoted for his orthodontic treatment of SZ. The Panel notes that QZT testified that she has been told that SZ's orthodontic treatment will cost $7,000. Although Dr. Xu may well owe SZ a refund, there is insufficient evidence for the Panel to make this finding.

295. The Panel finds that the College has proven the allegation in paragraph 21(b)(i) of the Citation. The Panel finds that the College has not proven the allegation in paragraph 21(b)(ii) of the Citation.

Allegation 22

With respect to your patient [redacted] *("FCW"), between November 2015 and September 2016, you did one or more of the following:*

(a) provided substandard care with regards to implant treatment, including failure to provide proper follow-up care; and

(b) failed to refund monies you received for treatment, including implant restoration that was not completed.

Facts and Evidence

296. On June 9, 2017, FCW's daughter filed a complaint with the College on her father's behalf, alleging that FCW paid Dr. Xu for implants but Dr. Xu did not complete his treatment.

297. FCW attended the hearing and gave evidence in Cantonese through a certified interpreter.

298. FCW first saw Dr. Xu on or around November 1, 2015, as a result of a toothache. FCW testified that Dr. Xu told him he had periodontal disease and that it was best to remove the affected teeth and get implants; FCW said that Dr. Xu told him that he would need 17 implants.

299. FCW testified that Dr. Xu said he would charge $3,500 per tooth, so treatment for both FCW and his wife would cost $95,000, but Dr. Xu would reduce the cost to $85,000 if FCW paid in cash as soon as possible.[3] FCW testified that a nurse working for Dr. Xu came to his work the next day to collect a cash payment of $15,000. FCW produced a handwritten receipt on Dr. Xu's letterhead dated November 1, 2015, acknowledging payment of $15,000.

[3] The panel notes that although Dr. Xu also treated FCW's wife, there is no allegation in the Citation relating to Dr. Xu's treatment of her.

300. FCW testified that he went to Dr. Xu's office on November 9, 2015, and paid Dr. Xu the remaining $70,000 in cash. FCW produced a receipt dated November 9, 2015, on Dr. Xu's letterhead acknowledging payment of $70,000.

301. FCW also produced a handwritten note dated November 9, 2016, signed by Dr. Xu guaranteeing that Dr. Xu would provide implants for FCW and his wife and that he would guarantee the quality and lifetime maintenance.

302. FCW confirmed that he received treatment from Dr. Xu in November and December 2015 and January and September 2016. Based on FCW's evidence, it appears that Dr. Xu extracted at least nine of his teeth and provided five or six implants. FCW testified that one of the implants Dr. Xu placed caused him so much pain that Dr. Xu had to remove it.

303. FCW testified that at some point Dr. Xu told him he could not treat him anymore. FCW said that Dr. Xu gave him an agreement setting out a schedule to repay FCW for treatment that Dr. Xu had not completed. However, FCW testified that he has not received any refund from Dr. Xu.

304. FCW was asked if Dr. Xu gave him any advice for taking care of his implants or follow up care. FCW's evidence was that he has not seen Dr. Xu since his last appointment, even though FCW has called Dr. Xu and gone to his offices many times to try and find him.

305. FCW testified that after Dr. Xu ceased treating him he saw Dr. L [redacted] who told him that two of the implants in his upper jaw appeared to be in his sinus. FCW said that Dr. L told him that if these implants were not currently causing him a problem he could leave them, but that he should seek treatment if they became symptomatic.

306. As part of her investigation into FCW's complaint, Dr. Coil obtained information from Dr. L, who had seen FCW in March 2017. In his treatment notes, Dr. L noted that Dr. Xu had placed some implants for FCW but that the treatment had not been completed. Dr. L also noted that part of the maxillary left implants appear to have perforated the sinus. Dr.

Coil reviewed the radiograph Dr. L provided and testified that in her view, the implants appear to be within FCW's sinus.

307. Dr. Coil was asked to provide her opinion on the appropriate standard of care and follow up care in relation to FCW. Dr. Coil was candid that without FCW's chart, the only information she had about Dr. Xu's treatment of FCW was that Dr. Xu had extracted some teeth and provided some implants.

308. In term of the standard of care, Dr. Coil testified that the radiographs show that the two implants on the lower right side of FCW's mouth appear to have some type of abutment in place, unrestored. With respect to the implants that appear to have perforated FCW's sinus, Dr. Coil testified that a dentist would have to inform the patient if this happened. Dr. Coil admitted that without FCW's chart, she was unable to say whether Dr. Xu advised FCW about the issue with these implants. Finally, Dr. Coil testified that in her view, given FCW's significant periodontal disease, it was questionable whether it had been appropriate for Dr. Xu to place implants in the first place. Again, Dr. Coil qualified that she did not have FCW's chart and that she could not presume that Dr. Xu had not recognized this issue.

Findings and Analysis

309. FCW was a credible witness and gave his evidence in a forthright manner.

310. The College has alleged that Dr. Xu provided substandard care to FCW with regard to implant treatment and follow up care. The Panel finds that there were numerous aspects of Dr. Xu's treatment of FCW that fell below the standard expected for a reasonable dentist. The Panel accepts Dr. L and Dr. Coil's opinions that part of the maxillary implants Dr. Xu placed appear to have perforated FCW's sinus. The Panel also accepts FCW's evidence that one of the implants Dr. Xu placed caused him so much pain that Dr. Xu had to remove it.

311. Dr. Coil was very fair in her evidence that without FCW's chart she could not tell whether Dr. Xu addressed the issue of the implants piercing FCW's sinus with FCW. FCW did not give direct evidence as to whether Dr. Xu told him about this issue.

However, based on FCW's evidence it appears that FCW was not aware of this until he saw Dr. L. The Panel finds it more likely than not that Dr. Xu failed to address the issue of the implants piercing the sinus with FCW, despite being obligated to do so.

312. Dr. Xu did not complete the treatment he promised FCW. The radiographs provided by Dr. L show that there are no crowns for four of the remaining implants he provided. Dr. Xu abandoned FCW mid-treatment and it does not appear that he referred FCW to another dentist or ensured follow up care was in place. The Panel finds that Dr. Xu's abandonment of FCW as a patient and his failure to refer FCW to another dentist was substandard care.

313. Further, the Panel accepts the documentary evidence that FCW paid Dr. Xu $85,000 for implants and for Dr. Xu's guarantee of long term dental care. Dr. Xu did not complete FCW's implant treatment and ceased treating him sometime before March 2017. The Panel also accepts FCW's evidence that he made many attempts to find Dr. Xu but that he was never able to find Dr. Xu and he has never received a refund from Dr. Xu.

314. The Panel finds that the College has proven the allegations in paragraph 23 of the Citation.

Allegation 24

With respect to your patient [redacted] *("CHJZ") from July 2016 you did one or more of the following:*

(a) provided substandard care in orthodontic treatment by failing to monitor and provide adequate follow up treatment; and

(b) failed to refund monies received for treatment that was not completed.

Facts and Evidence

315. On August 24, 2017, [redacted] ("JZ") submitted a complaint about Dr. Xu to the College on behalf of her daughter CHJZ about the orthodontic treatment Dr. Xu provided for CHJZ.

316. Neither JZ nor CHJZ attended the hearing to give evidence. Instead, the College submitted an affidavit from JZ. In her affidavit JZ deposed that she was not able to attend the hearing in person because she had just started a new job and would not be paid for her absence from work to attend the hearing. She deposed that she could not afford to miss work unpaid.

317. The Panel accepted JZ's affidavit, subject to weight.

318. JZ deposed that Dr. Xu began providing orthodontic treatment to CHJZ in July 2016 when she was 12 years old. Dr. Xu asked JZ to pay $4,500 in cash in advance for CHJZ's orthodontic treatment and JZ's evidence was that she paid Dr. Xu $4,500 in cash on August 22, 2016.

319. JZ deposed that Dr. Xu installed a brace on one of CHJZ's upper teeth in September 2016, and performed follow-ups and adjustments in October, November and December 2016.

320. In early 2017, JZ began having trouble reaching Dr. Xu and several of CHJZ's appointments were cancelled. JZ deposed that she went to Dr. Xu's office to try and find him but the office was closed and her calls to Dr. Xu were not answered.

321. JZ deposed that Dr. Xu did not complete her daughter's orthodontic treatment and that he has not provided her with a refund.

322. JZ deposed that she took CHJZ to another clinic and was told that CHJZ's braces were useless as a result of inconsistent treatment. JZ has been told that it will cost between $4,000 - $5,000 for CHJZ's orthodontic treatment.

323. Dr. Coil was asked to articulate the reasonable standard of care for orthodontic treatment. Dr. Coil testified that reasonable orthodontic care includes frequent appointments to assess and monitor any movement of the teeth, changing wires and elastics, monitoring oral hygiene and assessing the progress of the orthodontic treatment. Dr. Coil's opinion was that it is not acceptable practice for a dentist to abandon a patient or fail to manage the transition of a patient's care.

Analysis and Findings

324. The Panel accepted JZ's affidavit, subject to weight. In person evidence is preferable to affidavit evidence because it allows the Panel to observe the witness while they are giving evidence and it allows the opposing party to test the witness' evidence. The Panel finds that since Dr. Xu did not attend there hearing, he was not prejudiced by the fact that JZ did not give her evidence in person.

325. In a disciplinary hearing the rules of evidence are relaxed. Although it would have been preferable for JZ to attend the hearing, the Panel finds that her affidavit and the documents included in the complaint she submitted to the College establish that Dr. Xu provided orthodontic treatment to her daughter, that she paid Dr. Xu in advance and that Dr. Xu did not complete CHJZ's treatment.

326. The College has alleged that Dr. Xu provided substandard orthodontic treatment by failing to monitor CHJZ and failing to provide adequate follow up treatment.

327. Although initially Dr. Xu saw CHJZ monthly, the Panel accepts JZ's evidence that beginning in early 2017, her daughter's appointments were cancelled and she was unable to reach Dr. Xu. JZ described it as Dr. Xu abandoning her daughter as a patient. The Panel agrees with Dr. Coil's opinion that it is not acceptable for a dentist to cease treating a patient without putting a transition plan in place. The Panel finds that Dr. Xu provided substandard care to CHJZ.

328. The Panel also accepts JZ's evidence that she paid Dr. Xu in advance for her daughter's treatment. Although it was not attached as an exhibit to her affidavit, in her complaint materials JZ included an invoice dated December 5, 2016, on Dr. Xu's stationary confirming receipt of a cash payment of $4,500. Although in her affidavit JZ deposed that she paid Dr. Xu on August 22, 2016, the Panel finds that this discrepancy as to the exact date of payment is immaterial. The Panel accepts JZ's evidence that Dr. Xu did not complete her daughter's orthodontic treatment or provide her with a refund.

329. The Panel finds that the College has proven the allegations in paragraph 24 of the Citation.

Allegation 25

Since about November 2016, you have failed to respond in a substantive or timely manner, or at all, to College inquiries and/or requests for information with respect to complaints for the following patients:

(a) BML

(b) SYSZ

(c) HSS

(d) BWS

(e) WLY

(f) KZ

(g) SZ

(h) FCW

(i) SWC

(j) CHJZ

330. With respect to the patients in paragraph 25(a)-(b) and (d)-(j) of the Citation, Dr. Coil testified that the College sent correspondence to Dr. Xu regarding each complaint and requested that Dr. Xu provide the College with a response. Dr. Coil confirmed that the College did not receive a response from Dr. Xu in relation to any of these patients. The Panel accepts Dr. Coil's evidence and finds that the College has proven the allegations in paragraph 25(a)-(b) and (d)-(j) of the Citation.

331. The College withdrew the substantive allegation regarding HSS set out at paragraph 18 of the Citation, but maintained the allegation regarding HSS in paragraph 25(c) of the Citation. However, the College did not adduce any evidence regarding HSS. The Panel accepts that the College's general practice is to provide a registrant with a copy of all complaint materials, but there was no evidence before the Panel that HSS made a complaint to the College regarding Dr. Xu. Accordingly, the Panel finds that the College has not proven the allegation in paragraph 25(c) of the Citation.

Allegation 26

Since about October 2016, you have failed to respond in a substantive or timely manner, or at all, to inquiries and/or requests for information from the following patients and/or their representatives:

(a) BML

(b) SYSZ

(d) BWS

(f) KZ

(g) SZ

(h) FCW

(j) CHJZ

332. The patients set out in paragraph 26 (a)-(b), (d), (f)-(h) and (j) of the Citation (or their representatives) attended the hearing and gave evidence regarding their dealings with Dr. Xu. Their evidence is set out above. Without exception, these patients described their persistent but unsuccessful attempts to contact Dr. Xu, whether it was in relation to cancelled appointments, treatment issues or refunds for services Dr. Xu had not provided.

333. The Panel finds that the College has proven the remaining allegations in paragraph 26 of the Citation.

Allegation 28

With respect to your patient [redacted] *("MYL") you did one or more of the following:*

(a) in or about March and December 2016, accepted payment for dental services, namely partial denture fabrication and placement, but failed to provide and place the denture and provide follow up treatment;

(b) failed to refund monies you received from or on behalf of the patient for the treatment that was not completed;

(c) failed to respond in a substantive or timely manner, or at all, to inquiries and/or requests for information from the patient or the patient's representatives; and

(d) failed to respond in a substantive or timely manner, or at all, to College inquiries and/or requests for information with respect to the patient's complaint against you.

Facts and Evidence

334. On February 26, 2018, MYL's wife submitted a complaint to the College on his behalf, alleging that MYL paid Dr. Xu for a partial denture that Dr. Xu never provided.

335. MYL attended the hearing and provided evidence in Mandarin through a certified interpreter.

336. MYL saw Dr. Xu on March 18, 2016, to obtain a partial denture. His evidence was that he had seen an advertisement for Dr. Xu's clinic in the newspaper and that it appeared that Dr. Xu provided comprehensive service and gave a discount to seniors.

337. MYL testified that after conducting a quick an examination and taking impressions, Dr. Xu advised him that he would fix his teeth very quickly.

338. Dr. Xu told MYL that it would cost $1,600 to fix his teeth, but that he would give him a senior's discount and reduce his fee to $1,200 if he paid in cash. MYL testified that he was on government assistance and he did not have enough to pay Dr. Xu the full amount at that appointment but he paid Dr. Xu $500 in cash. MYL testified that he paid Dr. Xu the remaining $700 on May 12, 2016, and Dr. Xu told him to come back the next day and he would complete the partial denture.

339. MYL's evidence is that when he returned the next day, Dr. Xu told him that he could no longer use the impression of MYL's teeth from his appointment in March and that Dr. Xu would need to take another imprint of MYL's teeth. Dr. Xu took the imprint and told MYL to come back in three days.

340. MYL's evidence was that over the next month he had five appointments with Dr. Xu and each time either Dr. Xu was not at the clinic or Dr. Xu gave him some reason why the denture was not ready, including that the denture maker was in the hospital. MYL testified that he finally asked Dr. Xu to give him a refund so that he could go somewhere else to have his denture made, but Dr. Xu told him that he no longer had MYL's money because he had already paid the denture maker.

341. MYL testified that he has not been able to get in touch with Dr. Xu after this last appointment. MYL described going to Dr. Xu's clinic numerous times and calling and texting Dr. Xu, without success. MYL testified that Dr. Xu did not provide him with a partial denture or a refund.

Analysis and Findings

342. MYL is an elderly gentleman who has had some serious health issues. MYL advised the Panel that due to a previous illness, he has difficulty with his memory and as a result, he had brought his diary with him to assist him. MYL explained that when he was recovering from his illness his doctor told him to keep a daily diary about how he was feeling and MYL also included details about daily events, including details about his dealings with Dr. Xu.

343. The Panel accepts MYL's evidence that he made his diary contemporaneously with the events described in it and that he recorded these events accurately and fairly. MYL did not rely on his diary for all of his evidence, but did refer to it for certain details including the exact dates he saw Dr. Xu.

344. The Panel accepts MYL's evidence that he paid Dr. Xu for a partial denture. Although MYL did not have receipts confirming his two payments to Dr. Xu, he had a notation in his journal that he paid $1,200 for dental treatment and he testified as to the exact dates he made these payments to Dr. Xu.

345. MYL gave evidence about going to Dr. Xu's office many times to try and find him, describing the route in great detail. MYL also called and texted Dr. Xu, but Dr. Xu did not respond. The Panel accepts MYL's evidence that Dr. Xu did not provide him with a partial denture or a refund.

346. Dr. Coil confirmed that the College sent Dr. Xu a copy of MYL's complaint and requested that Dr. Xu provide a response to the complaint and a copy of MYL's chart. She also confirmed that the College did not receive any response from Dr. Xu.

347. The Panel finds that the College has proven the allegations set out paragraph 28 of the Citation.

V. DECISION

348. The College asked the Panel to find that through a variety of inadequate practices, Dr. Xu practised the profession of dentistry incompetently and committed professional misconduct or unprofessional conduct.

349. The Panel has applied the standard articulated in *F (H) v. McDougall* 2008 SCC 53, when making its findings. Dr. Xu's failure to participate in the hearing does not change the College's obligation to prove the charges set out in the Citation.

Characterization of Dr. Xu's Conduct

350. Given the Panel's finding regarding the allegations in the Citation, it must determine how to characterize Dr. Xu's conduct in accordance with the *HPA*.

351. Section 39 of the *HPA* gives the Panel the authority to make certain findings at the completion of a hearing. Counsel for the College submitted that for the purposes of this hearing the relevant sections are s. 39(1)(c), which allows for a finding that the respondent has committed professional misconduct or unprofessional conduct and s.39(1)(d), which allows for a finding that the respondent has incompetently practiced the designated health profession.

352. Section 26 of the *HPA* defines professional misconduct as including sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the profession. Unprofessional conduct includes professional misconduct.

353. Counsel for the College submitted that the distinction between "unprofessional conduct" and the subset of "professional misconduct" is based on how the type and ethical seriousness of the conduct are characterized. He submitted that unprofessional conduct connotes the breach of a standard, rule or expected behaviour, whereas professional misconduct is unprofessional conduct that has crossed a more serious ethical threshold.

354. The College submitted that Dr. Xu's pattern of recordkeeping inadequacies including diagnosis, treatment planning and informed consent is serious enough to constitute professional misconduct. The College pointed to the evidence, including evidence that

Dr. Xu misled the College, provided unnecessary treatment to patients (including minors), failed to schedule and attend appointments, and failed to refund patients for treatment he did not complete.

355. The allegations against Dr. Xu are numerous and weighty and the Panel has found that the College has proven almost all of the allegations in the Citation. Taken together, the issues with Dr. Xu's practice, including his practice of billing up front and not completing treatment, the fact that he took advantage of elderly and vulnerable patients and the nature of his dealing with both his patients and the College are very serious and crossed a serious ethical threshold. The Panel finds that Dr. Xu's conduct and practices set out in paragraphs 1-8, 9(a) & (c)-(d), 10 (a)-(b), 11- 17, 19, 21(a)(ii), 22, 24, 26 and 28 amount to professional misconduct.

356. Counsel for the College submitted that on every allegation of substandard care, the Panel should find that Dr. Xu practiced dentistry incompetently based on Dr. Coil's expert evidence on the professional standards for dentists in this province.

357. Incompetency can be defined in various ways. Counsel for the College referred to the decision in *Mason v. Registered Nurses' Association of British Columbia,* 1979 Can LII 419 where the court defined incompetence as follows:

> Incompetence… connotes want of ability suitable to the task, either as regards natural qualities or experience or deficiency of disposition to use one's abilities and experience properly.

358. The Panel has found a concerning pattern of deficiencies in the treatment Dr. Xu provided to his patients. The Panel finds that the allegations of substandard care that the College has proven show that Dr. Xu was practicing dentistry incompetently. According, the Panel finds that with respect to the allegations of substandard care set out in paragraphs 1-3, 9-12, 17, 21(b)(i), 22 and 24 of the Citation, Dr. Xu practiced incompetently.

(a) *Dr. Xu's Failure to Respond to the College*

359. The College submitted that Dr. Xu's failure to respond to the College as set out in paragraphs 25 and 28 of the Citation amounts to professional misconduct.

360. There is no specific obligation in the College's Code of Ethics or bylaws requiring a registrant to co-operate in an investigation. The College argued that the College regulates its registrants in the public interest and this interest includes ensuring qualified individuals are admitted to the profession and that unprofessionalism, incompetency and incapacity are properly addressed. The College's investigation and discipline process is intended to fulfill this latter public interest expectation.

361. The College cited authority for the proposition that a professional has a duty to co-operate with his or her regulatory authority. In *Law Society of BC v. Dobbin,*[4] the panel held that the duty to reply to communications from the Law Society is at the heart of its regulation of the practice and that failure to cooperate in an investigation by a regulatory body is professional misconduct. The College also cited *Artinan v. College of Physicians and Surgeons*[5] as authority for the proposition that every professional has an obligation to co-operate in an investigation by his or her self-governing body.

362. The College also referred to the decision by the College in *Re Kaburda*, where the panel characterized the registrant's failure to co-operate with the College during its investigation, including his failure to provide the College with records and other information it had requested as professional misconduct.

363. Dr. Xu's failure to respond to the College does not appear to be the result of defiance and a refusal to recognize the authority of the College, as was the case with the registrant in *Re Kaburda*. However, the Panel still finds that Dr. Xu's failure to respond to the College and his failure to provide patient records to the College amounts to professional misconduct. The College's investigation and discipline process requires co-operation from registrants. Dr. Xu's failure to respond to the College made this hearing more difficult for the College and the witnesses. The College (Dr. Coil) had to try and re-create treatment histories from information provided by other dentists, evidence from patients and inadequate records.

[4] [1999] LSBC 27
[5] (1990) 73 O.R. 2d

(b) Dr. Xu's Failure to Attend the Hearing

364. The College invited the Panel to draw an adverse inference from Dr. Xu's failure to attend the hearing that he had no defence, explanation or excuse for his conduct. The College cited the Manitoba decision of *Cross v. Wood*, [1993] M. J. No. 648, in which the Court of Appeal adopted the language from *R. v. Johnson*[6]:

> It is not so much that the failure to testify justifies an inference of guilt; it is rather that it fails to provide any basis to conclude otherwise…If the Crown's case cries out for an explanation, an accused must be prepared to accept the adverse consequences of his decision to remain silent….

365. The College contrasted Dr. Xu's absence at the hearing with the effort the witnesses made to attend the hearing. The Panel recognizes the effort witnesses made to attend the hearing and give evidence. Some witnesses were elderly and in poor health, others missed work uncompensated and others made a long commute to attend. The Panel also acknowledges that for some patients it was uncomfortable to give their evidence at a formal hearing. It was clear that for all the witnesses, their dealings with Dr. Xu had a significant emotional and financial impact on them and their families. The Panel also acknowledges the difficulty the College faced as a result of Dr. Xu failing to attend and failing to provide the College with patient charts.

366. In *R. v. Johnson*, the Ontario Court of Appeal clarified when it is appropriate to draw an adverse inference when the accused fails to testify. The Court of Appeal clarified that it is not proper to use a failure to testify to prove a case beyond a reasonable doubt and that the failure to testify does not justify an inference of guilt. However, if the finder of fact is satisfied beyond a reasonable doubt that the evidence is true, and the facts cry out for a response from the accused, the trier of fact may draw an inference unfavourable to the accused who did not testify.

367. If Dr. Xu could have provided an explanation for any of the allegations in the Citation, the consequence of his failure to participate in the hearing is that the College's evidence went unchallenged. Where the Panel was satisfied on the balance of probabilities that the evidence adduced by the College proved a certain allegation, it has made that finding.

[6] *R. v. Johnson*, (1993), 79 C.C.C. (3d) 42 (Ont. C.A.)

When the evidence before the Panel was not sufficient for it to find on the balance of probabilities that an allegation had been proven, the burden of proof cannot be met by it drawing an adverse inference from Dr. Xu's failure to attend. Accordingly, the Panel does not find it necessary or appropriate to draw a blanket adverse inference from Dr. Xu's failure to attend the hearing.

VI. ORDERS

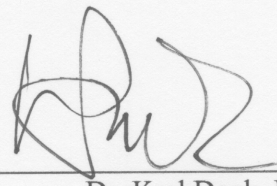
368. In sum, the Panel finds that the following portions of the Citation have been proven: paragraph 1-8, 9(a), (c) & (d), 10(a)-(b), 11-15, 17, 21(a)(ii), 21(b)(i), 22, 24, 25(a)-(b) & (d)-(j), 26(a)-(b), (d) & (f)-(h) & (j) and 28.

369. The Panel directs the College to serve Dr. Xu with a copy of this decision as soon as practicable and to provide the Panel with proof of service. The College is entitled to serve this decision on Dr. Xu by way of substituted service in the manner provided for in the August Orders.

370. The Panel also orders that a hearing be convened to hear submissions on the appropriate penalty for Dr. Xu.

For the Panel:

Date:



Dr. Karl Denk, Panel Chair

Date:

Dr. Myrna Halpenny, Panel Member

Date:

Mr. Paul Durose, Panel Member

When the evidence before the Panel was not sufficient for it to find on the balance of probabilities that an allegation had been proven, the burden of proof cannot be met by it drawing an adverse inference from Dr. Xu's failure to attend. Accordingly, the Panel does not find it necessary or appropriate to draw a blanket adverse inference from Dr. Xu's failure to attend the hearing.

VI. ORDERS

368. In sum, the Panel finds that the following portions of the Citation have been proven: paragraph 1-8, 9(a), (c) & (d), 10(a)-(b), 11-15, 17, 21(a)(ii), 21(b)(i), 22, 24, 25(a)-(b) & (d)-(j), 26(a)-(b), (d) & (f)-(h) & (j) and 28.

369. The Panel directs the College to serve Dr. Xu with a copy of this decision as soon as practicable and to provide the Panel with proof of service. The College is entitled to serve this decision on Dr. Xu by way of substituted service in the manner provided for in the August Orders.

370. The Panel also orders that a hearing be convened to hear submissions on the appropriate penalty for Dr. Xu.

For the Panel:

Date:

Dr. Karl Denk, Panel Chair

Date: June 12/19

Dr. Myrna Halpenny, Panel Member

Date:

Mr. Paul Durose, Panel Member

When the evidence before the Panel was not sufficient for it to find on the balance of probabilities that an allegation had been proven, the burden of proof cannot be met by it drawing an adverse inference from Dr. Xu's failure to attend. Accordingly, the Panel does not find it necessary or appropriate to draw a blanket adverse inference from Dr. Xu's failure to attend the hearing.

VI. ORDERS

368. In sum, the Panel finds that the following portions of the Citation have been proven: paragraph 1-8, 9(a), (c) & (d), 10(a)-(b), 11-15, 17, 21(a)(ii), 21(b)(i), 22, 24, 25(a)-(b) & (d)-(j), 26(a)-(b), (d) & (f)-(h) & (j) and 28.

369. The Panel directs the College to serve Dr. Xu with a copy of this decision as soon as practicable and to provide the Panel with proof of service. The College is entitled to serve this decision on Dr. Xu by way of substituted service in the manner provided for in the August Orders.

370. The Panel also orders that a hearing be convened to hear submissions on the appropriate penalty for Dr. Xu.

For the Panel:

Date:

Dr. Karl Denk, Panel Chair

Date:

Dr. Myrna Halpenny, Panel Member

Date:

Paul Durose

Mr. Paul Durose, Panel Member

THE MATTER OF THE COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA

AND

DR. BIN XU, A REGISTRANT

CORRIGENDUM TO REASONS FOR DECISION

Dr. Karl Denk, (Chair)

Dr. Myrna Halpenny

Mr. Paul Durose

Hearing Date:	November 1-2 & 5-7, 2018
Counsel for CDSBC:	Mr. Thomas Lutes and Mr. David Madani
Dr. Xu:	not in attendance and not represented by counsel
Counsel for the Discipline Panel:	Mr. William L. Roberts and Ms. Amy M. Nathanson
Date of Corrigendum:	July 24, 2019

1. This is a corrigendum to the reasons for decision dated June 12, 2019.

2. On page 1, the spelling of the last name of counsel for the CDSBC's is corrected to "Madani".

3. Paragraph 3, line 3 is changed by inserting "examination" after "(Canada)".

4. Paragraph 28, line 1 is changed to delete "attended at the College and".

5. Paragraph 46, line 1 is changed by deleting "Durng" and inserting "During".

6. Paragraph 51, line 1 is changed by deleting "was" after the word said.

7. Paragraph 58, line 2 is changed by changing "translator" to "interpreter".

8. Paragraph 85, line 2 is changed by deleting "substandard" after the words "explained that" and adding "the standard of".

9. Paragraph 155, line 4 is changed by inserting a space between the words the and tooth.

10. Paragraph 170, line 4 is changed by deleting "refer" and inserting "referred".

11. Paragraph 176, line 1 is changed by substituting a period for the "/" after the word Dr.

12. Paragraph 242, line 3 is changed by deleting "SZYZ" and inserting "SYSZ".

13. Paragraphs 250, 252, and 255 are changed by substituting "A.L." for the initials AL.

14. Paragraph 272, line 3 is changed by deleting the comma after 2016.

15. Paragraph 311, line 4 is changed by deleting “been” before the word aware.

16. Paragraph 318, line 2 is changed by deleting “examined” before the word asked.

17. Paragraphs 318, 319, 320, 322, 325, 326 and 327 are changed by deleting “CHJC” and inserting “CHJZ”.

18. Paragraph 322, line 2 is changed by deleting “costs” and inserting “cost”.

19. Paragraph 330, line 5, is changed by deleting “College” and adding “Panel” before the word accepts.

20. Paragraph 338, line 3 is changed by deleting the comma after the word amount.

Schedule "A"

Note to Panel:
This copy of the September 17, 2018 Further Amended Citation has been blacklined by counsel to the College to indicate charges withdrawn by the College at the opening of the hearing into this matter. Charges withdrawn have also been highlighted.

IN THE MATTER OF

The *Health Professions Act* RSBC 1996 c. 183

Between:

THE COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA

And:

DR. BIN XU

FURTHER AMENDED CITATION

TO: The Respondent
Dr. Bin Xu
[redacted]
(the "Respondent")

TAKE NOTICE that a Panel of the Discipline Committee (the "Panel") of the College of Dental Surgeons of British Columbia (the "College") will conduct a hearing under s. 38 of the *Health Professions Act* RSBC 1996 c. 183 (the *"Act").*

The purpose of the hearing is to inquire into your conduct and competence as a dentist. The College is conducting this inquiry to determine whether you:

a) have not complied with the Act, a regulation or a bylaw,

b) have not complied with a standard, limit or condition imposed under the Act,

c) have committed professional misconduct or unprofessional conduct,

d) have incompetently practised dentistry, and/or

e) suffer from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs your ability to practise dentistry.

The hearing will be held at Charest Reporting Services, #1650 - 885 West Georgia Street, Vancouver, BC V6C 3E8. The hearing will commence on 1 November through 2 November 2018, and continue from 5 November to 9 November 2018. The hearing will commence each day at 9:30 am, subject to the Panel's direction.

You are entitled to attend the hearing and may be represented by legal counsel. If you do not attend the hearing, the Panel is entitled to proceed with the hearing in your absence and, without further notice to you, the Panel may take any actions that it is authorized to take under the Act.

Particulars of the allegations against you are:

1. With respect to your patient [redacted] ("WSK"), between April 2015 to June 2015, you did one or more of the following:

   a) failed to properly diagnose the patient's presenting condition, particularly by failing to diagnose the patient's periodontal condition, extensive caries and failing restorations;

   b) failed to obtain and/or document informed consent for the treatment provided, particularly in relation to the patient's failing dentition and teeth 1.2 and 3.5;

   c) failed to develop an appropriate treatment plan;

   d) failed to create and/or maintain adequate dental records;

   e) provided substandard endodontic and prosthodontic treatment of teeth 1.2 and 3.5;

   f) billed and received payment for restorations on teeth 3.3 and 3.7 when you did not provide such treatment; and

   g) misled the College when you stated in communications to the College that you provided restorations for teeth 3.3 and/or 3.7, when you did not provide such treatment.

2. With respect to your patient [redacted] ("YHL"), between 2008 and 2016, you did one or more of the following:

   a) failed to properly diagnose and develop appropriate treatment plans for the patient's significant decay and periodontal, prosthodontic, and/or endodontic concerns;

   b) failed to obtain and/or document informed consent for the treatment provided;

   c) failed to create and/or maintain adequate dental records;

   d) provided substandard care in the endodontic treatment of teeth 2.2, 2.3 and 2.4; and

   e) billed, or allowed to be billed, for three units of time for bridge repair and/or re-cementation for tooth 2.4, when the patient records do not indicate that this treatment was provided.

3. With respect to your patient [redacted] ("WLQ"), between August 2015 and September 2015, you did one or more of the following:

   a) failed to properly diagnose the patient's presenting condition and develop an appropriate treatment plan;

   b) provided substandard care in the endodontic re-treatment of tooth 4.6; and

   c) failed to create and/or maintain adequate dental records.

4. With respect to your patient [redacted] ("CHC"), between August 2015 and January 2016, you failed to create and/or maintain adequate dental records, including failing to record informed consent and treatment rationale for extraction of tooth 1.5.

5. With respect to your patient [redacted] ("KL"), between December 2014 and February 2016, you did one or more of the following:

   a) failed to properly diagnose the patient's presenting condition and develop appropriate treatment plans;

b) failed to obtain and/or document informed consent for the treatment provided; and

c) failed to create and/or maintain adequate dental records.

6. With respect to your patient [redacted] ("DT"), between July 2015 and September 2015, you did one or both of the following:

a) failed to properly diagnose the patient's decay on tooth 1.2; and

b) failed to create and/or maintain adequate dental records, including failing to record informed consent for the treatment provided for tooth 2.1.

7. With respect to your patient [redacted] ("LW"), between September 2015 and October 2015, you did one or more of the following:

a) failed to properly diagnose the patient's presenting condition for tooth 2.5;

b) failed to properly diagnose the open crown margin on tooth 2.6; and

c) failed to create and/or maintain adequate dental records.

8. With respect to your patient [redacted] ("YVX"), since about February 2016, you did one or both of the following:

a) failed to provide follow-up orthodontic treatment; and

b) failed to create and/or maintain adequate dental records.

9. With respect to your patient [redacted] ("LSL"), in or about September 2015, you did one or more of the following:

a) provided substandard care in the endodontic treatment of tooth 4.7;

b) misled the patient about the endodontic treatment provided;

c) failed to provide options for further endodontic treatment of tooth 4.7; and

d) failed to create and/or maintain adequate dental records.

10. With respect to your patient [redacted] ("YHF"), in or about August 2015, you did one or more of the following:

a) provided substandard care in the endodontic treatment of tooth 3.6;

b) failed to provide options for further endodontic treatment of tooth 3.6; and

c) received payment for treatment not completed for tooth 3.6, and failed to provide a refund as indicated.

11. With respect to your patient [redacted] ("HCL"), between March 2015 and August 2015, you did one or more of the following:

a) failed to properly diagnose the patient's presenting condition;

b) failed to develop an appropriate treatment plan for the patient's periodontal condition;

c) provided substandard care in the endodontic treatment of tooth **1.**7;

d) failed to provide options for further endodontic treatment of tooth 1.7; and

e) failed to create and/or maintain adequate dental records including in relation to the patient's periodontal condition.

12. With respect to your patient [redacted] ("YAZ"), between October 2012 and March 2016, you did one or more of the following:

a) provided substandard care in the endodontic treatment of tooth 2.3;

b) provided substandard prosthodontic care in relation to teeth 2.2, 1.1 and 2.1;

c) failed to properly diagnose and/or develop an appropriate treatment plan in relation to teeth 1.1, 1.2, 2.1 and 2.3; and

d) failed to create and/or maintain adequate dental records.

13. With respect to your patient [redacted] ("JBY"), between or about August 2015 and September 2015, you did one or more of the following:

a) failed to properly diagnose and/or develop an appropriate treatment plan in relation to teeth 1.8 and 4.8; and

b) failed to create and/or maintain adequate dental records.

14. With respect to your patient [redacted] ("HLH"), between or about December 2010 and March 2016, you did one or both of the following:

a) failed to properly diagnose and/or develop an appropriate treatment plan for tooth 3.6; and

b) failed to create and/or maintain adequate dental records.

15. With respect to your patient [redacted] ("EZ"), between October 2009 and March 2016, you did one or more of the following:

a) failed to properly diagnose and/or develop an appropriate treatment plan for teeth 7.4, 7.3, 5.5, 5.4 and 8.4;

b) provided treatment and/or advice that was unnecessary and/or inappropriate, given the age of the patient, including scaling, root planing and recommending a nightguard; and

c) failed to create and/or maintain adequate dental records.

16. With respect to your patient [redacted] ("BML"), you did one or both of the following:

a) during or around the period April and October 2016, received payment from the patient for bone graft treatment that was not provided; and

b) since April 2016, failed to refund monies you received for bone grafting treatment not provided.

17. With respect to your patient [redacted] ("SYSZ"), during or around the period October 2016 and January 2017, you did one or more of the following:

a) provided substandard care, including failing to provide adequate or any follow-up care in relation to the orthodontic treatment you provided;

b) failed to schedule and/or attend appointments with the patient; and

c) failed to refund monies you received for orthodontic and implant treatment not provided.

18. With respect to your patient [redacted] ("HSS"), ~~in or about December 2016 you provided substandard care in failing to provide adequate or any follow-up care related to placement of a crown and denture treatment.~~

19. With respect to your patient [redacted] ("BWS"), since about September 2016, you failed to refund monies you received for prosthodontic treatment not provided.

20. With respect to your patient [redacted] ("WLY"), ~~you did one or both of the following:~~

~~a) since about August 2015, failed to provide follow-up treatment related to placement of a dental implant supported crown; and~~

~~b) since about August 2015, you failed to refund monies you received for prosthodontic treatment that was not completed.~~

21. With respect to your patients [redacted] ("KZ" and "SZ"), you did one or more of the following:

a) with respect to KZ, in or about the period December 2012 and September 2016:

i) provided substandard care in the patient's orthodontic treatment; and

ii) failed to provide appropriate follow up care;

b) with respect to SZ, in or about December 2012 and September 2016:

i) provided substandard care in the patient's orthodontic treatment including by failing to monitor and provide adequate follow-up treatment; and

ii) failed to refund monies you received for orthodontic treatment that was not completed.

22. With respect to your patient name [redacted] ("FCW"), between November 2015 and September 2016, you did one or more of the following:

a) provided substandard care with regards to implant treatment including failure to provide appropriate follow up care; and

b) failed to refund monies you received for treatment, including implant restoration that was not completed.

23. With respect to your patient [redacted] ("SWC"), ~~you provided substandard care in the patient's orthodontic treatment from about December 2016 by failing to monitor and provide adequate follow-up treatment.~~

24. With respect to your patient [redacted] ("CHJZ"), from July 2016 you did one or more of the following:

a) provided substandard care in the patient's orthodontic treatment, by failing to monitor and provide adequate follow-up treatment; and

b) failed to refund monies you received for orthodontic treatment that was not completed.

25. Since about November 2016, you have failed to respond in a substantive or timely manner, or at all, to College inquiries and/or requests for information with respect to complaints regarding the following patients:

a) BML
b) SYSZ
c) HSS
d) BWS
e) WLY
f) KZ
g) SZ
h) FCW
i) SWC
j) CHJZ

26. Since about October 2016, you have failed to respond in a substantive or timely manner, or at all, to inquiries and/or requests for information from the following patients and/or their representatives:

a) BML
b) SYSZ
c) ~~HSS~~
d) BWS
e) ~~WLY~~
f) KZ
g) SZ
h) FCW
i) ~~SWC~~
j) CHJZ

~~27. With respect to your patient [redacted] ("HPH"), you did one or more of the following:~~

~~a) in our about May 2017 and June 2017, you provided dental services, namely surgical placement of implant fixtures, despite having executed and while under a voluntary withdrawal from practice agreement with the College dated January 20, 2017;~~

~~b) provided substandard care in the surgical placement of implant fixtures, including failing to provide appropriate follow-up care; and~~

~~c) failed to respond in a substantive or timely manner, or at all, to inquiries and/or requests for information from the patient or the patient's representatives.~~

28. With respect to your patient [redacted] ("MYL"), you did one or more of the following:

a) in or about March and December 2016, accepted payment for dental services, namely partial denture fabrication and placement, but failed to provide and place the denture and provide follow-up treatment;

b) failed to refund monies you received from or on behalf of the patient for the treatment that was not completed;

c) failed to respond in a substantive or timely manner, or at all, to inquiries and/or requests for information from the patient or the patient's representatives; and

d) failed to respond in a substantive or timely manner, or at all, to College inquiries and/or requests for information with respect to the patient's complaint against you.

FURTHER TAKE NOTICE that after completion of the hearing under s. 38 of the *Act* the Panel, under s. 39 of the *Act*, may dismiss the matter or may determine that you:

a) have not complied with the *Act*, a regulation, or a bylaw,

b) have not complied with a standard, limit, or condition imposed under the *Act*,

c) have committed professional misconduct or unprofessional conduct,

d) have incompetently practised dentistry, and/or

e) suffer from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs your ability to practise dentistry.

This Citation is issued at the direction of the Inquiry Committee of the College under section 37 of the *Act.*

The Discipline Committee is constituted under the *Act* and the College's Bylaws thereunder. Copies of the Act, the *Dentists Regulation,* BC Reg 415/2008, and the College's Bylaws are enclosed with this Citation, and you are particularly referred to s. 37-39 of the *Act* and part 10 and schedule Hof the Bylaws.

THE COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA:

Dr. Chris N. Hacker, Acting Registrar

Date 17 September 2018