21-0716

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. LUN HANGFU**, of the City of Toronto, in the Province of Ontario;

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

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

NOTICE OF PUBLICATION BAN

This is formal notice that on October 7, 2022, the panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario made an Order directing that no person shall publish or broadcast the identity of any patients of the Member, or any information that could disclose the identity of any patients who are named in the Notice of Hearing and/or the Agreed Statement of Facts in this matter.

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

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

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

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

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

Dr. Richard Hunter, Chair
Discipline Panel

October 7, 2022
Date

21-0716

THE DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one Dr. Lun Hangfu of the City of Toronto, in the Province of Ontario;

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

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Ian Brockhouse
Mr. Mark Trudell

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	Appearances:
	Luisa Ritacca Independent Counsel for the Discipline Committee of the Royal College of Dental Surgeons of Ontario
- and -	
	Megan Shortreed for the Royal College of Dental Surgeons of Ontario
	Also in attendance Dr. Helene Goldberg from the Royal College of Dental Surgeons of Ontario
DR. LUN HANGFU	Dr. Lun Hangfu, Member

Hearing held by way of videoconference

REASONS FOR DECISION

1. This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on October 7, 2022. This matter was heard by way of videoconference.

THE ALLEGATIONS

2. The allegations against the Member were contained in the Notice of Hearing, dated August 25, 2021 (Exhibit 1), which is attached to these Reasons for Decision at Appendix A.

3. At the outset of the hearing, the College advised the Panel that it sought to withdraw the allegations contained in paragraphs 4 and 5 of the Notice of Hearing. With the consent of the Member, the Panel agreed with the College's request.

4. As a result of the withdrawals, the Panel made no findings against the Member in relation to the allegations contained in paragraphs 4 and 5.

THE MEMBER'S PLEA

5. The Member admitted the allegations of professional misconduct as set out in the Notice of Hearing, save for those allegations that were withdrawn.

6. The Panel confirmed that the Registrant had signed a plea inquiry and, after conducting an oral plea inquiry, was satisfied that the Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

7. On consent of the parties, the College introduced into evidence an Agreed Statement of Facts (Exhibit 3) which substantiated the allegations. The Agreed Statement of Facts provides as follows:

Background

1. Dr. Lun Hangfu ("Dr. Hangfu" or the "Member") has been registered with the Royal College of Dental Surgeons of Ontario (the "College") as a general dentist since 1983.

2. At the material times, Dr. Hangfu practiced at his own clinic located in Toronto, Ontario (the "Clinic").

The Notice of Hearing

3. The allegations of professional misconduct against Dr. Hangfu are set out in the Notice of Hearing dated August 25, 2021[1].

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

Withdrawals

5. The College is not proceeding with respect to Allegations 4 and 5 in the Notice of Hearing. Accordingly, with leave of the Discipline Committee, the College withdraws these allegations.

Facts and Admissions

6. The facts giving rise to the allegations in the Notice of Hearing came to the attention of the College through a complaint received on November 15, 2017 from Ms. Tina Kovacs, Risk Management, Health & Dental Operations at Manulife Financial ("Manulife"). The College received further complaint letters from Manulife on December 4, 2017, December 3, 2018 and December 6, 2018.

7. On November 30, 2017, Dr. Helene Goldberg, a College investigator, attended at the Clinic. During the attendance, Dr. Goldberg spoke with Dr. Hangfu and collected relevant patient records.

8. The College received further patient records from Dr. Hangfu on December 5, 2018.

9. Dr. Goldberg attended at the Clinic a second time on January 23, 2018. During this attendance, Dr. Goldberg spoke with Dr. Hangfu and his receptionist, and obtained further patient records relating to the more recent letters from Manulife.

10. The College provided a copy of the Registrar's Report dated December 2, 2019, which included an analysis of the patient records obtained during the investigation, to Dr. Hangfu.

11. Dr. Hangfu provided submissions to the Inquiries, Reports and Complaints Committee (the "ICRC") on January 29, 2020, February 18-19, 2020 and February 8, 2021.

12. On June 24, 2021, the College sent a letter to Dr. Hangfu indicating that the ICRC intended to refer specified allegations of professional

[1] Attached to these reasons as Appendix A

misconduct to the Discipline Committee. On July 16, 2021, Dr. Hangfu provided submissions in response to the intention letter.

13. The ICRC issued its decision on August 11, 2021 (Tab B), referring specified allegations of professional misconduct to the Discipline Committee.

14. The alleged misconduct occurred between 2008 and 2017 and relates to Dr. Hangfu's treatment of 16 patients: F.B., T.C., D.M., N.F., G.I., N.P., L.C., D.B., R.M., J.K., S.M., J.P., R.R., A.M., A.C-F., and E.W., (collectively, the "Patients").

I. Sedative Restorations (Allegations 1, 2, and 3)

15. The College's investigation identified three instances where Dr. Hangfu placed at least one sedative restoration (code 20111) seven days prior to placing a permanent composite resin restoration:

    a. F.B. – April 11, 2015 – teeth 14, 15;

    b. T.C. – February 14, 2015 – tooth 17; and

    c. D.M. – July 25, 2018 – teeth 36, 37.

16. If Dr. Hangfu were to testify he would state that he used sedative restorations, referred to as zinc oxide eugenol ("ZOE") restorations for clinical purposes to assist with pain control and reduce discomfort.

17. Nevertheless, Dr. Hangfu admits and acknowledges that:

    a. the sedative restorations were unnecessary as there was either no or insufficient clinical justification for them;

    b. a tooth with a sedative restoration should be left for several weeks with no further restorative treatment, and not treated within approximately one week's time by a permanent restoration; and

    c. it is contraindicated to place a composite restoration on top of a sedative restoration.

18. Dr. Hangfu admits that in placing the ZOE restorations as described above, he:

    a. breached the standards of practice contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing;

    b. recommended and provided unnecessary dental services contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing; and

c. charged a fee that was excessive or unreasonable contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

II. Multiple Restorations (Allegations 1, 2 and 3)

19. The College's investigation identified that from February 6, 2008 to September 13, 2017, for five patients involving 15 teeth, Dr. Hangfu documented placing 92 restorations, as follows:

a. F.B:

i. Tooth 16: restored March 7, 2015 (L),1 March 24, 2015 (L), April 30, 2016 (L);

ii. Tooth 25: restored March 7, 2015 (V), March 24, 2015 (V);

iii. Tooth 37: restored March 7, 2015 (OVL), March 14, 2015 (OV), April 20, 2016 (OV);

b. T.C:

i. Tooth 47: restored February 10, 2015 (O), February 18, 2016 (OV), August 16, 2016 (OV);

c. N.F:

i. Tooth 11: restored March 21, 2009 (V), November 7, 2009 (MVLI), April 2, 2010 (MVLI), June 12, 2010 (MDVLI), February 12, 2011 (MVLI), August 6, 2011 (V), May 22, 2015 (DVLI), August 14, 2015 (MV), September 5, 2015 (MVLI), August 12, 2016 (DVLI), August 26, 2016 (MVLI), July 15, 2017 (DVL);

ii. Tooth 12: restored March 21, 2009 (V), November 28, 2009 (MDV), April 12, 2010 (MDV), February 12, 2011 (MDVL), August 6, 2011 (V), May 22, 2015 (MLI), August 14, 2015 (MDVLI), August 26, 2016 (MVLI), July 15, 2017 (MDVL);

iii. Tooth 13: restored October 21, 2009 (V), August 6, 2011 (V), September 12, 2015 (DVL), August 12, 2016 (DVL), August 26, 2016 (DVLI), April 29, 2017 (MVL), July 15, 2017 (MVL), July 22, 2017 (MDVLI);

iv. Tooth 21: restored January 3, 2009 (V), November 8, 2009 (MVLI), June 12, 2010 (MDVLI), August 6, 2011 (V), May 22, 2015 (MVLI), August 14, 2015 (VI), September 5, 2015 (DVLI), August 12, 2016 (DVLI), August 26, 2016 (MVLI), November 30, 2016 (MVLI), July 15, 2017 (DVLI);

v. Tooth 22: restored December 13, 2008 (LI), January 3, 2009 (V), April 12, 2010 (MDV), January 22, 2011 (MDVLI), August 6, 2011 (V), September 16, 2015 (MDL), November 30, 2016 (MVL), July 15, 2017 (MVLI);

vi. Tooth 23: restored January 3, 2009 (V), Jun 12, 2010 (V), January 22, 2011 (V), August 6, 2011 (V), February 21, 2013 (DVLI), September 16, 2015 (MDL), May 7, 2016 (MVL), March 11, 2017 (MVLI);

vii. Tooth 41: restored December 20, 2008 (MI), December 28, 2010 (MDVLI), August 13, 2011 (MDVLI), February 11, 2016 (MDVLI), April 29, 2017 (MDV);

viii. Tooth 42: restored February 6, 2008 (I), April 12, 2008 (MDL), April 16, 2011 (I), August 13, 2011 (VI), February 15, 2013 (VI), January 3, 2014 (MDLI), August 12, 2016 (MVLI);

ix. Tooth 43: restored February 6, 2008 (DI), November 7, 2009 (DVI), December 28, 2010 (I), April 16, 2011 (I), August 13, 2011 (I), June 2, 2012 (VLI), February 15, 2013 (DVL), March 14, 2013 (MDL), August 12, 2016 (I);

d. G.I:

i. Tooth 27: restored May 5, 2016 (DOVL), September 13, 2017 (DOVL); and

e. N. P:

i. Tooth 75: restored July 19, 2016 (DOVL), June 8, 2017 (DOVL).

20. Dr. Hangfu admits and acknowledges that the number of restorations performed on these teeth was unnecessarily high. The frequency of restorations on the same teeth and surfaces indicates that Dr. Hangfu did not plan or execute restorative treatment in a manner that meets the standards of practice of the profession. Had he done so, fewer or longer-lasting restorations would have been needed.

21. As a result, Dr. Hangfu admits that in re-treating teeth as described above he:

a. breach of the standards of practice contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing;

b. recommended and provided unnecessary dental services contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing; and

c. charged fees that were excessive and unreasonable contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

III. In-Office Lab Charges (Allegation 3)

22. The College's investigation identified that for six of the Patients, in 10 instances, Dr. Hangfu submitted additional expenses as in-office lab charges for steps that are part of a comprehensive service for which there should be no additional charge, as follows:

a. In three instances, the associated procedure was the fabrication of a cast post and core (code 25711):

i. L.C. – June 20, 2016 – tooth 13;

ii. N. F. – November 30, 2017 – tooth 45; and

iii. D.M. – August 15, 2018 – tooth 46.

b. In five instances, the associated procedure was the fabrication of a porcelain-fused-to-metal crown (code 27211):

i. D. B. – February 17, 2016 – tooth 26;

ii. L. C. – September 28, 2016 – tooth 13;

iii. N. F. – December 12, 2016 – tooth 45;

iv. D. M. – August 28, 2018, tooth 46; and

v. R. M. – February 17, 2016 – tooth 26.

c. In one instance, the associated procedure was the fabrication of a cast metal crown (code 27301): D. B. – August 17, 217 – tooth 47.

d. In one instance, the associated procedure was the fabrication of a three-unit porcelain-fused-to-metal bridge (codes 62501 – pontic, 67211 – retainers): J.K. – June 12, 2018 – teeth 11/12/21.

23. The additional charges related to the above services ranged from $80 to $300.

24. If Dr. Hangfu were to testify, he would say that he did not know that if these services were provided in-office they could not be charged for separately.

25. Nevertheless, Dr. Hangfu admits and acknowledges that he should not have charged for above services. In doing so, he admits that he charged fees that were excessive and unreasonable contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

IV. Emergency Exam Charges (Allegation 3)

26. The College's investigation identified that Dr. Hangfu engaged in the practice of over-using and inappropriately using the emergency exam fee code (01205) when there was no basis or indication of an emergency.

27. An emergency exam involves the emergency investigation of discomfort and/or infection in a localized area, not broader or planned treatment. As a result, Dr. Hangfu charged excessive or unreasonable fees when he claimed emergency exams as described below.

28. In eight instances, Dr. Hangfu claimed emergency exams along with treatment involving multiple teeth and/or sites, as follows:

    a. F. B. – April 20, 2016 – teeth 16, 37, 46;

    b. G. I. – June 20, 2017 – teeth 15-17 and 35-37;

    c. S. M. – September 25, 2014 – unspecified sites; November 19, 2014 – unspecified sites; December 4, 2014, unspecified sites; December 3, 2015 – unspecified sites; May 17, 2016 – teeth 26, 47; and

    d. J. P. – June 24, 2016 – tooth 45 and unspecified site.

29. In one instance, Dr. Hangfu charged an emergency exam along with the delivery of a full-coverage crown:

    a. L. C. – November 23, 2016 – tooth 13.

30. In two instances, Dr. Hangfu charged an emergency exam for appointments that did not appear to be emergency exams based on the patient records and where there is no indication of the nature of the emergency:

    a. L.C. – July 6, 2015; and

    b. T.C. – July 30, 2015.

31. If Dr. Hangfu were to testify he would state that he thought the emergency exam code could be used when a patient attended the office when they did not have a scheduled appointment.

32. Dr. Hangfu admits that in using the emergency code in the manner described above, he charged fees that were excessive and unreasonable contrary to paragraph 31 of section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

V. Failure to Keep Records as Required (Allegation 6)

33. The College's investigation identified record keeping violations with respect to a number of the Patients.

34. In particular, for seven of the Patients, various chart entries were illegible and difficult to interpret for the following reasons:

    a. use of white-out (T.C. June 3, 2015);

    b. scribbled out text (D.M. February 19, 2016; S.M. February 9, 2017, November 14, 2017; R. R. June 25, 2016; N.P. April 15, 2015);

    c. entries made in pencil rather than ink (N.P. December 5, 2016 and December 6, 2016);

    d. use of multiple lines and overlapping text (T.C. February 10, 2015; D.M. October 12, 2016; S.M. Jan 5, 2016, February 9, 2017, November 4, 2017; R.R. June 25, 2016; J.P. June 24, 2016; N.P. April 15, 2015 and June 8, 2017); and

    e. alternation of treatment code(s) and/or fee(s) (J.P. February 20, 2016; N.P. June 8, 2017).

35. In addition, for five patients, in eight instances, a chief complaint and diagnosis for treatment were not documented/found in the progress notes:

    a. T. C. - February 18, 2015;

    b. D.M.– August 14, 2019;

    c. S. M –March 9, 2017, November 14, 2017;

    d. N. P – January 17, 2015, April 18, 2016; and

    e. A. M– January 7, 2015, May 20, 2017.

36. Finally, Dr. Hangfu failed to record the following necessary information in the charts for patients F. B, D. B, T. C, L. C, N.F, G.I, S. M, R. M, J.P., N.P, R.R, A. C-F, E.W, J.K, A.M, and D.M.:

    a. updated medical histories;

    b. updated periodontal and restorative charting;

c. sufficiently detailed clinical notes, including chief complaint, diagnosis and informed consent;

d. sufficient information regarding radiographic findings;

e. sufficient detail for root canal treatments such as trial file or fitting of the gutta percha; and

f. lack of sufficient or proper x-rays, including for the purposes of root canal treatments.

37. With respect to all of the above, Dr. Hangfu admits and acknowledges that he breached his professional, ethical and legal responsibilities that required him to maintain a complete record documenting all aspects of each patient's dental care, per the College's Dental Recordkeeping Guidelines, and s. 38 of Regulation 547.

38. Therefore, Dr. Hangfu admits that he failed to keep records as required by the regulations, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 6 of the Notice of Hearing.

Past History

39. In 1988, the Discipline Committee made findings of professional misconduct against Dr. Hangfu for:

a. knowingly submitting a false or misleading accounts or false or misleading charges to an insurance company respecting services rendered on 34 patients in 1985-1986;

b. failing to maintain the standards of practice of the profession when he submitted claims to an insurance company for 34 patients in which the claims represented fees for services in amounts in excess of the fee actually charged to the patients in 1985-1986; and

c. charging fees that were excessive and/or unreasonable in relation to the services performed with respect to 34 patients in 1985-1986.

40. The Discipline Committee imposed a penalty consisting of an oral reprimand, a fine, restitution, course work, community dental services, a 12 month suspension (with 10 months waived if the other conditions were fulfilled) and practice monitoring. A copy of this decision is attached at Tab C.

Summary

41. Dr. Hangfu admits that the acts described above constitute professional misconduct and he accepts responsibility for his actions and the resulting consequences.

42. Dr. Hangfu's admissions in this agreement and his plea to Allegations 1, 2, 3, and 6 in the Notice of Hearing are voluntary, informed and unequivocal.

43. Dr. Hangfu has had the opportunity to take independent legal advice with respect to his admissions.

DECISION AND REASONS FOR DECISION

The Panel finds that the Member engaged in professional misconduct as described in the Agreed Statement of Facts.

The Member pleaded guilty. He did not dispute the allegations, particulars or facts presented in the Agreed Statement of Facts. The Panel was of the view that the evidence contained in the Agreed Statement of Facts clearly substantiates the allegations and demonstrated the Member's disregard for the profession and his own personal integrity.

Dr. Hangfu admitted to:

a) Inappropriately placing sedative restorations with no justification 7 days before placing a permanent restoration and billing for both restorations.
b) Placing composite restorations on top of sedative restorations which is contrary to the standards of practice.
c) Performing multiple restorations on the same teeth during a relatively short period of time. The number of restorations on these teeth were unnecessarily high.
d) Submitting additional expenses as in-office lab charges for steps that are part of a comprehensive service for which there should be no additional charge.
e) Submitting an insurance claim that he knew or ought to have known was false and misleading.
f) Failing to keep records according to the standards of practice.

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission on Penalty (Exhibit 4), which sets out the following proposed penalty:

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

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

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

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

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

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

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

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

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

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

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

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

      ii. giving orders or standing orders to dental hygienists

iii. supervising work performed by others

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

v. acting as a clinical instructor;

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

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

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

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

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

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

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

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

a. the Member shall successfully complete, at his own expense, the following courses approved by the Registrar:

i. a hands-on restorative course with the following components:

1. treatment planning;

2. taking appropriate radiographs;

3. when and why radiographic evidence is required for treatment planning; and

4. placement of filings, including sedative filings (must obtain an "unconditional pass" grade);

ii. a one-on-one recordkeeping course;

iii. a billing course with the following components:

1. Proper use of billing codes and use of insurance;

2. Proper use of ODA fee guide; and

iv. a one-on-one ethics and professionalism course related to billing;

such courses to be completed within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar;

b. upon the Member's return to practice following the suspension, the Member will undergo practice mentoring for a period of six (6) months, on the following terms:

i. the Member will retain, at his own expense, a senior member of the College who is approved by the College (the "Mentor") to provide mentoring on treatment planning, all restorations (composites and amalgams) including sedative restorations, appropriate billing and record keeping;

ii. the Member and the Mentor will meet at least monthly, and engage in no less than six (6) mentoring sessions;

iii. the Member shall provide to the College, at his expense, an initial report from the Mentor within thirty (30) days of the Mentor being retained, and reports from the Mentor every month thereafter within thirty (30) days of each mentoring session. The reports shall include the date(s) and length of the mentoring session, the cases reviewed, the recommendations made to the Member pre-treatment, assessment of the Member's treatment post-treatment, and comments regarding the Member's progress, cooperation, ability to meet standards of practice, and concerns, if any;

iv. the Member's certificate of registration shall be restricted such that he shall not place any restorations (composites and

amalgams), including sedative restorations, without the review and approval of the Mentor to the treatment in advance; and

v. the Member will abide by and follow all of the recommendations of the Mentor;

c. after the Member successfully completes all courses and the practice mentorship described in paragraphs 4(a) and 4(b) above, the Member's practice shall be monitored by the College by means of inspections by a representative or representatives of the College for twenty-four (24) months. The inspections will be conducted quarterly during the first twelve (12) months and semi-annually during the second twelve (12) months. The inspections will focus on the Member's treatment planning, placement of restorations (composites and amalgams) including sedative restorations, the need for radiographic evidence, recordkeeping, and billing practices;

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

e. the representative or representatives of the College shall report the results of the inspections to the College and the College may, if deemed warranted, take such action as it considers appropriate, including that the monitoring cease, the monitoring be extended where there remain gaps or deficiencies relating to the issues listed in paragraph 4(c), or the frequency of the monitoring visits increase. If approved by the College, any extensions or variations of the practice monitoring will be completed by the Member;

f. the Practice Condition imposed by virtue of paragraph (4)(a) above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the courses described therein have been completed successfully;

g. the Practice Conditions imposed by virtue of paragraph 4(b) above shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the practice mentorship described therein has been completed successfully; and

h. the Practice Conditions imposed by virtue of paragraph 4(c)-(e) shall be removed from the Member's certificate of registration upon receipt by the College of confirmation in writing acceptable to the Registrar that the practice monitoring described therein has been completed successfully.

5. The Member shall pay costs to the College in the amount of $10,000.00, within thirty (30) days of the date of this Order becoming final.

PENALTY DECISION and REASONS FOR PENALTY DECISION

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

The Panel's primary concern when considering the adequacy of a penalty decision is public protection. The Panel is satisfied that public protection is met through the terms of the proposed order.

The Panel was satisfied that a five (5) month suspension, a reprimand and the recording of the results of these proceedings on the College register will act to deter the Member from behaving in this manner again and will also send a clear message to the members of the profession that professional misconduct of this nature will not be tolerated by the College.

Terms, Conditions and Limitations further afford public protection and will also provide remediation. Among other things, Dr. Hangfu is required to complete at his own expense:

- a hands-on restorative course
- a one-on-one recordkeeping course
- a billing course incorporating the use of the ODA Fee Guide and insurance claims
- a one-on-one ethics and professionalism course related to billing

Further, at the Member's expense, Dr. Hangfu shall obtain a College approved Mentor for six (6) months that will be followed by practice monitoring for 24 months.

The Panel considered the seriousness of the misconduct, the length of time that the misconduct occurred, the Member's previous history of appearing before a

Discipline panel for similar misconduct and the number of cases that contained billing irregularities as aggravating factors.

The Member co-operated with the College and acknowledged his misconduct. He has demonstrated a willingness to be remediated. By admitting the misconduct, he prevented a potentially costly and time-consuming hearing. These mitigating factors were considered as well.

The Panel determined that costs of $10,000.00 was appropriate in this case and ordered it to be paid within 30 days of this Order becoming final.

At the conclusion of the hearing, the Panel delivered its reprimand to Dr. Hangfu, following confirmation from him that he waived any right to appeal. A copy of the reprimand is attached hereto as Appendix B.

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

October 19, 2022

Date

APPENDIX A

21-0716

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 ("*Code"*) respecting one **DR. LUN HANGFU,** of the City of Toronto, in the Province of Ontario;

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

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

TO: DR. LUN HANGFU
1655 Dufferin St. #100
Toronto ON M6H 3L9

NOTICE OF HEARING

TAKE NOTICE THAT IT IS ALLEGED THAT:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that, during the year(s) 2008 to 2017, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one or more of your patients, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- You placed sedative restorations for the below patients in or around 7 days prior to placing permanent composite restorations. You contravened or failed to maintain the

standards of the profession in that:

- the sedative restorations were unnecessary, as there was no/insufficient clinical justification for them;
- a tooth with a sedative restoration should be left for several weeks with no further restorative treatment, and not treated within approximately one week's time by a permanent restoration; and/or
- it is contraindicated to place a composite restoration on top of a sedative restoration.

Patient	Date	Tooth
F.B.	Apr. 11, 2015	14, 15
T.C.	Feb. 14, 2015	17
D.M.	Jul. 25, 2018	36, 37

- You performed multiple restorations on the same teeth during relatively brief time periods. The number of restorations that you performed on these teeth was unnecessarily high. The frequency indicates that you did not plan and/or execute restorative treatment in a manner that meets the standards of the profession, that would have resulted in fewer and/or longer-lasting restorations overall.

Patient	Dates	Tooth & Surface(s)
F.B.	Mar 7, 2015	16L, 35V, 37OVL
	Mar. 14, 2015	37OV
	Mar. 24, 2015	16L, 35V
	Apr. 20, 2016	37OV
	Apr. 30, 2016	16L
T.C.	Feb. 10, 2015	47O
	Feb. 18, 2016	47OV
	Aug. 15, 2016	47OV
N.F.	Feb. 6, 2008	42I, 43DI
	Apr. 12, 2008	42MDL
	Dec. 13, 2008	22LI
	Dec. 20, 2008	41MI
	Jan. 3, 2009	21V, 22V, 23V
	Mar. 21, 2009	11V, 12V
	Oct. 21, 2009	13V
	Nov. 7, 2009	11MVLI, 21MVLI, 43DVI
	Nov. 28, 2009	12MDV
	Apr. 2, 2010	11MVLI
	Apr. 12, 2010	12MDV, 22MDV
	Jun. 12, 2010	11MDVLI, 21MDVL1, 23V
	Dec. 28, 2010	41MDVLI, 43I
	Jan. 22, 2011	22MDVLI, 23V
	Feb. 12, 2011	11MVLI, 12MDVL
	Apr. 16, 2011	42I, 43I
	Aug. 6, 2011	11V, 12V, 13V, 21V, 22V, 23V
	Aug. 13, 2011	41MDVLI, 42VI, 43I

	Jun. 2, 2012 Feb. 15, 2013 Feb. 21, 2013 Mar. 14, 2013 Jan. 3, 2014 May 22, 2015 Aug. 14, 2015 Sept. 5, 2015 Sept. 12, 2015 Sept. 16, 2015 Feb. 11, 2016 May 7, 2016 Aug. 12, 2016 Aug. 26, 2016 Nov. 30, 2016 Mar. 11, 2017 Apr. 29, 2017 Jul. 15, 2017 Jul. 22, 2017	4343VLI 42VI, 43DVL 23DVLI 43MDL 42MDLI 11DVLI, 12 MLI, 21MVLI 11MV, 12MDVLI, 21VI 11MVLI, 21DVLI 13DVL 22MDL, 23MDL 41MDVLI 23MVL 11DVLI, 13DVL,21DVLI, 42MVLI, 43I 11MVLI,12MVLI,13DVLI, 21MVLI 21MVLI, 22MVL 23MVLI 13MVL, 41MDV 11DVL, 12MDVL, 13MVL, 21DVLI, 22MVLI 13MDVLI
G.I.	May 5, 2016 Sept. 13, 2017	27DOVL 27DOVL
N.P.	Jul. 19, 2016 Jun 8, 2017	75DOVL 75DOVL

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2008 to 2017, you recommended and/or provided an unnecessary dental service relative to one or more of your patients, contrary to paragraph 6 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- You placed sedative restorations in or around 7 days prior to placing permanent composite restorations. The sedative restorations were unnecessary, because:
    - There was no/insufficient clinical justification for them; and/or
    - It is contraindicated to place composite restoration on top of a sedative restoration.

Patient	Date	Tooth
F.B.	Apr. 11, 2015	14, 15
T.C.	Feb. 14, 2015	17
D.M.	Jul. 25, 2018	36, 37

- You performed multiple restorations on the same teeth during relatively brief time periods. The number of restorations that you performed on these teeth was unnecessarily high. The frequency indicates that you did not plan and/or execute

restorative treatment in a manner that meets the standards of the profession, that would have resulted in fewer and/or longer-lasting restorations overall.

Patient	Dates	Tooth & Surface(s)
F.B.	Mar 7, 2015	16L, 35V, 37OVL
	Mar. 14, 2015	37OV
	Mar. 24, 2015	16L, 35V
	Apr. 20, 2016	37OV
	Apr. 30, 2016	16L
T.C.	Feb. 10, 2015	47O
	Feb. 18, 2016	47OV
	Aug. 15, 2016	47OV
N.F.	Feb. 6, 2008	42I, 43DI
	Apr. 12, 2008	42MDL
	Dec. 13, 2008	22LI
	Dec. 20, 2008	41MI
	Jan. 3, 2009	21V, 22V, 23V
	Mar. 21, 2009	11V, 12V
	Oct. 21, 2009	13V
	Nov. 7, 2009	11MVLI, 21MVLI, 43DVI
	Nov. 28, 2009	12MDV
	Apr. 2, 2010	11MVLI
	Apr. 12, 2010	12MDV, 22MDV
	Jun. 12, 2010	11MDVLI, 21MDVL1, 23V
	Dec. 28, 2010	41MDVLI, 43I
	Jan. 22, 2011	22MDVLI, 23V
	Feb. 12, 2011	11MVLI, 12MDVL
	Apr. 16, 2011	42I, 43I
	Aug. 6, 2011	11V, 12V, 13V, 21V, 22V, 23V
	Aug. 13, 2011	41MDVLI, 42VI, 43I
	Jun. 2, 2012	4343VLI
	Feb. 15, 2013	42VI, 43DVL
	Feb. 21, 2013	23DVLI
	Mar. 14, 2013	43MDL
	Jan. 3, 2014	42MDLI
	May 22, 2015	11DVLI, 12 MLI, 21MVLI
	Aug. 14, 2015	11MV, 12MDVLI, 21VI
	Sept. 5, 2015	11MVLI, 21DVLI
	Sept. 12, 2015	13DVL
	Sept. 16, 2015	22MDL, 23MDL
	Feb. 11, 2016	41MDVLI
	May 7, 2016	23MVL
	Aug. 12, 2016	11DVLI, 13DVL,21DVLI, 42MVLI, 43I
	Aug. 26, 2016	11MVLI,12MVLI,13DVLI, 21MVLI
	Nov. 30, 2016	21MVLI, 22MVL
	Mar. 11, 2017	23MVLI
	Apr. 29, 2017	13MVL, 41MDV
	Jul. 15, 2017	11DVL, 12MDVL, 13MVL, 21DVLI, 22MVLI
	Jul. 22, 2017	13MDVLI
G.I.	May 5, 2016	27DOVL
	Sept. 13, 2017	27DOVL
N.P.	Jul. 19, 2016	75DOVL
	Jun 8, 2017	75DOVL

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2008 to 2017, you charged a fee that was excessive or unreasonable in relation to the service performed relative to one or more of your patients, contrary to paragraph 31 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You submitted additional expenses as in-office lab charges for steps that are part of a comprehensive service for which there should be no additional charge.

Patient	Date	Associated Procedure & Code	Tooth
L.C.	Jun. 20, 2016 Sept. 28, 2016	Fabrication of cast post and core (25711) Fabrication of porcelain fused-to-metal crown (27211)	13 13
N.F.	Nov. 30, 2016 Dec. 12, 2016	Fabrication of cast post and core (25711) Fabrication of porcelain fused-to-metal crown (27211)	45 45
D.M.	Aug. 15, 2018 Aug. 28, 2018	Fabrication of cast post and core (25711) Fabrication of porcelain fused-to-metal crown (27211)	46 46
D.B.	Feb. 17, 2016 Aug. 17, 2017	Fabrication of porcelain fused-to-metal crown (27211) Fabrication of cast metal crown (27301)	26 47
R.M.	Feb. 17, 2016	Fabrication of porcelain fused-to-metal crown (27211)	36
J.K.	Jun. 12, 2018	Fabrication of three-unit porcelain-fused-to-metal bridge (62501 – pontic, 67211 – retainers)	11/12/21

- You charged/claimed emergency exams (01205) along with treatment involving multiple teeth and/or sites. These were excessive or unreasonable fees, as an emergency exam involves the emergency investigation of discomfort and/or infection in a localized area, not broader or planned treatment.

Patient	Date	Teeth/Sites
F.B	Apr. 20, 2016	16, 37, 46
G.I	Jun. 20, 2017	15-17 and 35-37
S.M	Sept. 25, 2014 Nov. 19, 2014 Dec. 4, 2014 Dec. 3, 2015	unspecified sites unspecified sites 17 and unspecified sites unspecified sites

	May 17, 2016	26, 47
J.P	Jun. 24, 2016	45 and unspecified site

- You charged/claimed an emergency exam (code 01205) along with the delivery of a full-coverage crown. This was an excessive or unreasonable fee, as an emergency exam involves the emergency investigation of discomfort and/or infection in a localized area, not broader or planned treatment.

Patient	**Date**	**Tooth**
L.C	Nov. 23, 2016	13

- You charged/claimed emergency exams (01205) for appointments that do not appear to be emergency exams based on the patient records and/or where there is no indication of the nature of the emergency.

Patient	**Date**
L.C	Jul. 6, 2015
T.C	Jun. 30, 2015

- You charged/claimed fees for sedative restorations (20111) that were placed in or around 7 days prior to placing permanent composite restorations. The fees for the sedative restorations were excessive or unreasonable insofar as the sedative restorations were unnecessary dental services. The sedative restorations were unnecessary, because:
    - There was no/insufficient clinical justification for them; and/or
    - It is contraindicated to place composite restoration on top of a sedative restoration.

Patient	**Date**	**Tooth**
F.B	Apr. 11, 2015	14, 15
T.C	Feb. 14, 2015	17
D.M	Jul. 25, 2018	36, 37

- You charged/claimed fees for multiple restorations for the same teeth during relatively brief time periods.

Patient	Dates	Tooth & Surface(s)
F.B.	Mar 7, 2015 Mar. 14, 2015 Mar. 24, 2015 Apr. 20, 2016 Apr. 30, 2016	16L, 35V, 37OVL 37OV 16L, 35V 37OV 16L
T.C.	Feb. 10, 2015 Feb. 18, 2016 Aug. 15, 2016	47O 47OV 47OV
N.F.	Feb. 6, 2008	42I, 43DI

	Apr. 12, 2008 Dec. 13, 2008 Dec. 20, 2008 Jan. 3, 2009 Mar. 21, 2009 Oct. 21, 2009 Nov. 7, 2009 Nov. 28, 2009 Apr. 2, 2010 Apr. 12, 2010 Jun. 12, 2010 Dec. 28, 2010 Jan. 22, 2011 Feb. 12, 2011 Apr. 16, 2011 Aug. 6, 2011 Aug. 13, 2011 Jun. 2, 2012 Feb. 15, 2013 Feb. 21, 2013 Mar. 14, 2013 Jan. 3, 2014 May 22, 2015 Aug. 14, 2015 Sept. 5, 2015 Sept. 12, 2015 Sept. 16, 2015 Feb. 11, 2016 May 7, 2016 Aug. 12, 2016 Aug. 26, 2016 Nov. 30, 2016 Mar. 11, 2017 Apr. 29, 2017 Jul. 15, 2017 Jul. 22, 2017	42MDL 22LI 41MI 21V, 22V, 23V 11V, 12V 13V 11MVLI, 21MVLI, 43DVI 12MDV 11MVLI 12MDV, 22MDV 11MDVLI, 21MDVL1, 23V 41MDVLI, 43I 22MDVLI, 23V 11MVLI, 12MDVL 42I, 43I 11V, 12V, 13V, 21V, 22V, 23V 41MDVLI, 42VI, 43I 4343VLI 42VI, 43DVL 23DVLI 43MDL 42MDLI 11DVLI, 12 MLI, 21MVLI 11MV, 12MDVLI, 21VI 11MVLI, 21DVLI 13DVL 22MDL, 23MDL 41MDVLI 23MVL 11DVLI, 13DVL,21DVLI, 42MVLI, 43I 11MVLI,12MVLI,13DVLI, 21MVLI 21MVLI, 22MVL 23MVLI 13MVL, 41MDV 11DVL, 12MDVL, 13MVL, 21DVLI, 22MVLI 13MDVLI
G.I.	May 5, 2016 Sept. 13, 2017	27DOVL 27DOVL
N.P.	Jul. 19, 2016 Jun 8, 2017	75DOVL 75DOVL

4. *allegation withdrawn*

5. *allegation withdrawn*

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year(s) 2008 to 2017, you failed to keep records as required by the Regulations relative to one or more of your patients, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars

- Your records for the below patients contained deficiencies, as follows:

Patient	Date	Recordkeeping Deficiencies
T.C.	Feb. 10, 2015 Feb. 18, 2015 June 3, 2015	Text entered in multiple inks with overlap Chief complaint and diagnosis not documented/found in progress notes Use of white-out in the progress note
D.M.	Feb. 19, 2016 Oct. 12, 2016 Aug. 14, 2019	Scribbled-out text Multiple lines of text between ruling lines Chief complaint and diagnosis not documented/found in progress notes
S.M.	Jan. 5, 2016 Feb. 9, 2016 Feb. 9, 2017 Mar. 9, 2017 Nov. 4, 2017	Multiple lines of text between ruling lines and chief complaint and diagnosis not documented/found in progress notes Scribbled-out text Multiple lines of text between ruling lines Chief complaint and diagnosis not documented/found in progress notes Multiple lines of text between ruling lines, and chief complaint and diagnosis not documented/found in progress notes
R.R.	Jun. 29, 2016 Jun. 25, 2016	Scribbled-out text Multiple lines of text between ruling lines
J.P.	Feb 20, 2016 Jun. 24, 2016	Treatment code(s) and/or fee(s) entered alongside progress notes appear to have been altered Multiple lines of text between ruling lines
N.P.	Jan. 17, 2015 Apr. 15, 2015 Apr. 18, 2016 Dec. 5, 2016 Dec. 6, 2016 Jun. 8, 2017	Chief complaint and diagnosis not documented/found in progress notes Multiple lines of text between ruling lines Chief complaint and diagnosis not documented/found in progress notes Progress notes entered in pencil Progress notes entered in pencil Text entered in multiple inks with overlap, and treatment code(s) and/or fee(s) entered alongside progress notes appear to have been altered
A.M.	Jan. 7, 2015 May 20, 2017	Chief complaint and diagnosis not documented/found in progress notes Chief complaint and diagnosis not documented/found in progress notes

- For one or more of the patients F.B., D.B., T.C., L.C., N.F., G.I., S.M., R.M., J.P., N.P., R.R., A.C., E.W., J.K., A.M., and D.M.;
    - You did not obtain up-to-date medical histories.
    - There is no updated periodontal or restorative charting.
    - You performed gingivectomies without proper charting including periodontal pocket information.

- The clinical notes routinely lack detail, including important details such as the patient's chief complaint, your diagnosis, and informed consent.
- The clinical notes lack information about your radiographic findings, including:
  - For the patient F.B, you took two x-rays on or about August 17, 2016, and the x-rays show decay on teeth 14 and 15; there is no mention of these radiographic findings in the clinical notes.
  - For the patient N.F, you performed a crown on tooth 45 but did not record any radiographic findings for other teeth in the 4th quadrant that have obvious decay.
- Your clinical notes for root canal treatments lack detail such as regarding the trial file or the fitting of the gutta percha.
- In multiple instances, you did not take sufficient or proper x-rays, including but not limited to instances where you performed root canal treatment without taking x-rays.

Such further and other particulars will be provided from time to time, as they become known.

AND TAKE NOTICE THAT the said allegations respecting professional misconduct will be heard and determined by a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario ("panel") on a date and time to be agreed upon by the parties, or on a date to be fixed by the Chair of the Discipline Committee, at the offices of the Royal College of Dental Surgeons of Ontario, 6 Crescent Road, Toronto, Ontario, M4W 1T1, or by electronic hearing as required. You are required to appear in person or by a legal representative before the panel with your witnesses, if any, at the time and place aforesaid.

ONCE A DATE IS FIXED, IF YOU DO NOT ATTEND ON THE FIXED HEARING DATE, THE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THE PROCEEDINGS.

The *Code* provides that if a panel finds that you have committed an act of professional misconduct, it may make an order doing any one or more of the following:

1. directing the Registrar to revoke your certificate of registration;
2. directing the Registrar to suspend your certificate of registration for a specified period of time;
3. directing the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time;

4. requiring you to appear before the panel to be reprimanded;
5. requiring you to pay a fine of not more than $35,000.00 to the Minister of Finance;

or any combination thereof.

Furthermore, the *Code* provides that if a panel is of the opinion that the commencement of these proceedings is unwarranted, it may make an order requiring the College to pay all or part of your legal costs.

The *Code* also provides that in an appropriate case, a panel may make an order requiring you, in the event the panel finds you have committed an act or acts of professional misconduct or finds you to be incompetent, to pay all or part of the following costs and expenses:

1. the College's legal costs and expenses;
2. the College's costs and expenses incurred in investigating the matter; and
3. the College's costs and expenses incurred in conducting the hearing.

If you have not done so already, you are entitled to and are well advised to retain legal representation to assist you in this matter.

You are entitled to disclosure of the evidence in this matter in accordance with section 42(1) of the *Code.* You or your representative may contact the solicitor for the College, Ms. Megan Shortreed, in this matter at:

Ms. Megan Shortreed
Paliare Roland Rosenberg Rothstein LLP
155 Wellington Street West, 35th Floor
Telephone: (416) 646-4300
Email: Megan.Shortreed@paliareroland.com

You, or your legal representative, should familiarize yourself with your disclosure obligations under law, including section 42.1 of the *Code*.

DATED at Toronto, this 25th day of August, 2021.

[Seal]

Royal College of Dental Surgeons of Ontario

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act*, *1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. LUN HANGFU,** of the City of Toronto, in the Province of Ontario;

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

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

N O T I C E O F H E A R I N G

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO
6 Crescent Road
Toronto ON M4W 1T1

Telephone: 416-961-6555
Fax: 416-961-5814

APPENDIX B

RCDSO v. Dr. Lun Hangfu

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

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

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

The panel has found that you have engaged in multiple acts of professional misconduct. The acts of misconduct related to recommending, undertaking and performing unnecessary dental services, and overcharging for dental services; improperly charging for in-office lab charges, and using the emergency exam code when not appropriate. Further, your conduct included a number of record keeping deficiencies.

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

Of special concern to us is the fact this is not the first time you have appeared before the Discipline Committee for similar misconduct.

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

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

(*Hear the Member's comments at this point)*

Thank you for attending today. We are adjourned.