H180007/H180008

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. CHRISTOPHER PAUL TSANG,** of the City of Aurora, 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.

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Frank Stechey
Marc Trudell

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	
	)	Ms. Andrea Gonsalves Independent Counsel for the Discipline Committee of the Royal College of Dental Surgeons of Ontario
- and -	)	
	)	Ms. Emily Lawrence For the Royal College of Dental Surgeons of Ontario
	)	
DR. CHRISTOPHER PAUL TSANG	)	Mr. Josh Koziebrocki and Ms. Lidiya Yermakova For Dr. Christopher Paul Tsang

Hearing held October 25, 2019

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on October 25, 2019.

PUBLICATION BAN

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

THE ALLEGATIONS

The allegations against Dr. Tsang (the "Member") were set out in two Notices of Hearing. The first Notice of Hearing, H180007 (exhibit #1) was dated July 30, 2018, and contains the following allegations against the Member.

1. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18, in that, during the year 2015, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely [S.K.], contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about August 17, 2015, you performed a complex procedure over the span of an appointment that was at least 11-hours in duration, without breaks and without offering the patient the option of sedation. You did this despite the facts that the patient was 72 years-old, and had a history of mini-strokes, and despite your knowledge that she was nervous and had a history of local anaesthetic not being effective.

- On or about August 17, 2015, you excessively adjusted the patient's maxillary crowns and/or retainer.

- On or about August 17, 2015, you extracted seven of the patient's mandibular teeth (teeth 31, 32, 33, 41, 42, 43, and 47) without establishing any prognosis or diagnosis for the teeth.

- Your treatment planning for the patient did not meet the standards of the profession:

    - Although you relied upon the NDX nSequence Dental Laboratory for treatment planning the patient's case, in particular surgical guides, no correspondence with the laboratory was found in your records

    - You did not create an appropriate case workup or treatment plan, including using the NDX nSequence implant system.

    - Your treatment plans for the patient were inconsistent and/or inaccurate in a number of ways:

        - Though you ultimately placed five implants, the following records indicate that you planned to place four implants:

            - "Option A" in your progress notes dated May 28, 2015;

            - "Treatment Plan #1" in the undated document titled "Treatment Plan"; and

            - "SICAT Planning Report", dated June 19, 2015.

        - A document in your records with the title "Teeth-in-a-Day in the Mandible for [S.K.] – July 2015" and signed by the patient indicates that the patient's lower right molar will be kept for support, and also indicates that tooth 47 will be extracted.

        - A document in your records with the title "Teeth-in-a-Day in the Mandible for [S.K.] – July 2015" and signed by the patient indicates that the final denture would be made from Zirconia, but the denture was

ultimately made from acrylic.

- You did not prepare and/or obtain a report of the interpretation of a SICAT scan for the patient dated June 19, 2015.

- You did not use a report of the interpretation of a SICAT scan dated June 19, 2015, to diagnose the patient or to treatment plan the patient's case.

- On or about August 17, 2015, your treatment of the patient was guided by a representative of the manufacturer of the implant system who was unknown to the patient.

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 2015, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one of your patients, namely [S.K.], contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about August 17, 2015, you placed five implants in the patient's mandible when you had only obtained the patient's consent to place four implants.

   - You did not obtain the patient's consent to use a new system that you were unfamiliar with, in that on or about August 17, 2015, you treated the patient using the NDX nSequence implant system, but you did not advise the patient that the system was new and that you were unfamiliar with it.

   - On or about August 17, 2015, without obtaining the patient's consent, you extensively adjusted the patient's opposing maxillary crowns/retainers.

3. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2015, you gave information about a patient to a person other than the

patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required or allowed by law relative to one of your patients, namely [S.K.], contrary to paragraph 17 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- On or about August 17, 2015, you permitted two individuals, namely Mr. Dinesh Shettigar, and Dr. Joshua Shieh, to be present while you treated the patient without obtaining the patient's consent to have these individuals present.
- On or about August 29, 2015, you distributed and/or facilitated the distribution of, multiple photographs of the patient and/or relating to the patient's treatment to two other individuals, namely Mr. Dinesh Shettigar, and Dr. Joshua Shieh, without obtaining the patient's consent.

4. You committed an act or acts of professional misconduct as provided by s. 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the years 2015, 2016, and 2017, you failed to keep records as required by the Regulations relative to one of your patients, namely [S.K.], contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- You failed to document and/or retain significant information in the patient's clinical records, specifically:
    - On a CT scan referral document:
        - Date;
        - Number of implants planned; and
        - Prosthesis planned.
    - Diagnoses or prognoses for any or all of seven of the patient's mandibular teeth (teeth 31, 32, 33, 41, 42, 43, and 47) which you extracted on or about August 17, 2015.
    - Documentation to and from the manufacturer of the NDX nSequence implant system.

- From the treatment you provided to the patient on or about August 17, 2015:
  - The lot and/or catalogue number and expiry date (if applicable) of the five implants placed;
  - Whether or not primary stability of the implants was obtained;
  - The torque value used for the implants;
  - The size of the abutments placed;
  - That a provisional denture was inserted;
  - That the provisional denture was adjusted/modified and details about the modification;
  - That significant adjustment of opposing maxillary crowns/retainer was performed;
  - Which specific opposing maxillary teeth were adjusted;
  - The degree to which you adjusted the opposing maxillary crowns/retainer.
- From the endodontic retreatment of the patient's tooth 15 that you provided to the patient on or about November 10, 2015, and on or about November 17, 2015:
  - Signs/symptoms in tooth 15 the patient presented with; and
  - Diagnosis/rationale for endodontic re-treatment.
- From the endodontic retreatment of the patient's tooth 15 that you provided on or about December 15, 2015:
  - Post-operative periapical radiograph;
  - Method used for endodontic retreatment; and
  - Materials used for endodontic retreatment.
- Approximately August, 2015 – May, 2017:
  - Clinical assessment of osseointegration of implants, prior to the fabrication and insertion of the final denture.

- Your clinical records for the patient from approximately May 30, 2017 – June 8, 2017, included significant discrepancies with respect to whether you inserted the patient's bridges with

permanent or temporary cement.

The second Notice of Hearing, H180008 (exhibit #2) was also dated July 30, 2018 and contains the following allegations against the Member.

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, in or about the years 2015 and/or 2016, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical, contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - You breached a requirement or requirements of an ICR Committee panel by breaching a specified continuing education or remediation program with respect to mentorship for multi-implant cases. Specifically, you breached a requirement or requirements as set out in the decision and reasons of the ICR Committee dated September 24, 2014. The ICR Committee required you to have, among other things, your case workups including appropriate records, treatment planning, implant selection and placement prosthetic design, and occlusal considerations on all such cases assessed, reviewed, and approved by a Mentor. The ICR Committee also required, that, "The member shall abide by any and all recommendations of the Mentor with respect to his prosthetic and implant therapy".
     - In or about the year 2015 you performed mandibular extractions and multi-implant replacement procedures on your patient [S.K.] without the review, assessment, and/or approval of your Mentor.
     - In or about the year(s) 2015 and/or 2016 you failed to abide by your Mentor's recommendations with respect to implant therapy you provided to your patient [M.F.] in that you made multiple surgical attempts to vertically graft the site of a compromised implant, despite your Mentor's recommendation that you remove the implant, graft the socket, and evaluate it 6-9 months later.

THE MEMBER'S PLEA

The Member admitted to all of the allegations of professional misconduct in both Notices of Hearing. The Member also made admissions in writing in an Agreed Statement of Facts, which he signed.

The Member answered a written plea inquiry and signed it. The plea inquiry was entered as an exhibit at the hearing. The Member confirmed at the hearing that he understood the conducts of that document. The Panel was satisfied that the Member's admissions of professional misconduct were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, College Counsel introduced into evidence an Agreed Statement of Facts which substantiated the allegations in the two Notices of Hearing. The Agreed Statement of Facts provides as follows (with references to tabs in the accompanying Document Book omitted).

Background

1. Dr. Christopher Paul Tsang has been registered with the College as a general dentist since 1988. He received his dental education at the University of Toronto. Dr. Tsang works at a clinic which he owns and operates in Aurora.

H180007 and H180008 to be heard and determined in a Joint Hearing

2. Dr. Tsang was served with two Notice of Hearings for H180007 and H180008, both dated July 30, 2018.

3. The College and the Member have agreed to resolve the allegations set out in both Notices of Hearing, to be heard at the same time and by the same panel, on the basis of the facts and admissions agreed to and set out below.

H180008

Requirements of the SCERP

4. On September 24, 2014, the Inquiries Complaints and Reports Committee ("ICRC") imposed a Specified Continuing Educational or Remediation Program in Prosthodontics and

Implants (the "SCERP"), in response to a patient complaint. It also issued a caution.

5. In that case, the ICRC concluded that Dr. Tsang had proposed a highly complex treatment plan involving multiple implants and fixed restorations, which the ICRC stated were, in its view, "of questionable value". The ICRC was concerned that Dr. Tsang did so without examining the patient in person or obtaining adequate pre-treatment records, and without completing and documenting an adequate case work-up and treatment plan. The ICRC was of the view that Dr. Tsang's clinical decision to complete this treatment in a condensed period of time did not allow for appropriate treatment planning, informed consent, or post-operative care. Also, the ICRC found that the documentation was lacking and deficient.

6. The SCERP required Dr. Tsang to complete a course in prosthodontics, to obtain a mentor for multi-implant procedures and to abide by any and all recommendations of his mentor, and for monitoring at the completion of the course and mentorship.. Per the terms of the SCERP, Dr. Tsang was to provide a mentor report to the ICRC within one month of the mentor's retainer and a report in respect of every proposed multi-implant case that the mentor consulted on, until the ICRC was satisfied that its concerns about Dr. Tsang had been addressed.

7. In November 2014, Dr. Tsang retained Dr. Mark Lin as his mentor to complete the mentorship requirement of the SCERP. Simultaneously, Dr. Tsang commenced a six-month "mini-residency" with Dr. Lin to fulfill the course requirement of the SCERP.

8. Dr. Lin confirmed his mentorship retained with the College in November 2014.

9. Dr. Lin delivered his first mentoring report in June 2015. This report covered three sessions between November 2014 and June 2015. Dr. Lin recommended continuous mentoring to review Dr. Tsang's diagnosis, treatment plans and final clinical outcomes for all his implant cases.

Mentor Recommendations re: S.K.

10. In his June 2015 report, Dr. Lin included a summary of the cases that he and Dr. Tsang had reviewed during the mentoring

sessions. Dr. Tsang and Dr. Lin discussed a possible treatment plan for S.K., the patient involved in H180007. Dr. Lin made the following notes in respect of S.K.:

> "S.K. - Entire mandibular arch
>
> Remaining mandibular anterior teeth are painful. Patient is unable to wear removable PLD due to pain & poor retention. All-On-4 fixed prosthetic solution was proposed by another dental clinic. Patient came to me for another opinion. Anterior mandible has sufficient bone volume to accommodate 4 implants with the distal being angled. CBCT scan will be prescribed to confirm this and help treatment plan".

11. Dr. Lin also recommended that Dr. Tsang obtain a comprehensive wax set-up with radiographic guide and CBCT imaging.

12. Dr. Tsang did not obtain a comprehensive wax set-up, submit the CBCT and wax set-up to Dr. Lin along with a revised treatment plan to Dr. Lin, or obtain approval to proceed from Dr. Lin.

13. Dr. Tsang performed extensive multi-implant mandibular treatment on S.K. in August 2015, as further detailed below.

Mentor Recommendations re: M.F.

14. In 2016, Dr. Lin and a periodontist who assisted him with Dr. Tsang's mentoring reviewed Dr. Tsang's past and proposed treatment of patient M.F. Dr. Tsang had placed an implant for M.F. but M.F. had developed vertical bone loss and complications associated with the healing pattern. Dr. Lin and the periodontist recommended that Dr. Tsang remove the implant and grafting of the site, and re-assess 6-9 months after removal. If Dr. Tsang were to testify, he would state that he raised Dr. Lin's proposed course of action with the patient M.F., who did not wish to proceed with it. Instead, the patient wished to proceed with the surgical grafting procedure with the goal of repairing the existing implant, which was recommended by Dr. Tsang.

15. If Dr. Tsang were to testify, he would state that he conveyed the patient's wishes to Dr. Lin. Lin continued to disagree with this assessment, and continued to be of the view that the only

appropriate course of action was to entirely remove the implant. Dr. Tsang proceeded with the grafting procedure, contrary to Dr. Lin's recommendation and contrary to the terms of the SCERP that required Dr. Tsang to follow all of Dr. Lin's recommendations. If Dr. Tsang were to testify, he would state that this accorded with patient wishes and he felt that he could perform the procedure safely, despite Dr. Lin's professional opinion to the contrary. However, Dr. Tsang acknowledges and admits he did not take any steps to document the professional difference of opinion, seek a neutral opinion from a third party, or contact the College about how to handle the difference of opinion he perceived, all of which were options to him. Dr Tsang admits and acknowledges that, in the face of the difference of opinion he perceived, he decided to act contrary to Dr. Lin's recommendations.

16. Dr. Tsang completed his "mini-residency" course component of the SCERP once M.F.'s case was completed. Dr. Lin confirmed in 2018 that Dr. Tsang completed the mini-residency course.

Admissions of Professional Misconduct in respect of H180008

17. If Dr. Tsang were to testify, he would state that Dr. Lin did not provide reports to the ICRC as required of him and was difficult to reach to discuss cases during the mentoring program. Dr. Tsang acknowledges, however, that he had the ultimate responsibility to discuss all his multi-implant cases with Dr. Lin, and obtain Dr. Lin's approval to proceed with proposed treatment plans, and otherwise follow Dr. Lin's recommendations and to ensure that Dr. Lin was reporting in accordance with the SCERP. He also acknowledges that, viewed in hindsight, he could have changed mentors instead of proceeding with cases contrary to Dr. Lin's recommendations, however if Dr. Tsang were to testify, he would state that he did not view this as an option at the time.

18. Dr. Tsang admits that, for both S.K. and M.F., he failed to abide by the recommendations of his mentor, and thus breached the terms of the SCERP. He further acknowledges, admits and agrees that in doing so, he engaged in conduct that would be reasonably regarded by members of the profession as disgraceful, dishonourable or unprofessional.

19. Dr. Tsang admits that he acted contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 in the Notice of Hearing.

H180007

Pre-Operative Discussions and Documentation with S.K.

20. S.K. was 71 years old when she first met with Dr. Tsang in May 2015 and 72 years old when Dr. Tsang performed oral surgery on her. She had a history of mini-strokes and was nervous about dental surgery.

21. S.K. consulted with Dr. Tsang because she was interested in obtaining a complete mandibular implant-supported denture, as her 20-year-old existing partial lower denture was loose and she had pain in her lower jaw. S.K. had seven lower teeth in place: teeth 31, 32, 33, 41, 42, 43, and 47. Teeth 35, 36, 37, 44, 45, 46, and 48 had been previously extracted.

22. On May 5, 2015, Dr. Tsang met with S.K. to discuss treatment options. At that appointment, S.K. advised Dr. Tsang that she was anxious about dental procedures, and required additional local anaesthetic as she had a history of incomplete or short-lived freezing.

23. Dr. Tsang provided several treatment options, which he later put in writing as a proposed "Treatment Plan" on May 28, 2015. Each option included the extraction of her seven remaining lower teeth. These options included:

    a. Option 1: four small diameter implants to secure a new removable complete lower denture

    b. Option 2: two titanium implants to secure a new complete lower denture

    c. Option 3: four titanium implants (two angled) to secure a new complete lower denture, with a fixed bridge option in the future.

24. At the appointment on May 28, 2015, S.K. reiterated that she was prone to incomplete or short-lived freezing.

25. Dr. Tsang did not establish or chart any prognosis or diagnosis for any of S.K.'s mandibular teeth before recommending extraction.

26. S.K. signed a written consent for treatment on May 28, 2015. Dr. Tsang acknowledges that S.K.'s consent provided on this day was limited to the proposed treatment options he provided to her, and that he was required to obtain consent from her as the treatment plan changed and was finalized.

27. On June 19, 2015, S.K. underwent a SICAT/CBCT scan for planning purposes at Dr. Lin's clinic. Dr. Tsang did not prepare and did not obtain an interpretation of the SICAT/CBCT scan from Dr. Lin. On this referral form, Dr. Tsang requested a CT for "Teeth in a Day", a term which Dr. Lin would have understood to imply 4-6 implants placed in the anterior region of the jaw and which avoids the need for bone grafting. The CT for "Teeth in a Day" is intended to measure bone volume to plan for implant location.

28. Dr. Tsang met with S.K. again on July 2, 2015 (this being after his mentoring session with Dr. Lin in which S.K.'s proposed treatment was discussed). S.K. reiterated her past poor reaction to local anaesthetic, which Dr. Tsang confirmed with S.K.'s regular dentist the following day. If Dr. Tsang were to testify, he would state that S.K. wished to undergo surgery under local anesthesia due to her past poor experience under sedation resulting in an incorrect bite.

29. At this appointment, Dr. Tsang formulated a treatment sequence in a document entitled "Teeth-in-a-Day", dated July 2, 2015, for the placement of titanium implants with a fixed lower set of teeth (not a removable denture). This document set out:

    a. the schedule for the extraction, implant placement, and provision of the permanent lower denture after healing;

    b. extractions of six lower teeth, with the "right lower molar" (tooth 47) being maintained for additional support and stability;

    c. the provision of implants. The number of implants were not specified in the written documentation but Dr. Tsang advised S.K. that he would likely implant 4 implants;

d. the extraction, implant placement and provision of a provisional prosthetic teeth would take 3 hours, but this was specifically stated to be an estimate;

e. the permanent teeth would be made of Zirconia; and

f. the total estimated cost would be $22,000 in total.

30. On July 2, 2015, Dr. Tsang charted that S.K. wanted tooth 47 removed as well, as it was painful to brush. Dr. Tsang examined tooth 47 and concluded that it was "painful to explore" but did not document any further prognosis or diagnosis for tooth 47.

31. S.K. ultimately consented to the extraction of seven teeth and placement of four implants at the extraction site.

32. At some point during the treatment planning period, Dr. Tsang decided to use the NDX nSequence Dental Laboratory planning report for guided implant placement. While this was a very new technology, Dr. Tsang had used similar CAD systems for many years.

33. Dr. Tsang did not complete or send S.K. for a diagnostic wax set-up as Dr. Lin recommended. If he were to testify, he would state that it is his view that the wax set-up was redundant in light of the NDX nSequence Dental Laboratory planning report.

34. On July 23, 2015, Dr. Tsang finalized the NDX nSequence Dental Laboratory computerized virtual planning report, using five implants at positions 31, 33, 35, 43, 45. Dr. Tsang did not document the rationale for placing five implants instead of four anywhere in S.K.'s record. If he were to testify, Dr. Tsang would state that he discussed placing five implants instead of four but failed to document the discussion. Dr. Tsang did not provide the College with a copy of this treatment plan, despite the College's request for all documents relating to S.K.'s treatment, until almost a year after referral of allegations.

35. On July 27 and 28, 2015, S.K. attended at Dr. Tsang's office for appointments to discuss post-operative needs, scheduling of the surgery to extract her lower teeth and place the implants, and to go over other details of the treatment plan. This included a visual presentation using a video monitor of the proposed changes to the upper crowns to correct S.K.'s bite and Curve of Spee. It also included a discussion that Dr. Tsang would be

using a new advanced planning system NDX nSequence Dental Laboratory with which he was partially unfamiliar. Dr. Tsang obtained S.K.'s verbal consent during these appointments to the placement of five implants, as opposed to four.

36. Pursuant to S.K.'s wishes, her treatment plan included the use of local anaesthetic only.

Admissions relating to Treatment Planning

37. The College's *Educational Requirements and Professional Responsibilities for Implant Dentistry* Guideline (2003) ("Implant Guidelines") states that "[p]roper patient evaluation and treatment planning is of utmost importance in dental implant treatment. [...] [S]tudy models and diagnostic set-ups may facilitate treatment planning for the optimal positioning of dental implants in complex cases, including those involving high aesthetic requirements. These same study models may also elucidate unfavourable jaw relationships (e.g. pseudo-Class III jaw relationship resulting from advanced maxillary alveolar bone resorption), which may not be suitable for treatment with fixed bridges. Surgical guides may assist placement in cases requiring precise positioning of dental implants (e.g. multi-unit fixed cases, single unit cases in the aesthetic zone)."

38. Dr. Tsang admits and acknowledges that his treatment planning was deficient, and failed to meet the standards of practice. In particular, Dr. Tsang agrees and admits that:

    a. The standards of practice required him to establish and document the prognosis and diagnosis for S.K.'s lower teeth and he admits that he failed to do so.

    b. The standards of practice required him to prepare written treatment plans that were consistent with the treatment that was planned and ultimately provided. He acknowledges that the treatment planning documentation he shared with S.K. referenced four implants and retaining tooth 47, when five implants were used and tooth 47 was extracted, and referenced the use of Zirconia for the permanent teeth, when acrylic was used. Dr. Tsang acknowledges that he could have and should have prepared revised treatment planning documentation as his treatment plan changed,

both for planning purposes and to assist with ensuring that he had S.K.'s informed consent.

c. The standards of practice required him to prepare a report for the interpretation of the SICAT scan, and that he failed to do so and to use such a report to aid in his prognosis and treatment planning for S.K. If he were to testify, he would state that he viewed the NDX nSequence Dental Laboratory system as a replacement for such a report. However, he acknowledges that he should have obtained an interpretation report to aid in his use of the guided NDX nSequence Dental Laboratory system.

39. Dr. Tsang also admits that he failed to keep records that are required, in respect of his treatment planning. In particular, he admits that he failed to keep the following records, all of which were required:

a. the date, number of implants planned, and prosthesis planned for the CT scan referral;

b. the diagnosis or prognosis for any or all of S.K.'s lower teeth; and

c. documentation to and from the manufacturer of the NDX nSequence Dental Laboratory system including photos and radiographs of S.K. and treatment planning discussions with staff from the manufacturer.

Treatment on August 17, 2015

40. On August 17, 2015, S.K. underwent surgery at Dr. Tsang's office for the extractions of her lower teeth and the placement of implants.

41. S.K. attended with her adult daughter.

42. Dr. Tsang attended the procedure throughout, with the assistance of his dental assistants, Ashley Richards (who primarily observed as it was her first day in the office) and Brianne Jolly (who assisted although it was her last day in the office before a maternity leave).

43. Dr. Joshua Shieh also attended. Dr. Shieh was not an associate dentist in the office but attended to observe. Dr. Shieh assisted when Dr. Tsang's assistants left the room.

44. Mr. Dinesh Shettinger, a representative from the company that manufactures Hiossen implants, also attended. Mr. Shettinger took photographs throughout the procedure. After the procedure, Dr. Tsang distributed these photographs to Dr. Shieh and Mr. Shettinger.

45. Dr. Tsang obtained S.K.'s verbal consent to have Dr. Shieh or Mr. Shettinger attend and observe the procedure during the treatment planning appointments on July 27 and 28, 2015. S.K. had also previously consented to photographs of her mouth being taken, as this usually took place as a matter of course. However, Dr. Tsang acknowledges that he provided photographs of S.K.'s mouth to Dr. Shieh or Mr. Shettinger for educational purposes, and acknowledges that he failed to obtain S.K.'s informed consent to the distribution of photographs to these individuals.

46. The surgery appointment commenced at 10:00am and was completed at approximately 9:00pm. The appointment and surgery lasted several hours longer than both S.K. and Dr. Tsang had anticipated. The appointment and surgery lasted longer than anticipated in part because Dr. Tsang was unfamiliar with some aspects of the NDX nSequence Dental Laboratory system.

47. If S.K. were to testify, she would state that Dr. Tsang did not give her sufficient breaks during the lengthy surgery.

48. During the treatment on August 17, 2015, S.K. received 272mg of 4% (40mg/cc) articane, 102mg of 2% (20mg/cc) lidocaine, 324mg 3% (30mg/cc) mepivacaine, and 72mg of 4% (40mg/cc) prilocaine. Dr. Tsang did not document that he discussed sedation options with S.K. in his progress notes at all, or that he provided sufficient information about sedation options to ensure that he had informed consent to proceed with the lengthy treatment using only local anaesthetic.

49. If Dr. Tsang were to testify, he would state that he considered S.K.'s age, medical history, nervousness, and reaction to local anaesthetic, and her preference to have local anaesthetic over other sedation options, and the anticipated length of the surgery,

when he planned the surgery using local anaesthetic. However, Dr. Tsang acknowledges that, in hindsight, the length of the entire procedure was physically stressful to S.K. Given her age, medical history, nervousness, and past reactions to local anesthetic, if Dr. Tsang had anticipated that the entire procedure would last 11 hours, he would have further discussed other sedation options, scheduled two shorter treatment periods, built in much longer breaks, or otherwise structured the procedure differently.

50. Dr. Tsang extracted teeth 31, 32, 33, 41, 42, 45, and 47 and implanted five Hiossen implants.

51. In addition to extracting S.K.'s mandibular teeth and placing implants and the temporary fixed bridge, Dr. Tsang also adjusted (filed down) S.K.'s opposing maxillary crowns on teeth 16, 15, 24, 25, and 26, and her retainer on tooth 14. Adjustment was required in order to achieve a corrected Curve of Spree and bite.

52. If Dr. Tsang were to testify, he would state that S.K. verbally consented to this adjustment during the July 27 and 28, 2015 treatment planning appointments. He did not document obtaining this consent. If S.K. were to testify, she would state that Dr. Tsang had not advised her that he would be adjusting her maxillary crowns and had not obtained her consent to do so or her consent to proceed with the implant placement knowing that adjustment would be necessary. Dr. Tsang acknowledges that, in hindsight and given S.K.'s anticipated evidence on this point, he did not give S.K. sufficient information about the potential for adjustment in order to obtain her informed consent.

53. Dr. Tsang documented brief notes in S.K.'s chart. He noted the teeth that were extracted, the tooth position where he placed the implants, the brand of implants, and the amount of local anaesthetic used.

54. Although Dr. Tsang documented the procedure by photograph, he did not create a written record of the lot and/or catalogue number and expiry date of the five implants as required by the Implant Guidelines, and he did not document if primary stability was obtained, the torque value used, the size of the abutments placed on this date, that a provisional denture was inserted on this date, or if the provisional denture was adjusted/modified

and details about the modification. Dr. Tsang did not document the specific teeth that were adjusted and to what degree.

55. If Dr. Tsang were to testify, he would state that his work was documented in the photographs. However, he acknowledges that he should have made written notes about the information above.

Admissions relating to Treatment on August 17, 2015

56. Dr. Tsang admits and acknowledges that some aspects of his execution of the extraction and implant surgery failed to meet the standards of practice. In particular, Dr. Tsang agrees and admits that he failed to meet the standards of practice when he performed the complex and lengthy surgery on S.K. without offering additional breaks and without considering whether local anaesthetic was appropriate.

57. Dr. Tsang also admits that that he did not provide S.K. with sufficient information regarding the adjustment of her maxillary crowns and retainer to obtain her informed consent. Dr. Tsang admits and acknowledges that he did not have S.K.'s express and informed consent to place five implants in advance of the procedure, when the treatment planning documents that he provided her and his discussions with her only referenced the placement of four implants. If Dr. Tsang were to testify, he would state that he did obtain S.K.'s verbal consent, but he acknowledges that he should have obtained her written consent and/or documented the discussion in which he states he obtain her verbal consent, which he did not do.

58. Dr. Tsang admits and acknowledges that he gave information to third parties without consent, in that he did not have consent from S.K. to distribute photographs to Dr. Shieh or Mr. Shettinger

59. Dr. Tsang admits and acknowledges that he failed to keep records of the lot and/or catalogue number and expiry date of the five implants as required by the Implant Guidelines, and he did not document if primary stability was obtained, the torque value used, the size of the abutments placed on this date, that a provisional fixed bridge was inserted on this date, or if the provisional fixed bridge was adjusted/modified and details about the modification, and which specific teeth that were adjusted and to what degree. Dr. Tsang acknowledges that while

photographs of his work provide context to written documentation, he should have documented the above information in written form.

Post-August 17, 2015 Treatment of S.K.

60. S.K. recovered over the following weeks from surgery. After the oral surgery, she was unhappy with her upper smile, as Dr. Tsang had adjusted the crowns such that they appeared visibly thin due to metal showing on the chewing surfaces. On August 26, 2015, Dr. Tsang agreed to replace or repair S.K.'s upper crowns at no additional cost.

61. In October to November 2015, Dr. Tsang replaced her PFM crowns for teeth 14, 15, 24, and 25 with ceramic crowns.

62. During this process, he also completed endodontic treatment on tooth 15 due to pulpal inflammation on November 10, 2015, and completed endodontic treatment on this tooth in December 2015. Apart from a reference to "pain", Dr. Tsang did not document a diagnosis for this tooth, a rationale for this re-treatment, the method used, or the materials used. He did not take or retain a post-operative radiograph.

63. In February 2016, Dr. Tsang first advised S.K. that she would need to wear a night guard because both her upper and lower teeth would be porcelain/Zirconia and the combination made them more prone to damage, or elect to use acrylic in the permanent lower denture instead of porcelain. S.K. eventually agreed to acrylic instead of the Zirconia as agreed in the original treatment planning documents. Dr. Tsang acknowledges that he should have informed S.K. about the need for a night guard if S.K. elected for Zirconia during the extraction and implant placement treatment planning phase, and during their discussions about replacing her upper crowns.

64. In May 2016, Dr. Tsang placed the fixed mandibular implant-retained acrylic bridge. Dr. Tsang did not document any clinical assessment of osseointegration prior to placement.

65. Dr. Tsang again replaced S.K.'s maxillary crowns (teeth 24, 25, 14 and 15) between June and December 2016 primarily for cosmetic reasons.

66. In May 2017, Dr. Tsang replaced S.K.'s bridge teeth (13-11 and 21-23), at an additional cost. Dr. Tsang's documentation and communication to S.K. referenced the use of both temporary cement and permanent cement. S.K. and her family were confused about whether Dr. Tsang had used temporary or permanent cement and whether S.K. was required to return to permanently affix the bridge. Dr. Tsang acknowledges that his documentation and communication about the cement he used was ambiguous and caused a breakdown in communication with S.K.

67. S.K. was ultimately very pleased with Dr. Tsang's work. Her permanent lower fixed bridge and upper crowns and two upper anterior bridges have a good prognosis. If Dr. Tsang were to testify, he would state that, in his view, he has always treated S.K. with the utmost care and compassion.

Admission relating to Post-August 2015 Treatment

68. Dr. Tsang admits and acknowledges that he failed to keep records relating to his endodontic treatment of S.K.'s tooth 15, including the symptoms S.K. presented with and his diagnosis of the tooth, the post-operative radiograph and the method and materials used for the endodontic retreatment in December 2015.

69. Dr. Tsang admits that he failed to keep records relating to his assessment of the osseointegration of S.K.'s implants prior to placement of her bridge in May 2016.

70. Dr. Tsang admits that his documentation regarding the use of temporary or permanent cement to affix S.K.'s bridge in May 2017 contained significant discrepancies.

Admissions of Professional Misconduct relating to H180007

71. Dr. Tsang admits that he contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 in the Notice of Hearing.

72. Dr. Tsang admits that he treated S.K. in a situation that required consent, without consent, contrary to paragraph 1 of Section 7 of the Dentistry Act Regulation, as set out in Allegation 2 in the Notice of Hearing.

73. Dr. Tsang admits that he gave information about S.K. to third parties without her consent, contrary to paragraph 17 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 in the Notice of Hearing.

74. Dr. Tsang admits that he failed to keep records as required, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 in the Notice of Hearing.

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

76. Dr. Tsang has received legal advice with respect to his admissions in respect of both H180007 and H180008.

DECISION

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

REASONS FOR DECISION

The Member pled guilty to the allegations as set out in the Notices of Hearing and agreed to the facts presented in the Agreed Statement of Facts.

With respect to Notice of Hearing H180007, the Panel found, based on the Member's own admissions and on the evidence contained in the Agreed Statement of Facts, that Dr. Tsang failed to maintain the standards of practice of the profession as set out in Allegation 1 in the Notice of Hearing. Dr Tsang admitted, and the agreed facts established, that he treated S.K. in a situation that required consent, without obtaining her consent, as set out in Allegation 2 in the Notice of Hearing. Dr. Tsang further admitted, and the agreed facts established, that he gave information about S.K. to third parties without her consent, as set out in Allegation 3 in the Notice of Hearing. Finally Dr. Tsang admitted, and the facts established, that he failed to keep records as required, as set out in Allegation 4 in the Notice of Hearing.

With respect to Notice of Hearing H180008, the Panel found, based on the Member's own admission and on the evidence contained in the Agreed Statement of Facts, that Dr. Tsang engaged in conduct or performed an act or acts that, having regard to all circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional or

unethical as set out in Allegation 1. Dr. Tsang breached a requirement of an ICR Committee panel in that he performed treatment on S.K. without the review, assessment and/or approval of his Mentor. Dr. Tsang also failed to abide by his Mentor's recommendations with respect to the management of a compromised implant site when treating M.F.

PENALTY SUBMISSIONS

The parties presented the Panel with a Joint Submission with respect to Penalty and Costs, which provides as follows.

1. The Royal College of Dental Surgeons of Ontario ("College") and Dr. Christopher Paul Tsang ("the Member") jointly submit that this panel of the Discipline Committee, impose the following penalty on the Member as a result of the panel's finding that the Member is guilty of professional misconduct, namely, that it make an order:

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

   (b) directing the Registrar to suspend the Member's certificate of registration for a period of six (6) months, to be served consecutively, such suspension to commence within thirty (30) days of this Order becoming final;

   (c) that the Registrar impose the following terms, conditions and limitations on the Member's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 1(b) above has been fully served, namely:

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

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

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

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

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

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

f. 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;

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

a. 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

b. giving orders or standing orders to dental hygienists

c. supervising work performed by others

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

e. acting as a clinical instructor;

iii. 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;

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

   a. 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.

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

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

v. 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

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

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

i. requiring that the Member successfully complete, at his/her own expense, a course in recordkeeping, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

ii. requiring that the Member successfully complete, at his/her own expense, a course on informed consent, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

iii. requiring that the Member successfully complete, at his/her own expense, the ProBE Program on Professional/Problem-Based Ethics, to be completed with an "unconditional pass" within twelve (12) months of this Order becoming final;

iv. within six (6) months of this Order becoming final, requiring the Member to retain a mentor, being a senior member of the College, approved by the College (the "Mentor"), at his own cost, to provide Mentoring, which includes the following Mentoring Requirements:

    a. the Member and the Mentor will meet at least once every three (3) months for a Mentoring Session. During the Mentoring Session, the Member will present and the Mentor will review, assess and approve the adequacy of the Member's multi-implant treatment cases, prior to the Member initiating treatment, and discuss the treatment after it occurs. In particular, with a view to compliance with the College's Guidelines with respect to Educational Requirements & Professional Responsibilities for Implant Dentistry and the standards of practice, the Mentor will review the Member's (i) case selection, (ii) case work-up including treatment planning, implant selection and placement, prosthetic design, occlusal considerations, referral protocols, and informed consent discussions with the patient, and (iii) case implementation/treatment and documentation;

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

c. the Member will ensure that the Mentor will file with the Inquiries Complaints and Reports Committee of the College a report within thirty (30) days of each Mentoring Session, which 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; and

d. the Mentoring shall last until such time as the Inquiries Complaints and Reports Committee is satisfied that the concerns raised in C130310T and H180007 have been addressed and the Committee relieves the Member in writing of the Mentoring Requirements.

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

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

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

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

ix. the Practice Condition imposed by virtue of subparagraphs (1)(d)(iv)(a)-(d) above shall be removed from the Member's certificate of registration upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the Mentoring Requirements; and

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

(e) that the member pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing, such costs to be paid in full within three (3) months of this Order becoming final.

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

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

3. Dr. Tsang has not previously appeared before the Discipline Committee of the College.

Both parties submitted that the proposed penalty should be accepted by the Panel.

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

PENALTY DECISION

The Panel accepted the Joint Submission with respect to Penalty and Costs and made the following order:

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

2. The Registrar is directed to suspend the Member's certificate of registration for a period of six (6) months, to be served consecutively, such suspension to commence within thirty (30) days of this Order becoming final.

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

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

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

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

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

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

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

f. 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;

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

a. 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

b. giving orders or standing orders to dental hygienists

c. supervising work performed by others

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

e. acting as a clinical instructor;

iii. 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;

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

a. 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.

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

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

v. 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

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

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

i. requiring that the Member successfully complete, at his/her own expense, a course in recordkeeping, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

ii. requiring that the Member successfully complete, at his/her own expense, a course on informed consent, approved by the College, and provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

iii. requiring that the Member successfully complete, at his/her own expense, the ProBE Program on Professional/Problem-Based Ethics, to be completed with an "unconditional pass" within twelve (12) months of this Order becoming final;

iv. within six (6) months of this Order becoming final, requiring the Member to retain a mentor, being a senior member of the College, approved by the College (the "Mentor"), at his own cost, to provide Mentoring, which includes the following Mentoring Requirements:

a. the Member and the Mentor will meet at least once every three (3) months for a Mentoring Session. During the Mentoring Session, the Member will present and the Mentor will review, assess and approve the adequacy of the Member's multi-implant treatment cases, prior to the Member initiating treatment, and discuss the treatment after it occurs. In particular, with a view to compliance with the College's Guidelines with respect to Educational Requirements & Professional Responsibilities for Implant Dentistry and the standards of practice, the Mentor will review the Member's (i) case selection, (ii) case work-up including treatment planning, implant selection and placement, prosthetic design, occlusal considerations, referral protocols, and informed consent discussions with the patient, and (iii) case implementation/treatment and documentation;

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

c. the Member will ensure that the Mentor will file with the Inquiries Complaints and Reports Committee of the College a report within thirty (30) days of each Mentoring Session, which 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; and

d. the Mentoring shall last until such time as the Inquiries Complaints and Reports Committee is satisfied that the concerns raised in C130310T and H180007 have been

addressed and the Committee relieves the Member in writing of the Mentoring Requirements.

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

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

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

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

ix. the Practice Condition imposed by virtue of subparagraphs 4(iv)(a)-(d) above shall be removed from the Member's certificate of registration upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the Mentoring Requirements; and

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

the requirements set out in subparagraphs 4(i)-(iii) above have been completed successfully, or upon receipt of written confirmation from the Inquiries, Complaints and Reports Committee that the Member has successfully completed the monitoring program, whichever date is later.

5. The Member shall pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing, such costs to be paid in full within three (3) months of this Order becoming final.

REASONS FOR PENALTY DECISION

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

The Panel was satisfied that a six (6) month suspension, a reprimand and the publication of the results of these proceedings on the College register will provide adequate specific and general deterrence. Those terms can be expected to deter the Member from engaging in similar misconduct again and they send a clear message to the members of the profession that the College will not tolerate professional misconduct of this nature.

The terms, conditions and limitations imposed on the Member's certificate of registration will serve to protect the public by helping the Member remediate his practice. Dr Tsang is required to take courses in record keeping, informed consent, and in ethics (ProBE), which will help him gain insight and improve his practice in the future. Public protection will also be afforded by a 24-month period of practice monitoring by the College, the cost of which will be paid by the Member.

At the conclusion of the discipline hearing on October 25, 2019, the Panel administered a public, oral reprimand to the Member in accordance with paragraph 1 of the Panel's order. A copy of the reprimand is attached to these Reasons for Decision.

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

Chairperson

November 26, 2019

Date

RCDSO v. Dr. Tsang

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

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

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

The panel has found that you have engaged in multiple acts of professional misconduct. The misconduct related to many areas of your practice, including deficient recordkeeping, breaching the standards of practice, and treating patients without properly obtained informed consent. The cumulative effect of your conduct would reasonably be regarded by members as disgraceful, dishonourable, unprofessional and unethical.

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

Of special concern to us is the fact that the professional misconduct in which you engaged has involved failing to abide by the SCERP issued by the ICRC. This order was implemented in an attempt to rehabilitate your deficiencies in treatment planning and related treatment. We trust this penalty will give you time to reflect on your practice and give you time to improve your treatment skills.

The penalty imposed today is a fair one. We expect that should you appear before the Discipline Committee in the future, any penalty imposed would likely be more severe.

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.