H190004

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. DANIEL LEE** of the City of Oakvillle, in the Province of Ontario;

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

Members in Attendance: Dr. Richard Hunter
Dr. Carol Janik
Mr. Rod Stableforth

BETWEEN:

ROYAL COLLEGE OF DENTAL	)	Appearances:
SURGEONS OF ONTARIO	)	
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Mr. Nick Coleman
	)	For the Royal College of Dental
	)	Surgeons of Ontario
	)	
DR. DANIEL LEE	)	Mr. Neil Abramson
	)	For Dr. Lee

Hearing held by way of videoconference on April 29, 2020

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on April 29, 2020. This matter was heard electronically.

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

THE ALLEGATIONS

The allegations against the Member were contained in the Notice of Hearing, dated July 5, 2019 (Exhibit 1).

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 following years, you failed to keep records as required by the Regulations relative to the following patients, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993.

Patients	Year(s)
SA	2015
MA	2016, 2018
KD	2017, 2018
TH	2015, 2016, 2017
LL	2015, 2016, 2017
KM	2015
ES	2015, 2017, 2018
PW	2017, 2018
MY	2015, 2016, 2017
VY	2016, 2017, 2018

Particulars

- Your recordkeeping was inadequate.
- For one patient, there is a missing chart entry (KD – April 6, 2017).

- For one patient, involving one procedure, there was documentation on the financial ledger of a laboratory fee billed, where the laboratory invoices were not provided (SA – January 5, 2015).
- For three patients in four instances, you failed to document the examination of the hard/soft tissue and occlusion during the recall examinations (MA– December 31, 2016, January 24, 2018; LL – April 5, 2016; MY – June 3, 2017).
- For five patients in 16 instances, you failed to document the diagnosis for the restorative treatment provided (KD – January 25, 2017, February 17, 2017, February 21, 2017, March 7, 2017, June 13, 2015, August 8, 2017, October 30, 2017, January 25, 2018; LL – February 3, 2015; MY – March 14, 2015; PW – May 31, 2017, June 5, 2017, June 23, 2017, January 29, 2018; VY – November 29, 2016, November 30, 2016).
- For three patients in three instances, you failed to document the treatment plan for the restorative treatment provided (KD – February 23, 2017; LL – February 3, 2015; PW – January 29, 2018).
- For four patients in 10 instances, you failed to document the surfaces of the teeth for the restorative treatment provided (KD – January 25, 2017 [two teeth], February 23, 2017; LL – February 3, 2015; PW – May 31, 2017, June 5, 2017, June 23, 2017, January 29, 2018; VY – November 29, 2016, November 30, 2016).
- For three patients, you failed to document the diagnosis and/or treatment plan for the endodontic treatment provided or the diagnosis that you documented was incomplete (KD – February 15, 2017, February 21, 2017, May 12, 2017, August 22, 2017, August 23, 2017; TH – July 3, 2015, July 22, 2015; MY – October 3, 2016).
- For one patient in two instances, you failed to document the diagnosis and treatment plan for the extractions provided (KD – March 2, 2017, November 11, 2017).
- For one patient, you failed to document the diagnosis or treatment plan for the orthodontic treatment provided (VY – November 29, 2016-June 29, 2018).
- For one patient, you failed to document a diagnosis for the implant treatment provided (PW – June 23, 2017, July 3, 2017).
- For one patient who was provided a crown treatment, you failed to document the informed consent (PW – May 31, 2017, June 23, 2017, January 29, 2018).
- For three patients, you failed to document the informed consent for endodontic treatment (KD – February 21, 2017, May 12, 2017, August 23, 2017; TH – July 3, 2015, July 22, 2015, March 6, 2017; MY – October 3, 2016, October 24, 2016).

- For three patients, you failed to document the informed consent for extractions (KD – February 15, 2017, March 2, 2017, November 11, 2017; TH – September 4, 2015; ES– January 31, 2018).
- For one patient, you failed to document the informed consent where a denture repair and fabrication was provided (KD – February 15, 2017, February 16, 2017, July 4, 2017, July 21, 2017, July 28, 2017, January 16, 2018, February 21, 2018).
- For one patient, where orthodontic treatment was provided, you failed to document the nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, the treatment alternatives, the consequences of treatment and/or if the documented were discussed with the patient (V. Y – November 29, 2016-June 29, 2018).
- For three patients in six instances, where periodontal surgery, flap approach, with curettage of osseous defect and osteoplasty, was provided, you failed to document the informed consent (LL – January 13, 2015, February 3, 2015, February 11, 2015, June 21, 2016, KM – January 15, 2015; ES – January 22, 2015).
- For four patients where implants were placed, you failed to document the nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, the treatment alternatives, the consequences of not having treatment and costs (KD – May 24, 2017, June 6, 2017; TH – September 30, 2015, July 20, 2016, August 3, 2016; LL – April 5, 2016, April 15, 2016; PW – July 3, 2017, October 17, 2017, June 17, 2018).
- For two patients in three instances, your progress notes did not contain sufficient detail about the restorative treatment, including the materials and methods, and whether etch and bond were used in the treatment (KD – August 8, 2017, October 30, 2017; LL – February 3, 2015).
- In five instances for three patients in which teeth were endodontically treated, although the working notes make reference to a working length, you failed to provide a working length radiograph and you failed to document that an apex locator was used (KD – February 21, 2017, May 12, 2017, August 23, 2017; TH – July 3, 2015, July 22, 2015; MY – October 24, 2016).
- In one instance in which a tooth was endodontically treated, you failed to take/provide a post-operative radiograph (MY – October 24, 2016).
- For four patients, you failed to document the method of implant placement and post-operative instructions as required by the College's Guidelines "*Educational Requirements & Professional*

Responsibilities for Implant Dentistry," 2013 (KD – May 24, 2017, June 6, 2017; TH – September 30, 2015, August 3, 2016, LL – April 15, 2016; PW – July 3, 2017, June 17, 2018).

- For two patients, you failed to document in the progress notes that radiographs/cepholometric x-rays and/or intra/extra oral photographs were taken (ES – November 25, 2015; VY – December 19, 2016).
- For one patient, you documented the incorrect tooth number in the financial ledger with respect to an implant procedure (PW – July 3, 2017).
- For one patient, your dates of service in the financial ledger/insurance claim do not correspond with the date in the progress area (MY – May 2, 2016/May 3, 2016).
- For two patients, involving 7 instances, white out appears in the patient record (TH – June 10, 2015, July 3, 2015, September 30, 2015, November 25, 2015, January 4, 2016, January 13, 2016; ES – October 25, 2017), contrary to the College's Guidelines, *"Dental Recordkeeping,"* 2008.
- For one patient, you failed to make progress notes entries between the implant placement and the implant crown cementation (TH - September 30, 2015- November 25, 2015.

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 following years, you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to the following patients, contrary to paragraph 28 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Patient	Year
SA	2015, 2017
MA	2016, 2017
TH	2015, 2016, 2017
LL	2015, 2016, 2017
KM	2015, 2017
ES	2015, 2017
PW	2017
MY	2015, 2016, 2018

- For two patients, you billed/claimed a complete examination when a recall examination was performed (KM – May 1, 2015; MY – February 28, 2015).
- You billed/claimed a complete examination that was not performed (MA– May 24, 2016).
- For two patients, you billed/claimed an emergency extraction that was not performed (TH – July 3, 2015; MY – January 31, 2018).
- You billed/claimed a recall examination when a specific examination was performed (PW – May 31, 2017).
- In six cases, involving four patients, you billed/claimed a recall examination that was not performed (SA– May 4, 2015, November 9, 2015, November 29, 2017; KM – April 15, 2017; ES – October 25, 2017; MY – April 9, 2016).
- For two patients, you billed/claimed radiographs that were not documented as taken in the progress notes and were not provided to the College (TH – January 4, 2016; LL – October 23, 2015).
- For two patients, you billed/claimed for periapical radiographs where bitewing radiographs were taken and bitewing radiographs were provided to the College (SA– May 4, 2015; MY – April 9, 2016).
- For three patients, you billed/claimed for hygiene treatments that were not performed (SA– August 30, 2017; MA – May 24, 2016, July 10, 2017; LL – June 30, 2017).
- For four patients on 8 occasions, you billed/claimed for scaling and polishing units over and above the time documented (SA– November 29, 2017; MA – July 10/17; LL – October 24, 2017; MY – February 28, 2015, September 5, 2015, April 9, 2016, November 5, 2016).
- In three cases involving two patients, you claimed temporization of teeth in conjunction with endodontic treatment (TH – July 3, 2015, January 27, 2017; MY – October 3, 2016).
- In two cases, involving one patient, you billed/claimed caries/trauma/pain control that was not performed (TH – August 28, 2015, January 4, 2016).
- For one patient, you billed/claimed for a surface restorations that was not performed (TH – February 13, 2016).
- For one patient, in three instances, where restorations were provided, you billed/claimed for an additional surface (TH – July 22, 2015, July 13, 2016, March 24, 2017).
- You billed/claimed for a flap approach, with curettage of osseous defect and osteopathy for treatment of a periodontal abscess but your progress notes do not document that curettage was performed,

and your treatment plan does not correspond to the treatment, and the treatment notes are not sufficiently detailed for one patient (LL – February 11, 2015).

- You billed/claimed flap approach, with curettage of osseous defect and osteoplasty for esthetic crown lengthening in the absence of an existing periodontal condition, including probing depths, radiographs, records and periodontal diagnosis, and the chart notes do not indicate the curettage of an osseous defect was performed (KM – January 15, 2015).
- You billed/claimed flap approach, with curettage of osseous defect and osteoplasty to correct implant bone levels in the absence of curettage of a diagnosed osseous defect (LL – February 3, 2015).
- In two cases, you billed/claimed flap approach, with curettage of osseous defect and osteoplastic in absence of a documentation of a periodontal condition to justify the procedures with respect to the sextants claimed (LL – January 13, 2015; ES – January 22, 2015).
- For four patients, you billed/claimed flap approach, with curettage of osseous defect and osteoplasty without chart entries or no documentation that the treatment was provided (SA– March 10, 2015, April 7, 2015, April 20, 2015, TH – November 21, 2016, January 17, 2017, LL – June 21, 2016, and KM – March 26, 2015).
- You billed/claimed a gingivectomy when whitening was provided (M. Y – May 3, 2016, May 10, 2016).
- In one case (TH – November 25, 2015), when the patient returned for the final restoration of the tooth 25 implant, you billed/claimed for surgical re-entry, removal of healing screw and placement of healing element without documentation that there was a surgical re-entry, removal of healing screw and placement of healing element.
- For one patient, you billed/claimed laboratory fees that could not be verified as the laboratory invoice was not provided to the College (SA– January 5, 2016).

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 following years, you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to the following patients, contrary to paragraph 33 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

<u>Patient</u> <u>Year</u>

SA	2015, 2017
MA	2016, 2017
TH	2015, 2016, 2017
LL	2015, 2016, 2017
KM	2015, 2017
ES	2015, 2017
PW	2017
MY	2015, 2016, 2018

- For two patients, you billed/claimed a complete examination when a recall examination was performed (KM – May 1, 2015; MY – February 28, 2015).
- You billed/claimed a complete examination that was not performed (MA – May 24, 2016).
- For two patients, you billed/claimed an emergency extraction that was not performed (TH – July 3, 2015; MY – January 31, 2018).
- You billed/claimed a recall examination when a specific examination was performed (PW – May 31, 2017).
- In six cases, involving four patients, you billed/claimed a recall examination that was not performed (SA– May 4, 2015, November 9, 2015, November 29, 2017; KM – April 15, 2017; ES – October 25, 2017; MY – April 9, 2016).
- For two patients, you billed/claimed radiographs that were not documented as taken in the progress notes and were not provided to the College (TH – January 4, 2016; LL – October 23, 2015).
- For two patients, you billed/claimed for periapical radiographs where bitewing radiographs were taken and bitewing radiographs were provided to the College (SA– May 4, 2015; MY – April 9, 2016).
- For three patients, you billed/claimed for hygiene treatments that were not performed (SA– August 30, 2017; MA – May 24, 2016, July 10, 2017; LL – June 30, 2017).
- For four patients on 8 occasions, you billed/claimed for scaling and polishing units over and above the time documented (SA– November 29, 2017; MA – July 10/17; LL – October 24, 2017; MY – February 28, 2015, September 5, 2015, April 9, 2016, November 5, 2016).
- In three cases involving two patients, you claimed temporization of teeth in conjunction with endodontic treatment (TH – July 3, 2015, January 27, 2017; MY – October 3, 2016).

- In two cases, involving one patient, you billed/claimed caries/trauma/pain control that was not performed (TH – August 28, 2015, January 4, 2016).
- For one patient, you billed/claimed for a surface restorations that was not performed (TH – February 13, 2016).
- For one patient, in three instances, where restorations were provided, you billed/claimed for an additional surface (TH – July 22, 2015, July 13, 2016, March 24, 2017).
- You billed/claimed for a flap approach, with curettage of osseous defect and osteopathy for treatment of a periodontal abscess but your progress notes do not document that curettage was performed, and your treatment plan does not correspond to the treatment, and the treatment notes are not sufficiently detailed for one patient (LL – February 11, 2015).
- You billed/claimed flap approach, with curettage of osseous defect and osteoplasty for esthetic crown lengthening in the absence of an existing periodontal condition, including probing depths, radiographs, records and periodontal diagnosis, and the chart notes do not indicate the curettage of an osseous defect was performed (KM – January 15, 2015).
- You billed/claimed flap approach, with curettage of osseous defect and osteoplasty to correct implant bone levels in the absence of curettage of a diagnosed osseous defect (LL – February 3, 2015).
- In two cases, you billed/claimed flap approach, with curettage of osseous defect and osteoplastic in absence of a documentation of a periodontal condition to justify the procedures with respect to the sextants claimed (LL – January 13, 2015; ES – January 22, 2015).
- For four patients, you billed/claimed flap approach, with curettage of osseous defect and osteoplasty without chart entries or no documentation that the treatment was provided (SA– March 10, 2015, April 7, 2015, April 20, 2015, TH – November 21, 2016, January 17, 2017, LL – June 21, 2016, and KM – March 26, 2015).
- You billed/claimed a gingivectomy when whitening was provided (MY – May 3, 2016, May 10, 2016).
- In one case (TH – November 25, 2015), when the patient returned for the final restoration of the tooth 25 implant, you billed/claimed for surgical re-entry, removal of healing screw and placement of healing element without documentation that there was a surgical re-entry, removal of healing screw and placement of healing element.
- For one patient, you billed/claimed laboratory fees that could not be verified as the laboratory invoice was not provided to the College (SA– January 5, 2016).

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in the Notice of Hearing, marked as Exhibit 1.

The parties provided the Panel with a written plea inquiry (Exhibit 2), which was signed by the Member. The Panel confirmed with the Member that he understood the plea inquiry and as such was satisfied that Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

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

Allegations of Professional Misconduct

1. The allegations of professional misconduct against Dr. Daniel Lee are set out in the Notice of Hearing, dated July 5, 2019 (Exhibit 1).

Background

2. Dr. Lee received his dental degree from the University of Toronto in 1998. He has been registered with the College as a general dentist since June 1998. His practice is at Joshua Creek Dental in Oakville, Ontario. Dr. Lee has no record of prior discipline with the College.

Request for Registrar's Investigation

3. Sun Life requested a Registrar's investigation of Dr. Lee in November 2017 regarding his billing practices.

4. Initially, the Registrar did not have sufficient information to have reasonable and probable grounds to believe that Dr. Lee had committed an act or acts of professional misconduct. The Registrar requested additional information and documentation from Sun Life if Sun Life wanted him to proceed with the Registrar's investigation.

5. Sun Life provided additional information and documents from the charts of five patients in December 2017 to establish reasonable and

probable cause to initiate an investigation. An investigator was appointed by the Acting Registrar on January 17, 2018, as approved by the Inquiries, Complaints and Reports Committee ("ICRC").

6. The College investigator attended at Dr. Lee's office in Oakville on February 23, 2018. The investigator asked Dr. Lee to produce patient records for the patients identified by Sun Life and another randomly selected five patients as well. The investigator also questioned Dr. Lee regarding his office and billing practices.

7. Following the investigator's attendance at his office, Dr. Lee provided submissions to the investigator in March 2018.

8. The College investigator completed her review of the Sun Life claims data, patient records and other information received from Dr. Lee and issued her report to the Registrar on January 31, 2019. In turn, the Registrar provided the Registrar's Report dated January 31, 2019 to the ICRC.

9. The Registrar's Report sets out in detail the actions taken in the course of the investigation and the investigator's assessment of problematic claims and other practices of Dr. Lee in relation to the patient charts. The Investigator's detailed analysis of the patient charts is attached at Appendix A.

10. In summary, the investigator noted that Dr. Lee submitted numerous insurance claims for procedures other than the procedures actually performed or for procedures not provided at all. As well, Dr. Lee failed to document many significant details regarding his assessment and treatment of the patients. The discrepancies are listed in the particulars to the three allegations set out in the Notice of Hearing (Exhibit 1).

11. A copy of the Registrar's Report was provided to then-counsel for Dr. Lee on February 1, 2019. Counsel responded on February 4, 2019 advising that he no longer acted for Daniel Lee and that he would deliver the Registrar's Report to Dr. Lee.

12. Dr. Lee advised the College on March 14, 2019 that he did not wish to submit a response to the Registrar's Report at that time.

13. A panel of the ICRC reviewed the file regarding Dr. Lee on May 16, 2019. Dr. Lee was advised on May 24, 2019 that the panel had formed an intention to refer specified allegations of professional misconduct against him to the Discipline Committee. Dr. Lee was notified regarding the panel's concerns and was invited as well to make written submissions to the panel on or before June 22, 2019.

14. Dr. Lee did not provide any further submissions regarding the Registrar's Report to the ICRC.

15. The panel of the ICRC met again on July 3, 2019 and decided to refer specified allegations of professional misconduct against Dr. Lee to the Discipline Committee.

16. Dr. Lee was notified regarding the Decision of the ICRC on July 3, 2019. The College recommended that he seek legal counsel.

17. Dr. Lee reimbursed Sun Life in the amount of $226,548.63 with a series of cheques in February-May 2018 in full payment of the contested claims.

Dentistry Regulation

18. Regulation 547 (R.R.O 1990), section 38 provides that a dentist must exercise generally accepted standards of practice and procedures in the performance of professional services. Section 38(b) stipulates that a dentist must keep clinical and financial records regarding his or her patients, including at a minimum the patient's history, examination procedures used, clinical findings obtained, treatment prescribed and provided, and the dentist's fee and charges.

Dental Recordkeeping Guidelines

19. The College's guidelines on Dental Recordkeeping also set standards of recordkeeping that dentists are expected to maintain. The patient charts should include all relevant details regarding assessment tools utilized (such as radiographs and photographs), diagnoses, treatment plans, risks and benefits, informed consent, progress notes and financial records (including fees charged, laboratory fees incurred, payments received and adjustments to accounts).

Admissions of Professional Misconduct

20. Dr. Lee admits that he committed the acts of professional misconduct as alleged in the Notice of Hearing (Exhibit 1). Although he does not agree with every detail of the College investigator's analysis of the patient records in question, he accepts that that the analysis was substantially correct.

21. In particular, Dr. Lee admits that:

    - he failed to keep records as required by the Regulations, as alleged in paragraph 1 of the Notice of Hearing;

- he signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement, as alleged in paragraph 2 of the Notice of Hearing; and
- he submitted an account or charge for dental services that he knew or ought to have known was false or misleading, as alleged in paragraph 3 of the Notice of Hearing.

DECISION

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

REASONS FOR DECISION

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

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. Lee admitted to:

- Inadequate recordkeeping
- Signing or issuing a document that he knew or ought to have known contained a false, misleading or improper statement
- Submitted an account or charge for dental services that he knew or ought to have known was false or misleading

The Panel was satisfied that this conduct fell well below what is minimally expected of members of this profession and therefore clearly professional misconduct.

PENALTY SUBMISSIONS

The parties presented the panel with a Joint Submission with respect to Penalty and Costs (Exhibit 4), which provides as follows.

1. The Royal College of Dental Surgeons of Ontario ("College") and Dr. Daniel Lee ("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 five (5) months, to be served consecutively, such suspension to commence within thirty (30) days of this Order becoming final;

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

(i) while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;

(ii) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

(iii) during the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry during the suspension;

(iv) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in the connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

(v) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(iv) above shall be removed at the end of the period 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 own expense, a course in the appropriate use of billing codes, including when to bill a complete, recall or emergency examination, caries/trauma/pain control, hygiene treatment, surface(s) of restorations, periodontal surgeries, implants, laboratory fees, and co-payment, approved by the College, and provide proof of successful completion in writing to the Registrar within nine (9) months of this Order becoming final;

(ii) 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 nine (9) months of this Order becoming final;

(iii) 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 with the date of the finalization of this Order 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 the monitoring program, whichever date is later;

(iv) 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);

(v) 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;

(vi) the Practice Conditions imposed by virtue of subparagraphs (1)(d)(i)-(ii) 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)-(ii) above have been completed successfully;

(vii) the Practice Condition imposed by virtue of subparagraph (1)(d)(iii) 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)-(ii) 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 $5,000.00 in respect of this discipline hearing, such costs to be paid in full within thirty (30) days 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. This joint submission on penalty and costs was reached as a result of a pre-hearing conference held with respect to these matters and it received the endorsement of the pre-hearing conference presider.
4. Dr. Lee has not previously appeared before the Discipline Committee of the College.

PENALTY DECISION

The Panel agreed and accepted the Joint Submission with respect to Penalty and Costs and ordered that:

1. (a) the Member is required 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) the Registrar is directed to suspend the Member's certificate of registration for a period of five (5) months, to be served consecutively, such suspension to commence within thirty (30) days of this Order becoming final;

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

(i) while the Member's certificate of registration is under suspension, the Member shall not be present in his dental office when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;

(ii) upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

(iii) during the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do

anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry during the suspension;

(iv) the Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in the connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

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

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

(i) the Member is required to successfully complete, at his own expense, a course in the appropriate use of billing codes, including when to bill a complete, recall or emergency examination, caries/trauma/pain control, hygiene treatment, surface(s) of restorations, periodontal surgeries, implants, laboratory fees, and co-payment, approved by the College, and provide proof of successful completion in writing to the Registrar within nine (9) months of this Order becoming final;

(ii) the Member is required to successfully complete, at his/her own expense, the ProBE Program on Professional/Problem-Based Ethics, to be completed with an "unconditional pass" within nine (9) months of this Order becoming final;

(iii) 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 with the date of the finalization of this Order 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 the monitoring program, whichever date is later;

(iv) 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);

(v) 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;

(vi) the Practice Conditions imposed by virtue of subparagraphs (1)(d)(i)-(ii) 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)-(ii) above have been completed successfully;

(vii) the Practice Condition imposed by virtue of subparagraph (1)(d)(iii) 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)-(ii) 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 $5,000.00 in respect of this discipline hearing, such costs to be paid in full within thirty (30) days of this Order becoming final.

2. 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.

REASONS FOR PENALTY DECISION

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

The Panel’s primary concern when considering the adequacy of a penalty decision is public protection. The Panel was satisfied that public protection is met through the terms of the Joint Submission on Penalty.

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 also sends 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. Dr. Lee is required to complete at his own expense courses in ethics (ProBE) and billing codes that must be approved by the College. The Member's practice shall be monitored by the College for a period of 24 months at his expense.

The Panel considered the seriousness of the misconduct, the length of time that the misconduct occured and the number of cases that contained billing irregugularites as aggravating factors.

The Member co-operated with the College and pled guilty. By admitting the misconduct, he prevented a potentially costly and time consuming hearing. Dr. Lee has never appeared before a Discipline Panel before and voluntarily refunded the insurance company the money in dispute. These mitigating factors were considered as well.

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

May 25, 2020

Richard Hunter

Date

REPRIMAND

RCDSO v. Dr. DANIEL LEE

Dr. Lee, 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 inadequate or false record-keeping, signing and issuing false, misleading or improper financial statements relative to a number of patients, and submitting an account for dental services that you knew or ought to have known was false or misleading.

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 deceiving third party payors by submitting false or misleading information for your own financial gain. You admitted to engaging in this conduct over a three -year period. Although only 10 of your patient records were audited, this panel is concerned that the pattern of behaviour may have involved more patients.

The panel recognizes your cooperation with the College. We expect that as a result of this experience, and the imposed remedial activities, you have learned an important lesson about professional behaviour, and as such you will not find yourself in front of the Discipline Committee again.

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.