IN THE MATTER OF THE DENTAL DISCIPLINES ACT, SS 1997, c D-4.1, AND BYLAWS

AND

IN THE MATTER OF A FORMAL COMPLAINT DATED AUGUST 15, 2024, AGAINST DR. CAMERON CHIANG, A MEMBER OF THE COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN

DECISION OF THE DISCIPLINE COMMITTEE

Discipline Committee Members:

Dr. Cameron Roberts, Chair

Dr. Mina Patel

Dr. Heather Torrie

Dr. Erika Ridgway

Don Robinson, Public Representative

Faith Baron, Stevenson Hood Thornton Beaubier LLP, Counsel for the Discipline Committee

Appearing for the Professional Conduct Committee: Candice Grant and Tessa Dyer, Robertson Stromberg LLP

Appearing for the Member: None

A. INTRODUCTION

1. The College of Dental Surgeons of Saskatchewan (the "**College**") received a complaint against Dr. Cameron Chiang (the "**Member**") on or about February 15, 2024, as well as a subsequent informal report, which caused the Registrar of the College to submit a second complaint against the Member on March 11, 2024. The College referred the matter to the Professional Conduct Committee (the "**PCC**"), who referred the matter for an investigation.

2. On April 3, 2024, the Registrar of the College imposed an interim suspension of the Member's license.

3. Following the investigation, the PCC prepared a Formal Complaint, which is attached to this decision as Appendix A. The PCC referred the matter to the Discipline Committee of the College to hear and determine the Formal Complaint.

4. The hearing was conducted on February 24, 2025, in Saskatoon, Saskatchewan.

B. HEARING

5. At the outset of the hearing, counsel for the PCC presented the Book of Documents as Exhibit 1 and it was so entered. The Book of Documents contained the following:

    a) CDSS Complaint Form, February 15, 2024
    b) CDSS Complaint Form, March 11, 2024
    c) Interim Suspension letter, April 3, 2024
    d) Report of the PCC to the Discipline Committee and Formal Complaint, August 15, 2024
    e) Notice of Hearing, December 18, 2024
    f) Affidavit of Service, February 21, 2025
    g) Curriculum Vitae of Dr. Kelly Gagllagher
    h) Patient Records for L.C.
    i) Patient Records for K.B.
    j) Patient Records for A.B.
    k) Patient Records for J.M.
    l) Patient Records for M.S.
    m) Patient Records for T.P.D.
    n) Patient Records for C.W.
    o) Patient Records for A.B.
    p) Patient Records for P.K.
    q) Patient Records for D.B.
    r) Patient Records for G.M.

6. The Curriculum Vitae for Dr. Kelly Kudryk was entered at the hearing as Exhibit 2.

7. The Member did not appear at the hearing. As a preliminary issue, the Discipline Committee considered whether the hearing could proceed in the Member's absence.

8. Pursuant to subsection 33(10) of *The Dental Disciplines Act*, SS 1997, c D-4.1 (the "**Act**"), the Discipline Committee is permitted to proceed with the hearing in the Member's absence upon proof of service in accordance with the Act. Subsection 33(1) provides the following:

33(1) Where a report of the professional conduct committee recommends that the discipline committee hear and determine a formal complaint, the registrar shall, at least 14 days before the date the discipline committee is to sit:

(a) send a copy of the formal complaint to the member whose conduct is the subject of the hearing; and

(b) serve notice on the member whose conduct is the subject of the hearing of the date, time and place of the hearing.

9. The Act further describes the method of service required at section 52:

52(1) Unless otherwise provided for in this Act or the bylaws, any notice or other document that is required to be served pursuant to this Act may be served by:

(a) personal service made:

(i) in the case of an individual, on that individual;

(ii) in the case of a partnership, on any partner; or

(iii) in the case of a corporation, on any officer or director; or

(b) registered mail addressed to the last business or residential address of the person to be served shown on the register.

(2) A notice or document sent by registered mail is deemed to have been served on the seventh day following the date of its mailing, unless the person to whom it was mailed establishes that, through no fault of that person, the person did not receive the notice or document or received it at a later date.

(3) If it is for any reason impractical to effect service of any documents in the manner provided for in subsection (1), the court may, on application that may be made ex parte, make an order for substituted service.

(4) A document served in accordance with the terms of an order mentioned in subsection (3) is deemed to have been properly served.

10. Section 7 of the Regulatory Bylaws of the College of Dental Surgeons of Saskatchewan (the "**Regulatory Bylaws**") provides as follows:

(1) Service of Regulatory Documents

a. Service of regulatory and other documents and communications may be made by any method prescribed pursuant to the Act, including personal service and service by registered mail.

b. In addition to the methods of personal service described in the Act, service of documents may be affected by an alternate mode, including but not limited to:

i. electronic mail transmission;

ii. website portal;

iii. courier;

iv. ordinary mail.

11. Dr. Dean Zimmer, Registrar of the College, appeared at the hearing as a witness and, as above, his affidavit of service as to the efforts made to ensure that the Member received notice of the hearing, was submitted as part of the Book of Documents.

12. Dr. Zimmer's affidavit identified the contact information for the Member as contained in the records of the College, which included two email address and two phone numbers. Dr. Zimmer confirmed that he had sent the Notice of Hearing and the Report of the PCC to the Member by email to both email addresses on January 27, 2025, and had received a delivery confirmation for both. He also sent the Notice of Hearing by text message on February 2, 2025, to one of the numbers in the records of the College and explained that this number was the number he had previously communicated the Member on previous occasions.

13. Dr. Zimmer also described that he had searched for possible places of practice of the Member but had no success in locating a current place of practice. In addition, the College engaged a skip tracer to try to locate the Member, but this effort was not successful in locating the Member.

14. The Discipline Committee adjourned the hearing briefly and met *in camera* to determine whether the matter could proceed in the Member's absence. The Discipline Committee concluded that proof of service had been submitted in accordance with the Regulatory Bylaws of the College in that the Notice of Hearing had been sent by email to the addresses in the records of the College. In addition, the College had made significant efforts to determine the physical whereabouts of the Member, but these efforts were not successful. Mindful of the importance and responsibility of any member of the College to ensure that their contact information is updated and current within the records of the College, and to respond to communications from the College, the Discipline Committee concluded that the College had fulfilled the service requirements on the Member and that it was appropriate to proceed in the Member's absence.

15. The Discipline Committee therefore resumed the hearing and proceeded in the Member's absence pursuant to subsection 33(10) of the Act.

C. WITNESS TESTIMONIES

16. Testimony at the hearing was provided by three witnesses called by the PCC.

Dr. Dean Zimmer

17. Dr. Dean Zimmer, Registrar of the College, testified that in his role as registrar he evaluates complaints that come to the College and forwards them on to PCC for investigation, where appropriate. On February 15, 2024, a complaint was received from a patient against the Member and was forwarded to the PCC. A copy was also sent to the Member. A second communication identifying several issues was received from a therapist working at the Member's office, but this was not filed as an official complaint by the therapist. Dr. Zimmer requested a formal complaint to be submitted but did not receive one. Given that the nature of the complaint was significant, Dr. Zimmer decided to file his own complaint based on the information provided by the therapist.

18. Dr. Zimmer explained that the PCC pursued an in-office investigation of the complaints and reported that the complaints were warranted. The investigation also revealed concerns with additional patients. Upon receipt of this information, Dr. Zimmer issued an interim suspension order pursuant to section 31(1) of the Act on April 3, 2024, which restricted the Member from practicing dentistry within Saskatchewan. Dr. Zimmer believes that the Member did not practice dentistry within Saskatchewan after that time and also recalled that the Member cancelled his malpractice insurance in the spring of 2024, which automatically deemed his license inactive.

Dr. Kelly Gallagher

19. Dr. Kelly Gallagher was then called as an expert witness for the PCC and the Discipline Committee accepted the witness as a qualified expert witness after presentation and review of Dr. Gallager's curriculum vitae. In particular, he was accepted as a qualified expert in general dentistry and the standard of care applicable to clinical dental treatment.

20. Dr. Gallagher testified that after the PCC did an initial investigation of the complaint, it was decided that more information was required, so a team went to the dental office of the member to review patient charts and files. The team reviewed specific patient files that had been previously identified but also identified further patient files that were of concern. Another member of the College was sent to do onsite examinations of several patients they were able to contact in order to evaluate the treatment of the Member. After all this information was reviewed, the PCC met to review the evaluations and make their recommendations to the College.

21. Dr. Gallagher addressed several patient files.

Patient L.C.

22. The records pertaining to patient L.C. were reviewed by Dr. Gallagher. On November 17, 2023, the Member charted that he performed a 5-surface restoration on tooth 41. However, Dr. Gallagher testified that the radiographs show that tooth 41 appears clinically intact with no signs of decay. On November 17, 2023, the Member charted that he performed a 5-surface restoration on tooth 45, but the radiographic exam showed a badly broken-down tooth with guarded prognosis and no mesial surface treatment. That is, the radiograph is not consistent with what the Member charted.

23. Dr. Gallagher also testified with respect to the quality of the treatment in relation to patient L.C. On November 23, 2023, the Member charted that he performed a root canal on tooth 44. Dr. Gallagher testified that the treatment was well below the standard of care that you would expect from a competent practitioner. The canal was half-cleaned and shaped. The apical (i.e. the bottom part of the canal at the end of the root) was not touched and the canal appeared to be split in two, but the second canal was not addressed. The post was very short and not functional. The surface restoration performed was also not functional. Dr. Gallagher concluded that tooth 44 was highly likely to fail and become reinfected. He noted that the patient was probably worse off after this treatment.

24. The Member also performed a root canal on tooth 43, which Dr. Gallagher assessed as highly suspect to fail given that the root canal filling was well short of the apex of the root and the post was nowhere near long enough down the canal to prevent dislodgment. The fill also had evidence of voids. Dr. Gallagher concluded that the treatment was well below the standard of care.

25. On tooth 45, Dr. Gallagher assessed the root canal procedure as relatively acceptable, but the placement of the post was not ideal since it was angled away from the canal space. Dr. Gallagher concluded that the placement was not up to the standard of care. In addition, the 5-surface restoration showed gaps, which means that the cavity was not removed entirely, or it was not filled correctly. Either way, this was below the standard of care.

26. Dr. Gallagher noted that the Member's charts did not contain a record of the testing completed to form a diagnosis for the procedures the Member completed. Additionally, Dr. Gallagher noted that where a procedure does not go the correct way, the patient needs to be informed and presented with options. There were no indications in the chart that these conversations ever happened.

Patient K.B.

27. The records pertaining to patient K.B. were reviewed by Dr. Gallagher. On May 31, 2023, the Member charted that he performed an extraction of tooth 38 and a cyst excision. There was no entry indicating that the alleged cyst was sent for biopsy. This would be important because if it was a cyst, it would have a tendency to recur and required follow up with the patient. Further, the entry charted for the cyst excision should not have been charged as an extra procedure where an extraction was also performed on the same tooth. Dr. Gallagher testified that the fee guide specifically says a separate amount for the cyst excision should not be charged where an extraction is also performed.

Patient A.B.(1)

28. Records pertaining to patient A.B.(1) were reviewed by Dr. Gallagher. On October 16, 2023, the Member entered that he had performed 26 restorations and 1 extraction, which was noted as a highly unusual amount of work on one patient in one sitting. Dr. Gallagher testified that that he could not imagine that this would be appropriate for the patient in terms of safety. He opined that it might be appropriate if the work was performed under sedation in a hospital setting but not in a general office setting. The estimation was that it would probably take around 6 or 7 hours of continuous work to perform all of these procedures, noting that many of them were noted to have been performed on back molars and lower front teeth, which are very complicated procedures. There was also a concern as to the amount of anesthetic that would have been required for that many procedures in one day. It was noted that there were no post-procedure radiographs in evidence for this patient (i.e. it was not possible to determine whether some or all of this work was actually performed or not). Dr. Gallagher stated that it is not common for post-procedure radiographs to be taken.

29. Dr. Gallagher explained that there were multiple 5-surface restorations included in the entries, which are complicated procedures. The Member charted that he performed a 5-surface filling on tooth 16, but the radiograph showed a previous silver filling that would not have justified a 5-surface filling at that time. Similarly, the Member charted that he performed 3-surface fillings on tooth 15 and tooth 14, but the radiographs did not show that these teeth required such a procedure. Tooth 13 was charted as a 5-surface filling, which was also not warranted. Tooth 34 was charted as a 4-surface filling, which was not warranted. Tooth 44 was charted as a 4-surface filling and Dr. Gallagher indicated that this tooth may have required a small restoration, but not a 4-surface restoration. Tooth 45 was also charted as a 4-surface filling, which was not warranted.

30. Tooth 36 was charted as a 5-surface filling. Dr. Gallagher testified that this tooth was not a restorable tooth and required extraction. There was no indication on the patient chart that the Member discussed the options for this tooth.

31. In general, Dr. Gallagher testified that for patient A.B.(1), there was no way to tell if the work was performed or not since A.B.(1) did not respond to their request for a follow-up examination during the investigation. However, either way, he testified that this is either a fraudulent billing issue or a patient safety issue. Both scenarios would be of "huge" concern.

Patient J.M.

32. Records for patient J.M. were reviewed by Dr. Gallagher. On the same day as the treatment charts for patient A.B.(1), being October 16, 2023, the Member charted that he performed 27 restorations and 2 extractions on patient J.M. Dr. Gallagher confirmed that his previously stated concerns would apply to patient J.M. as well, given the number of procedures stated to have been performed in one day.

33. For teeth 12, 11, 21, 22, 32, 31, 41, and 42, the Member charted that he performed 5-surface restorations on each of them. Dr. Gallagher reviewed the radiographs showing each of these teeth. None of them required a 5-surface restoration. In addition, there was no indication on the chart as to whether or how much anesthetic was used.

Patient M.S.

34. In relation to patient M.S., whose chart indicated that on October 16, 2023 (the same date as the above-noted patients) the Member performed 19 restorations, Dr. Gallagher reiterated the concerns already discussed above as to the number of procedures said to have been performed in one sitting. Additionally, Dr. Gallagher addressed the complexity of a particular procedure that appears on the Member's chart for this patient in relation to increasing the vertical dimension of occlusion (i.e. adjusting the contact relation between the upper and lower jaws as it relates to facial height and jaw position). This procedure takes a significant amount of time to assess and plan for, and the Member's chart had no detail as to why or how this procedure was to take place. Dr. Gallagher indicated that if he was going to do this procedure, he would start with diagnostics (i.e. obtaining models of the top and lower jaw and placing the models onto an articulator to create a simulation of the joint adjustment). Ongoing treatment would be required to ensure that existing teeth would still touch each other, which sometimes requires additional overlays to existing teeth. Dr. Gallagher described the procedure as very, very complex and that it would probably involve 2 to 4 months of preliminary

treatment. Dr. Gallagher noted that there is no indication at all that the Member followed any of those processes and also no indication that the Member discussed any of this with the patient at all.

35. In terms of the multiple restorations on Patient M.S.'s chart, Dr. Gallagher testified that tooth 17 did not require the restoration that was charted (i.e. the lingual surface). In addition, the restoration that was required (i.e. the mesial decay) was not charted as having been performed. Dr. Gallagher did observe that the Member's chart noted the mesial decay accurately.

36. In relation to tooth 24, the radiograph showed there was an existing 3-surface restoration. The Member charted a 4-surface restoration, but this was not necessary. Dr. Gallagher did state that there may have been an area that was a little darker and possibly requiring treatment, but not to the extent that was entered on the chart. Tooth 34, tooth 44, and tooth 45 were all charted as requiring 4-surface restorations, all of which were not warranted. Tooth 46 was charted as requiring a 5-surface restoration, but there was no indication that this restoration was warranted either.

37. The same patient, M.S., had further treatments on January 8, 2024, including a 5-surface restoration of tooth 14. In looking at the radiographs, Dr. Gallagher acknowledged that they were taken on October 16, 2023, but also stated that it would be unlikely that the extent of decay would have developed during that time period such that a 5-surface restoration would become warranted by January 2024. He indicated that if a fracture had occurred, that could warrant such a treatment. In any event, Dr. Gallagher was of the view that if such restorations were being considered, updated radiographs should have been completed on the day of the procedure.

38. When looking at tooth 25, which the Member charted as requiring a 5-surface restoration, Dr. Gallagher stated he could not conclude with certainty that this tooth did not require the declared restorations as he did note some discrepancies on the radiograph. He did note, however, that further investigation of this tooth would have been warranted. For tooth 27, Dr. Gallagher stated that the 5-surface restoration was absolutely not warranted.

Patient T.P.D.

39. In relation to patient T.P.D., Dr. Gallagher confirmed that the chart states that 21 restorations were performed on July 26, 2023, which was described as unusual and inappropriate for the same reasons previously discussed. These included restorations on teeth 17, 16, 15, 14, 27, 26, 25, 24, 23, 22, 37, 36, 35, 34, 32, 31, 37, 46, 45, 44, and

42. Dr. Gallagher stated that there were no radiographs in the patient file, only one panoramic. A follow-up request to the clinic was made to ensure the complete file had been provided. The clinic confirmed that the file was complete. When looking at that one panoramic radiograph, Dr. Gallagher testified that the teeth appear quite healthy and the individual quite young. However, to diagnose and require the restorations that were charted for this patient, the provider would require more radiographs. While the one panoramic radiograph that had been taken was from 2021, Dr. Gallagher opined that it would be unusual for that amount of deterioration to have occurred in that amount of time. In addition, the chart indicated recurrent decay on fractured enamel, but Dr. Gallagher did not see anything on the panoramic radiograph that would indicate a need for the extent of restorations that were provided.

Patient C.W.

40. In relation to patient C.W., Dr. Gallagher testified that on July 19, 2023, the Member charted an entry for a surgical excision of a benign tumour. Anesthetic was described as being administered in quadrant 4, but there is no description of where the tumour was located. In addition, there is no record of the tissue being sent for a biopsy and therefore no way of concluding that it was benign. The College requested records of any biopsy completed by the health region, but none were identified. While the chart contained a note that "options [were] discussed" with the patient, there were no details other than that, which Dr. Gallagher noted was below the standard of care.

41. The same patient, C.W., received treatment again on July 24, 2023, for what the Member charted and diagnosed as dysplasia requiring surgical removal of tissue on the side of the tongue. Dr. Gallagher explained that dysplasia cannot be diagnosed unless you see it under a microscope, which would be done by a pathologist. There was no further description, no follow-up, and no biopsy records. Dysplasia can be precancerous, so this was very concerning. There were also no notes regarding consent or anesthetic. It was notable as well that this treatment occurred 5 days after the last treatment date, when nothing about the "dysplasia" had been noted previously. Dr. Gallagher noted that jumping to the conclusion of dysplasia and proceeding to cut it off when nothing had been noted previously is not something most clinicians would do, and below the standard of care.

General Charges

42. Dr. Gallagher testified as to the general charges contained in the formal complaint. He stated that the Member's charting and recordkeeping in general were not up to the standard of care. He estimated that in 95% of the Member's patient records, there was

no mention of anesthetic or consent to anesthetic at all. It would be very unusual to not administer an anesthetic, particularly when a root canal or multiple surface restorations are being performed. As well, many entries seemed to have been cut and pasted from one patient chart into another. Dr. Gallagher testified that there were multiple discrepancies identified in the Member's charting habits and he opined that they probably have only "scratched the surface" of the problems.

43. Dr. Gallagher also commented on the lack of signature on any of the Member's charts. The entries should have been confirmed by signature of the treatment provider, regardless of who entered them. In any event, the provider is responsible for the accuracy of their patient charts.

44. Lack of diagnostic testing was also noted by Dr. Gallagher as a general failure to meet the standard of care. As an example, Dr. Gallagher noted that some of the patients had more than one root canal being performed with little description of any testing as to the health of the nerves. Doing more than one root canal at a time is highly unusual, so you would expect to see more description. There were no indications in any of the notes reviewed as to what diagnostic criteria were used to come up with the conclusions reached by the Member with respect to these patients.

45. Finally, Dr. Gallagher commented on the standard of care with respect to consent. He emphasized the importance of good recordkeeping. For less invasive procedures, verbal consent is often sufficient but still needs to be recorded. For more intense procedures, like a root canal or extraction, the patient needs to know that there are things that could go wrong and understand their options so one would expect to see written informed consent on the file. Dr. Gallagher confirmed that there were none in any of the records.

Dr. Kelly Kudryk

46. Dr. Kelly Kudryk was called as an expert witness for the PCC and the Discipline Committee accepted the witness as a qualified expert witness after presentation and review of Dr. Kudryk's curriculum vitae. In particular, he was accepted as a qualified expert in general dentistry and the standard of care applicable to clinical dental treatment.

47. Dr. Kudryk performed in-person examinations for some patients who responded to the College's request for a follow up. He also took radiographs for some patients where that was appropriate. He recorded his conclusions as to the quality and acceptability of the treatments and reported those findings to the College. Dr. Kudryk confirmed that he had never treated any of these patients previously and had no connection to the

Member or his clinic. Dr. Kudryk is a member of the College, but has no involvement with council, the PCC, or the Discipline Committee. He was asked to examine patients of the Member to give an independent opinion on treatment actually done compared to what had been charted. He was also asked to give an opinion of the work that had been performed in terms of the standard of care.

Patient A.B. (2)

48. Dr. Kudryk reviewed his findings in relation to patient A.B.(2). He commented on the amount of time it would have taken to perform the amount of treatment stated in the chart to have been performed on November 20, 2023. The Member had charted restorations on teeth 16, 26, 46, 36, and 44, but none of them were done properly or at all. On January 18, 2024, the Member charted restorations on teeth 12, 11, 22, 75, 32, 31, 85, 42, and 41. Dr. Kudryk stated these were not done at all.

49. Dr. Kudryk observed that treatments that were attempted were not done in an acceptable manner. He described that some teeth appeared to have some composite placed on top of cavities. Some restorations were broken. There was indication that the Member performed vestibuloplasties and frenectomies (i.e. cutting the gum tissue), but Dr. Kudryk saw no scarring that should have been present if these procedures were performed and frenum was still present. The patient still had steel crowns on two teeth, but the chart indicated restorations performed on them (i.e. this was clearly not done). He commented that this patient was quite young, probably 11 or 12 years old, and these treatments were not appropriate for someone of that age.

50. Additionally, the root canal on tooth 36 was inadequate, with evidence of an abscess around the tooth, which was painful for the patient. It was clear there were 4 roots, but only 3 were filled. The fillings were inadequate. He questioned whether the procedure was required at all. There was also evidence of endodontic care on teeth 75 and 85, which are primary teeth, and it would be unusual to do root canals on primary teeth.

51. In general, Dr. Kudryk concluded that that the work performed by the Member did not meet the standard of care and, further, the charting completed by the Member did not meet the standard of care.

Patient P.P.

52. Dr. Kudryk examined patient P.P. On January 13, 2024, the Member charted that he performed multiple restorations and 3 root canals. The chart says nothing about anesthetic. Dr. Kudryk noted that the entries made by the Member were exactly the

same for each of the three root canals, which would be rare, and he suspected a lot of "cut and paste" going on. While multiple restorations were charted for the lower teeth, none of them were actually done. On the upper jaw, there were some restorations performed but generally not adequately. The majority of the restorations that were recorded and billed as having been completed were not completed, and many of them were not necessary.

53. More specifically, Dr. Kudryk explained that tooth 17 still had cavities. Tooth 16 had an old filling present but there was still cavity. Tooth 26 was declared as a 5-surface filling, but this tooth appeared to have an old 5-surface filling with a 2-surface filling added to it and then another 3-surface filling added. Tooth 21 had an overhang. The root canal on tooth 37 was unacceptable. Tooth 36 had an old 5-surface filling, and it appeared to Dr. Kudryk that the Member just drilled a hole through the old filling to access the root. The Member charted that he had performed restorations on teeth 37, 35, 34, 17, 13, 11, 32, 31, 47, 42, and 41, but none of these were done at all.

54. The root canals on teeth 34 and 35 had no associated diagnostic notes as to why the procedure was necessary. There was no evidence that he had done thermal or electric pulp testing, or any observations of gum issues, fractures, or cracks. Dr. Kudryk opined that that these teeth did not need root canals to begin with. Both of the posts were not adequate. The teeth were poorly cleaned out and the fillings were inadequate, either too big or too small. The teeth were painful to the patient. Oddly, there was also a root canal performed on an upper left tooth, but this procedure does not appear in the patient's chart and there was no evidence that the patient had seen another dentist in the meantime.

Patient D.B.

55. Dr. Kudryk examined patient D.B. The Member had charted that he performed 14 restorations on January 10, 2024, and none of these were present in the patient's mouth. These included declared restorations on teeth 16, 53, 12, 11, 21, 22, 63, 26, 73, 31, 32, 41, 42, and 83.

56. For tooth 55, the Member declared a large restoration had performed, but there was only a small restoration present and there was still decay. For tooth 65, the Member declared a large restoration. There was extensive decay still present and Dr. Kudryk observed that composite material seemed to have just been placed over top of the decay. Dr. Kudryk also observed that this patient had two front teeth that were fused together, almost like one tooth. Curiously, the Member had charted nothing about this and, instead, charted that he had performed fillings on both of these teeth.

Patient G.M.

57. Dr. Kudryk examined patient G.M. The Member charted that, on November 15, 2023, he performed root canals on each of teeth 15, 14, 13, 23, 24, and 25. The patient recalled that he had been at the clinic for about 5 hours that day and had initially come in because his denture was ill-fitting. However, the patient had reported no pain or discomfort, and the diagnostic notes indicated abscesses that were not otherwise symptomatic. Dr. Kudryk testified that this does happen, but it would be very rare for all of these teeth to be asymptomatic and require root canals. All of the work was charted the same way, even the lengths of each of the teeth were noted as having the exact same length. Nothing on the x-rays justified this work and there was no testing recorded. The opening he created to go into the tooth to the root was excessively large and would have likely perforated the side of the tooth, which would probably lead to extraction. This patient did have to have 2 of these teeth extracted later because of pain and discomfort. The remaining ones are sore and failing and will likely need extractions too.

58. The Member claimed to have done pulpectomies on teeth 26, 36, 35, 34, and 33. Dr. Kudryk observed from the post-operative radiographs that for teeth 33, 34, and 35, the drilled openings did not come close to accessing the pulp. Rather, it appeared that the Member merely drilled a hole in each of the teeth and put a filling in. On teeth 26 and 36, Dr. Kudryk observed that there were no new restorations and no evidence that the Member had drilled into these teeth at all. There were no issues identified with these teeth.

59. Dr. Kudryk testified that he has observed inadequate treatment by other dentists over the years. When asked how he would rate the quality of treatment performed by the Member on patient G.M., Dr. Kudryk stated that it was a 10, being the worst he had ever seen and "grossly incompetent". He commented that the patient is going to need thousands of dollars of work after this. The patient's denture was still ill-fitting after the work performed by the Member.

60. Dr. Kudryk confirmed that 18 restorations had been charted as performed by the Member but were not present in the patient's mouth as charted. These include teeth 35, 32, 31, 45, 42, 41, 13, 14, 23, 24, 26, 27, 33, 34, 45, 14, 15, and 25.

General Charges

61. Dr. Kudryk commented generally on the four patients he examined and the charts he reviewed. He noted that many entries appeared to have been "cut and paste" because

they were identical wording, which was very strange. He observed no notes regarding diagnostic testing, if any was done at all. There was nothing in the files about consent, verbal or written. For more complex procedures, more discussion is necessary, and one would expect something in the file regarding the patient's consent.

D. SUBMISSIONS BY THE PARTIES

62. The Member did not make submissions as to the charges. The PCC submitted written argument after the hearing concluded and after the transcripts of the hearing had been obtained and circulated to both parties.

63. The PCC submitted that the evidence presented is uncontroverted and unchallenged.

64. With respect to the allegations of professional misconduct, the PCC submitted that the task of the Discipline Committee is to determine whether the conduct outlined in the complaint did in fact occur and, if so, does the conduct constitute professional misconduct.

65. The PCC noted that the determination is discretionary. As stated by the Saskatchewan Court of King's Bench in *McCulloch v Investigation Committee of the Saskatchewan Registered Nurses Association,* 2023 SKKB 203 at para 62, the Discipline Committee must ask: "What are the norms of professionalism and what degree of departure from those norms will move commonplace error into the realm of professional misconduct?"

66. In this case, the PCC submitted that there was clear and uncontroverted evidence from expert witnesses as to the numerous shortcomings in the conduct of the Member.

67. With respect to the allegations of professional incompetence, the PCC submitted that there is a wide and inclusive definition of prohibited conduct. In *Nanson v Saskatchewan College of Psychologists*, 2013 SKQB 191 at para 24, the Court stated:

> Professional regulators frequently have a wide or inclusive definition of prohibited conduct. This is to ensure that a regulator is not restricted from dealing with conduct that requires attention from the perspective of protections of the public.

68. The PCC submitted that the Member demonstrated both a lack of knowledge, skill or judgment, and a disregard for the welfare of his patients, of a nature and to the extent that they demonstrate the Member is unfit to continue in the practice of dentistry. The

PCC submitted that the evidence was that the Member provided treatment that was markedly below the standard of care.

E. DECISION ON MISCONDUCT AND/OR INCOMPETENCE

69. Following receipt of the written submissions, the Discipline Committee met *in camera* to deliberate the charges of incompetence and misconduct, pursuant to sections 26 and 27 of the Act, which read as follows:

Professional incompetence

26 Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment, or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:

(a) continue in the practice of that member's profession; or
(b) provide one or more services ordinarily provided as a part of the practice of that member's profession;

is professional incompetence within the meaning of this Act.

Professional misconduct

27 Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:

(a) it is harmful to the best interests of the public or the members of the association;
(b) it tends to harm the standing of the member's profession;
(c) it is a breach of this Act or the bylaws of that member's association; or
(d) it is a failure to comply with an order of the professional conduct committee, discipline committee or council of that member's association.

70. The Discipline Committee carefully considered the Formal Complaint, the oral evidence given at the hearing, which was transcribed and reviewed by the members of the Discipline Committee, the exhibits entered into the record at the hearing, and the written submissions from the PCC.

71. The Discipline Committee accepted the PCC's submissions generally that the evidence tendered was uncontroverted and unchallenged. The expert witness' testimonies were accepted as qualified, credible, and reliable. There were some instances where the

members of the Discipline Committee were concerned that the patient charts and radiographs were inconclusive but, in those instances, the Discipline Committee relied upon the clinical observations of Dr. Kudryk, who testified that he examined those patients' post-treatment directly. The Discipline Committee accepted his evidence as to his in-person clinical observations.

72. In particular, each of the charges were considered with respect to each patient and each tooth described in the Formal Complaint and it was determined that:

a) Charge A: Professional Misconduct
    i. Patient A.B.(2)
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional misconduct.
    ii. Patient P.K.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional misconduct.
    iii. Patient D.B.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional misconduct, with the exception of the following comments respecting Tooth 26:
            a. Tooth 26 – The Member declared that he restored the MODBL surfaces of the tooth. The Formal Complaint identified that radiographic and clinical examination showed only that the OL surfaces were restored. The Discipline Committee noted that there was no radiographic evidence for this tooth and also noted that the clinical examination revealed that no restoration was completed at all. The charge as worded is therefore slightly inaccurate but nonetheless made out with respect to tooth 26 in that the Member declared that he performed work that was not actually performed.
    iv. Patient G.M.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional misconduct.

v. Patient L.C.
    1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional misconduct.

vi. Patient K.B.
    1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional misconduct.

b) Charge B: Professional Incompetence
    i. Patient P.K.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.
    ii. Patient A.B.(2)
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.
    iii. Patient D.B.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.
    iv. Patient G.M.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.
    v. Patient L.C.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.
    vi. Patient A.B.(1)
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.
    vii. Patient J.M.
        1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.

viii. Patient M.S.
    1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence, with the exception of the charge related to Tooth 17. The Discipline Committee was not convinced that the charge as stated constitutes professional incompetence, as the Member's chart did note the mesial decay even though the restoration performed was recorded as having been performed on the lingual surface. The Discipline Committee concluded that this could have been a minor charting oversight and not necessarily rising to the level of professional incompetence.

ix. Patient T.P.D.
    1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.

x. Patient C.W.
    1. The Discipline Committee determined that the charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.

xi. General Charges
    1. The Discipline Committee determined that the general charges as listed in the Formal Complaint occurred and the conduct constitutes professional incompetence.

73. The Discipline Committee also accepted and confirmed the PCC's submission that the charges that were made out are also violations of the duties articulated in Part 9 of the Bylaws of the College, which also constitute professional misconduct:

a) 9.2(1)(c): duty to uphold the honour and dignity of the profession of dentistry, and abide by the provisions of the code of ethics of the College;
b) 9.2(1)(f): duty to maintain the records that are required by the bylaws to be kept in respect of a member's patients or practice;
c) 9.2(2)(b): duty to not charge for services not performed;
d) 9.2(2)(f): duty to not falsify a record regarding the examination or treatment or patient;
e) 9.2(2)(g): duty to not knowingly submit a false or misleading account or false or misleading charges for services rendered to a patient;
f) 9.2(2)(w): duty to not conduct or commit, or in the case of a professional corporation, permit a member to conduct or commit any act relevant to the

practice of dentistry that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and

g) 9.2(2)(x): duty to not practise his or her profession, or in the case of a professional corporation, permit a member to practise his or her profession in such a way that the member may be unable to give full force and effect to his or her training, experience, and judgment as acquired in the course of the member's education.

74. The Discipline Committee would like to thank counsel for the PCC for their organized manner of presenting evidence at the hearing and for their helpful written submissions.

75. The Chair of the Discipline Committee will arrange for a hearing and/or submissions from the parties on the issue of penalty.

DATED at the City of Saskatoon, in the Province of Saskatchewan this 21 day of August, 2025.

Dr. Cameron Roberts, Chair of the Discipline Committee

SCHEDULE A

Formal Complaint

IN THE MATTER OF
THE DENTAL DISCIPLINES ACT, 1997 S.S.C. D-4.1
AND DR. CAMERON CHIANG
PRINCE ALBERT, SASKATCHEWAN

FORMAL COMPLAINT

TO: Dr. Cameron Chiang
Prince Albert, Saskatchewan

WHEREAS Dr. Chiang was at all relevant times on the Register of the College of Dental Surgeons of Saskatchewan ("College").

AND WHEREAS Dr. Chiang was required to comply with the terms of *The Dental Disciplines Act* (the "Act") and the bylaws of the College.

AND WHEREAS the Professional Conduct Committee recommends that the Discipline Committee hear the following complaint against Dr. Chiang.

CHARGE A

Dr. Cameron Chiang has committed professional misconduct pursuant to section 27 of the Act in that:

1. In relation to patient [redacted] on November 20, 2023 and January 18, 2024, Dr. Chiang charted that he completed and ultimately billed NIHB for the following treatments:

   (a) Tooth 16 - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the occlusal surface was restored.

   (b) Tooth 26 - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the OL surfaces were restored.

   (c) Tooth 46 - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the OB surfaces were restored.

(d) Tooth 36- Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the occlusal surface was restored.

(e) Tooth 44 - Dr. Chiang declared that he restored the tooth. There is no evidence of such treatment having been undertaken.

(f) Tooth 11 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of the mesial or distal surfaces being restored.

(g) Tooth 12 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of any restoration on the tooth.

(h) Tooth 22 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of any restoration on the tooth.

(i) Tooth 75 - Dr. Chiang declared that he restored the tooth with an MO restoration. Radiographic and clinical examination showed only the occlusal surface was restored.

(j) Tooth 32 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of any restoration on the tooth.

(k) Tooth 31 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of any restoration on the tooth.

(l) Tooth 85 - Dr. Chiang declared that he restored the tooth with an MO restoration. Radiographic and clinical examination showed only the occlusal surface was restored.

(m) Tooth 42 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of any restoration on the tooth.

(n) Tooth 41 - Dr. Chiang declared that he restored the tooth with an MIDVL restoration. There is no clinical evidence of any restoration on the tooth.

2. In relation to patient [redacted] on January 13, 2024 Dr. Chiang charted that he completed and ultimately billed NIHB for the following treatments:

(a) Tooth 37 – Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the OB surfaces were restored.

(b) Tooth 35 – Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the occlusal surface was restored.

(c) Tooth 34 – Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the occlusal surface was restored.

(d) Tooth 17 - Dr. Chiang declared that he restored the MODB surfaces of the tooth. Radiographic and clinical examination showed only the occlusal surface was restored.

(e) Tooth 13 - Dr. Chiang declared that he restored the MIDB surfaces of the tooth. Radiographic and clinical examination showed only the DL surfaces were restored.

(f) Tooth 11 - Dr. Chiang declared that he restored the MIDB surfaces of the tooth. The tooth is impacted and not present intraorally.

(g) Tooth 32 - Dr. Chiang declared that he restored the MIDBL surfaces of the tooth. Radiographic and clinical examination showed the Mesial and Distal surfaces were not restored.

(h) Tooth 31 - Dr. Chiang declared that he restored the MIDBL surfaces of the tooth. Radiographic and clinical examination showed no preparation or restoration on the tooth and there was decay present on the MIDBL.

(i) Tooth 47 - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the MO surfaces were restored.

(j) Tooth 42 - Dr. Chiang declared that he restored the MIDBL surfaces of the tooth. Radiographic and clinical examination showed the Distal surface was not restored and decay is present on the MIDBL.

(k) Tooth 41 - Dr. Chiang declared that he restored the MIDBL surfaces of the tooth. Radiographic and clinical examination showed the Mesial surface was not restored and decay is present on the MIBL.

3. In relation to patient [redacted] on January 10, 2024, Dr. Chiang inappropriately charted that he completed and ultimately billed Supplementary Health for the following treatments:

   (a) Tooth 16 - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed no restoration on the tooth.

   (b) Tooth 53 - Dr. Chiang declared that he restored the IVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

   (c) Tooth 12 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

   (d) Tooth 11 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

   (e) Tooth 21 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

   (f) Tooth 22 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

   (g) Tooth 63- Dr. Chiang declared that he restored the I surface of the tooth. Clinical examination showed no restoration on the tooth.

   (h) Tooth 26 - - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed only the OL surfaces were restored.

   (i) Tooth 73 – Dr. Chiang declared that he restored the I surface of the tooth. Clinical examination showed no restoration on the tooth.

   (j) Tooth 31 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

   (k) Tooth 32 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

(l) Tooth 41 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

(m) Tooth 42 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Clinical examination showed no restoration on the tooth.

(n) Tooth 83 - Dr. Chiang declared that he restored the I surface of the tooth. Clinical examination showed no restoration on the tooth.

4. In relation to patient [redacted] between November 15, 2023 and March 11, 2024, Dr. Chiang charted that he completed and ultimately billed NIHB for the following treatments:

(a) Tooth 35 - Dr. Chiang declared that he restored the tooth with an OL restoration on November 15, 2023 and an MODBL restoration on January 22, 2024. Radiographic and clinical examination show that only the Occlusal surface was restored.

(b) Tooth 32 - Dr. Chiang declared that he restored the MIDBL surfaces of the tooth. Radiographic and clinical examination showed no restoration or evidence of preparation for a restoration.

(c) Tooth 31 - Dr. Chiang declared that he restored the MIDBL surfaces of the tooth. Radiographic and clinical examination showed no restoration or evidence of preparation for a restoration.

(d) Tooth 45 - Dr. Chiang declared that he restored the tooth with an MODBL composite restoration. On radiographic and clinical examination the only restoration present was the occlusal amalgam restoration placed prior to any treatment by Dr. Chiang.

(e) Tooth 42 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Radiographic and clinical examination showed no restoration or evidence of preparation for a restoration.

(f) Tooth 41 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Radiographic and clinical examination showed no restoration or evidence of preparation for a restoration.

(g) Tooth 13 - Dr. Chiang declared that he restored the tooth with an MIDLV restoration. Radiographic and clinical examination show that only the lingual surface was restored.

(h) Tooth 14 - Dr. Chiang declared that he restored the tooth with an MODLB composite restoration. Radiographic and clinical examination show that only the restoration was limited to a DO and the distal aspect of that was the pre-existing amalgam restoration.

(i) Tooth 23 - Dr. Chiang declared that he restored the MIDVL surfaces of the tooth. Radiographic and clinical examination showed that only the lingual was restored

(j) Tooth 24 - Dr. Chiang declared that he restored the MODBL surfaces of the tooth. Radiographic and clinical examination showed that only the occlusal was restored

(k) Tooth 26 - Dr. Chiang declared that he restored the tooth with an MODLB composite restoration. Radiographic and clinical examination show that only the area of composite restoration was the occlusal access and the remaining restoration was the pre-existing amalgam restoration.

(l) Tooth 27 - Dr. Chiang declared that he restored the tooth with an MODLB restoration. Radiographic and clinical examination show that the mesial and distal surfaces were not restored.

(m) Tooth 33 - Dr. Chiang declared that he restored the tooth with an MIDLV restoration. Radiographic and clinical examination show that only the lingual surface was restored.

(n) Tooth 34 - Dr. Chiang declared that he restored the tooth with an MODLB restoration. Radiographic and clinical examination show that only the occlusal surface was restored.

(o) Tooth 45 - Dr. Chiang declared that he restored the tooth with an MODLB composite restoration. Radiographic and clinical examination show that only the restoration was the occlusal amalgam which was a pre-existing amalgam restoration.

(p) Tooth 14 - Dr. Chiang declared that he completed root canal treatment on 14 involving 2 canals. Only one canal has been obturated on the radiographic evaluation.

(q) Tooth 15 - Dr. Chiang declared that he placed two posts following endodontic treatment. There was only one canal treated in tooth 15.

(r) Tooth 25 - Dr. Chaing declared that he placed two posts following endodontic treatment. There was only one canal treated in tooth 25

5. In relation to patient [redacted] between November 17, 2023 and November 23, 2023, Dr. Chiang charted that he completed and ultimately billed NIHB for the following treatments:

(a) Tooth 41 - Dr. Chiang declared that he restored the tooth with an MIDLV composite restoration on November 17, 2023. Radiographs taken on November 23, 2024 show no evidence of the restoration.

(b) Tooth 45 - Dr. Chiang declared that he restored the tooth with an MODLB composite restoration on November 17, 2023. Radiographs taken on November 23, 2024 show the restoration did not involve the mesial surface.

6. In relation to patient [redacted]:

(a) Dr. Chaing declared that he billed code 74611 in the amount of $414.00 for curetting the eruption follicle in the 38 extraction site on the day of the extraction. The CDSS Fee guide states that this code is not to be used in conjunction with tooth removal and that it includes biopsy which was not completed.

CHARGE B

Dr. Cameron Chiang has displayed professional incompetence pursuant to section 26 of the Act in that:

7. In relation to patient [redacted]:

(a) Dr. Chiang completed root canals on teeth 34 and 35 with no radiographic or clinical evidence to provide such treatment

(b) Dr. Chiang failed to provide endodontic treatment to the standard of care on tooth 37 as the obturation of the mesial canal was well short of the apex.

(c) Dr. Chiang failed to provide endodontic treatment to the standard of care on tooth 35 as the obturation is well short of the apex

(d) Dr. Chiang placed posts on teeth 34, 35 and 37. All of these posts did not meet the standard of care and serve no purpose in aiding the restoration of the teeth.

8. In relation to patient [redacted]

(a) The root canal of tooth 36 is inadequate and failed to meet the standard of care as the distal canal was not obturated as evidenced on the post-operative radiograph.

(b) There was no radiographic or clinical indication to provide endodontic treatment on teeth 75 and 85

9. In relation to patient [redacted]

(a) Dr. Chiang placed a composite restoration on tooth 65 over a large occlusal carious lesion without carries removal, contrary to the standard of care. Dr. Chiang billed for an OBL restoration on this tooth and there is no evidence of restorations on the Buccal surface. Dr. Chiang did not treat the obvious mesial decay present on the pre-op radiograph.

(b) Dr. Chiang placed an OL composite on tooth 55 and billed for an OBL. He did not treat the obvious mesial decay that was present on the pre-op radiograph.

10. In relation to patient [redacted]

(a) [redacted] had an appointment on January 22, 2024 with the chief complaint of an ill-fitting denture. At this appointment, Dr. Chiang initiated, and in some teeth completed, endodontic treatment on ten teeth (13,14,15,23,24,25,26,33,34,35). There was no radiographic or clinical indication for any of this endodontic treatment.

(b) Tooth 15 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-

instrumented and the obturation was several millimeters short of the radiographic apex. The post placed by Dr. Chiang had no therapeutic value and was below the standard of care. Tooth 15 had to be extracted on February 20, 2024.

(c) Tooth 25 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was several millimeters short of the radiographic apex. Any post placed by Dr. Chiang had no therapeutic value and was below the standard of care. Tooth 25 had to be extracted on February 20, 2024.

(d) Tooth 13 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was several millimeters short of the radiographic apex. Any post placed by Dr. Chiang had no therapeutic value and was below the standard of care.

(e) Tooth 23 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was several millimeters short of the radiographic apex. The access to the canal space was on very mesial to the required path and resulted in a significant loss of tooth structure. Any post placed by Dr. Chiang had no therapeutic value and was below the standard of care.

(f) Tooth 14 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was several millimeters short of the radiographic apex. On radiographic assessment only one canal has been obturated and only one post is present. Any post placed by Dr. Chiang had no therapeutic value and was below the standard of care.

(g) Tooth 24 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was several millimeters short of the radiographic apex.

Any post placed by Dr. Chiang had no therapeutic value and was below the standard of care.

(h) Tooth 33 - Dr. Chiang initiated endodontic treatment on this tooth. The access to the canal was too mesial and well below the standard of care and has compromised the remaining tooth structure.

(i) Tooth 34 - Dr. Chiang initiated endodontic treatment on this tooth. The access to the canal was too mesial and well below the standard of care and has compromised the remaining tooth structure.

11. In relation to patient [redacted]:

(a) Tooth 44 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was only to the level of the post and was at least 8mm short of the radiographic apex.

(b) Tooth 43 - Dr. Chiang provided endodontic treatment on this tooth. The completed endodontic treatment was below the standard of care as the canal was under-instrumented and the obturation was well short of the radiographic apex. The post placed by Dr. Chiang had no therapeutic value and was below the standard of care.

(c) Tooth 45 - Dr. Chiang declared that he provided an MODBL restoration on tooth 45. Radiographic evaluation shows the restoration was below the standard of care. The margins were not sealed and there was insufficient cavity preparation and decay removal. The contour of the restoration did not meet the standard of care.

(d) Tooth 44 - Dr. Chiang declared that he provided an MODBL restoration on tooth 44. Radiographic evaluation shows the restoration was below the standard of care. The margins were not sealed and all the decay had not been removed.

12. In relation to patient [redacted]

(a) Dr. Chiang declared that he provided direct restorations on 26 teeth as well as provided one extraction on October 16, 2023. Providing 26 direct restorations in one appointment falls below the standard of care.

(b) Tooth 16 - Dr. Chiang declared that he provided an MODBL restoration on tooth 16. There is no evidence of decay on the mesial surface on the pre-op radiograph.

(c) Tooth 15 - Dr. Chiang declared that he provided an MOD restoration on tooth 15. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(d) Tooth 14 - Dr. Chiang declared that he provided an MOD restoration on tooth 14. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(e) Tooth 13 - Dr. Chiang declared that he provided an MOD restoration on tooth 13. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the distal surface.

(f) Tooth 34 - Dr. Chiang declared that he provided a DOBL restoration on tooth 34. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the distal surface.

(g) Tooth 44 - Dr. Chiang declared that he provided an MOBL restoration on tooth 44. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial surface.

(h) Tooth 45 - Dr. Chiang declared that he provided an MOBL restoration on tooth 45. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial surface.

(i) Tooth 36 - Dr. Chiang declared that he restored the 36 with an MODBL restoration. It is readily apparent from radiographic evaluation that there was insufficient tooth structure for a direct restoration and other treatment options needed to be presented.

13. In relation to patient [redacted]:

(a) Dr. Chiang declared that he provided direct restorations on 27 teeth as well as provided two surgical extractions on October 16, 2023. Doing 27 direct restorations and two surgical extractions in one appointment falls below the standard of care.

(a) Tooth 12 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 12. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(b) Tooth 11 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 11. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(c) Tooth 21 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 21. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(d) Tooth 22 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 22. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(e) Tooth 32 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 32. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(f) Tooth 31 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 31. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(g) Tooth 41 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 41. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(h) Tooth 42 - Dr. Chiang declared that he provided an MIDVL restoration on tooth 42. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

14. In relation to patient [redacted]:

(a) On October 16, 2023 Dr. Chiang declared that he provided nineteen teeth with direct restorations after the patient presented for an examination that day. Completing 19 direct restorations in one appointment falls below the standard of care.

(b) Dr. Chiang failed to meet the standard of care by not taking any diagnostic records prior to changing the vertical dimension of occlusion. He failed to provide documented informed consent for this treatment.

(c) Dr. Chiang restored tooth 17 with a lingual restoration but failed to treat the mesial decay that was evident on the radiograph and noted by himself in the chart.

(d) Tooth 24 - Dr. Chiang declared that he provided an ODBL restoration on tooth 24. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the distal surface.

(e) Tooth 34 - Dr. Chiang declared that he provided an ODBL restoration on tooth 34. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the distal surface.

(f) Tooth 44 - Dr. Chiang declared that he provided an ODBL restoration on tooth 44. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the distal surface.

(g) Tooth 45 - Dr. Chiang declared that he provided an ODBL restoration on tooth 45. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the distal surface.

(h) Tooth 46 - Dr. Chiang declared that he provided an MODBL restoration on tooth 46. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(i) Tooth 14 - Dr. Chiang declared that he provided an MODBL restoration on tooth 14. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(j) Tooth 25 - Dr. Chiang declared that he provided an MODBL restoration on tooth 25. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

(k) Tooth 27 - Dr. Chiang declared that he provided an MODBL restoration on tooth 27. There is no evidence of decay on the tooth on the pre-op radiograph, most evidently on the mesial and distal surfaces.

15. In relation to patient [redacted]

(a) On July 26, 2023 Dr. Chiang declared he provided restorations on the following teeth for [redacted] (17 OBL, 16 OBL, 15O, 14O, 27 OBL, 26O, 25O, 24O, 23 IVL, 22 IVL, 37 DOBL, 36 OBL, 35 OL, 34 OL, 32 MIDVL, 31 MIDVL, 47 ODBL, 46 OBL, 45 OL, 44OL, 42 MIDVL). Only a panoramic radiograph was obtained that day and there is no decay evident on this panoramic radiograph. Dr. Chiang's standard notes declare that bitewing radiographs were obtained but they were not billed for and they are not part of the comprehensive patient record. Dr. Chiang's clinical notes indicate recurrent decay and fractured enamel which is not corroborated by the findings on the panoramic radiograph. There is no indication to provide this extensive of restorative treatment.

16. In relation to patient [redacted]

(a) Dr. Chiang declared that on July 19, 2023 he removed a 2mm x3mm red and white lesion that he referred to as a benign tumour. There is no record of where the lesion was in the mouth, aside from a note about local anesthetic in Quad 4 and the tongue being retracted. There is no record of the tissue being sent for microscopic examination and during the course of the investigation the oral health professionals at Prince Albert Dental informed us that no tissue is ever sent for biopsy.

(b) Based on the limited notes on July 24, 2023 it appears that Dr. Chiang removed another lesion, this time from the right side of the tongue. The diagnosis was given as dysplasia and once again there were no notes on sending for microscopic examination.

17. Dr. Chiang's patient charts demonstrated a consistent lack of administration of local anesthetic. Dr. Chiang either failed to properly record the amount of local anesthetic used, failed to provide a sufficient amount of local anesthetic for the treatment he purported to deliver, or failed to complete the treatment as indicated in the chart.

18. Dr. Chiang's patient charts demonstrated a consistent lack of diagnostic testing for the extent of treatment performed.

19. Dr. Chiang's patient charts demonstrated a consistent lack of documented informed consent that was commensurate with the extent of treatment he purported to deliver.

CONTRARY TO:

(a) Sections 26 and 27 of *The Dental Disciplines Act, 1997*;

(b) Section 9.2(1)(c) of the Bylaws of the College (duty to uphold the honour and dignity of the profession and abide by the code of ethics);

(c) Section 9.2(1)(f) of the Bylaws of the College (maintain the records that are required to be kept in respect of a member's patients or practice);

(d) Section 9.2(2)(b) of the Bylaws of the College (charge for services not performed);

(e) Section 9.2(2)(f) of the Bylaws of the College (falsify a record regarding the treatment of a patient);

(f) Section 9.2(2)(g) of the Bylaws of the College (knowingly submit a false or misleading account or false or misleading charges for services rendered to a patient);

(g) Section 9.2(2)(w) of the Bylaws of the College (commit any act relevant to the practice of dentistry that would be regarded by members as disgraceful, dishonourable or unprofessional);

(h) Section 9.2(2)(x) of the Bylaws of the College (practise in such a way that the member may be unable to give full force and effect to his training);

(i) The principles of honesty and competence in the Canadian Dental Association Principles of Ethics.

TAKE NOTICE you are entitled to be represented by counsel at your own expense.

AND FURTHER TAKE NOTICE the Discipline Committee shall set a time and place for the hearing and determination of the formal complaint in consultation with yourself or your counsel and counsel for the Professional Conduct Committee;

AND FURTHER TAKE NOTICE if you should fail to attend the hearing at the date, time, and place set by the Discipline Committee, the Discipline Committee, on proof of service of the notice of the date, time, and place of the hearing on you, may proceed with the hearing in your absence.

DATED at the City of Regina, in the Province of Saskatchewan, this 15 day of August 2024.

Drew Krainyk
Chair of the Professional Conduct Committee