IN THE MATTER OF THE *HEALTH PROFESSIONS ACT*, R.S.A 2000, c. H 7

AND IN THE MATTER OF A HEARING CONCERNING ALLEGATIONS OF UNPROFESSIONAL CONDUCT ABOUT JINGPEI (LISA) DUAN, RDA, REGULATED MEMBER OF THE COLLEGE OF ALBERTA DENTAL ASSISTANTS

DECISION OF THE HEARING TRIBUNAL ON MERITS

INTRODUCTION

The Hearing Tribunal held a hearing in Calgary, Alberta into the conduct of Ms. Jingpei (Lisa) Duan over the following dates: November 18-19, 2019, October 5, 2020, April 19, 2021 and September 27, 2021.

The Hearing Tribunal was made up of Ms. Patricia Demchuk, RDA and chairperson, Ms. Lorraine Aldridge, RDA, Ms. Arlene Pettifer, RDA and Mr. David Rolfe, public member.

Attending the hearing throughout were Ms. Susan vander Heide, Complaints Director and her legal counsel Mr. Blair Maxston. Ms. Duan attended the hearing with her representative Mr. Shaoli Wang on November 18 and19, 2019. Mr. Wang attended the hearing without Ms. Duan on October 5, 2021 and on April 19, 2021. Neither Ms. Duan nor Mr. Wang attended the hearing on September 27, 2021. Mr. Gregory Sim attended the hearing as independent legal counsel for the Hearing Tribunal.

There were no objections to the composition of the Hearing Tribunal or the jurisdiction of the Hearing Tribunal to proceed with a hearing.

ALLEGATIONS

The Notice of Hearing listed the following allegations of unprofessional conduct:

1. On or about November 6, 2017, Jingpei (Lisa)Duan carried out a restricted activity she was not authorized to perform, specifically using the high speed handpiece in a patient's mouth, which contravenes section 1(1)(pp)(ii) of the Health Professions Act, section 4 of Schedule 7.1 to the Government Organization Act, section 12 of the Dental Assistants Profession Regulation and College of Alberta Dental Assistants Standards of Practice section 2.9 and the College of Alberta Dental Assistants Code of Ethics articles 1.4, 2.1 and 3.1.

2. On or about November 6, 2017, Jing Pei (Lisa) Duan performed dental assisting services that were not authorized to her by the College of Alberta Dental Assistants, specifically fabricating, fitting, trimming and/or cementing temporary crowns which contravenes section 1(1)(pp)(ii) of the Health Professions Act, and College of Alberta Dental Assistants Standards of Practice section 2.9 and the College of Alberta Dental Assistants Code of Ethics articles 1.4, 2.1 and 3.1 and the Granting of Intra Oral Skills Policy.

PRELIMINARY MATTERS

As Mr. Wang is not a lawyer, Ms. Duan was asked if she understood that she had the right to legal representation. Ms. Duan confirmed that she was aware and that she chose to proceed with Mr. Wang as her representative.

A Mandarin interpreter was present for the commencement of the hearing, but Ms. Duan and Mr. Wang confirmed the interpreter would not be necessary.

Mr. Wang then requested to make his own recording of the hearing. Mr. Maxston opposed this request noting that the Court Reporter would make an independent, accurate and complete transcript of the hearing. The Hearing Tribunal directed that the Court Reporter's transcript would be the official record of the hearing and no other recording devices would be permitted.

OPENING STATEMENTS

Complaints Director

Mr. Maxston made an opening statement on behalf of the Complaints Director. He began by explaining that the hearing would be contested and the Hearing Tribunal would have to decide whether Ms. Duan committed unprofessional conduct as alleged in the Notice of Hearing.

Mr. Maxston then described the process for the hearing. Mr. Maxston then explained that the legal onus of proof is on the Complaints Director to prove the allegations and that Ms. Duan's conduct amounted to unprofessional conduct. He asserted that the applicable standard of proof is the civil balance of probabilities standard which is less stringent that the standard in criminal matters in court.

Mr. Maxston then explained that the Hearing Tribunal would have to address issues of unauthorized practice under the *Health Professions Act*, the *Dental Assistants Profession Regulation*, the *Government Organization Act*, the College's Standards of Practice and Code of Ethics. He said the Hearing Tribunal would hear black and white evidence and decide whether the alleged facts happened or not. This would require assessments of credibility.

Mr. Maxston then cautioned that the hearing was not about any other issues that Ms. Duan may have had with her employer, Practice . Mr. Maxston said that Ms. Duan may refer to other forums in which she is pursuing claims against Practice . Mr. Maxston reminded the Tribunal that its jurisdiction is limited to determining the allegations in the Notice of Hearing and imposing sanctions if either or both allegations are found proven.

Mr. Maxston described the witnesses he would call on behalf of the Complaints Director. He said he would first call Ms. Susan vander Heide, the Complaints Director to describe the complaint, the investigation and the scope of practice for Registered Dental Assistants ("RDAs"). Next, the Hearing Tribunal would hear from A.B. , RDA about the events of November 6, 2017. Mr. Maxston said he would then call S.G. , a dentist at Practice and finally S.H. , the office and human resources manager for Practice .

Ms. Duan

Mr. Wang did not make an opening statement. Mr. Wang instead advised the Hearing Tribunal that he had requested the College's Hearings Director to provide him with contact information for his proposed witnesses. He said he was told he was responsible for obtaining witnesses' contact information himself.

Mr. Maxston then confirmed that it was not up to the Hearings Director to locate and provide contact information for possible witnesses.

EVIDENCE

Ms. Susan vander Heide, Complaints Director

Mr. Maxston first called Ms. Susan vander Heide to testify. Ms. vander Heide testified that she had been employed by the College since 2005. She originally served as the College's Director of Professional Competence. In 2009 she became the Assistant Executive Director and Complaints Director. In 2013 Ms. vander Heide became the Executive Director and remained the Complaints Director.

Ms. vander Heide described her training and experience with investigations. She has completed basic and advanced investigator training with the Council on Licensure, Enforcement and Regulation and with the Workplace Institute of Canada. She said she had conducted about 10 investigations as of the date of her testimony since the College does not receive many complaints.

Ms. vander Heide then described the RDA scope of practice. The profession has a supportive role. RDAs carry out certain tasks on their own while other tasks are done to assist a dentist. Those tasks include applying dental dams, taking impressions of a patient's teeth, polishing teeth, applying topical fluoride, removing sutures, applying desensitizing agents and liners.

Ms. vander Heide also discussed restricted activities that RDAs can be authorized to perform. These include taking radiographs, orthodontic procedures, preliminary fittings of partial or complete dentures, probing. There are also "additional skills" that RDAs can be authorized by the College to perform after obtaining additional training. These additional skills include limited scaling of teeth, and provisional coverage and restorations, or "PCR". Ms. vander Heide explained that with the requisite training and authorization, RDAs can place temporary restorations, make and cement temporary crowns and bridges and they can also pack gingival retraction cord. When an RDA completes the required training to complete additional skills this is recorded in the College's Registry. RDAs are also given a wallet-sized registration card which confirms their registration and lists any skills they are not authorized to perform.

Ms. vander Heide next discussed the two types of handpieces used in dental practice. A low speed handpiece operates at about 40,000 rpm. It generally will not cut tooth enamel. It makes a distinct sound that Ms. vander Heide described as like a truck driving around. RDAs are permitted to use a low speed handpiece to polish teeth, to adjust sealants that are applied to teeth, and to adjust the fit of temporary crowns and bridges. She said that using a low speed handpiece in this manner is not a restricted activity.

A high speed handpiece operates at about 400,000 rpm. It has a higher potential to cause harm as it is capable of cutting tooth enamel. Enamel cannot be replaced once it has been cut. The high speed handpiece also has the potential to cause very serious damage to other tissue if used incorrectly. The high speed handpiece also creates a lot of heat that can damage the patient's nerves, so it sprays a combination of air and water to dissipate the heat. It also sounds distinct from the low-speed handpiece. Ms. vander Heide described it as a high pitched whine.

Ms. vander Heide explained that RDAs are not permitted to use a high-speed handpiece in a patient's mouth under any circumstances. It is not an "additional skill" that RDAs can be authorized to perform.

Ms. vander Heide explained that Ms. Duan was first registered with the College on June 1, 2010 based on her international education. As of November 6, 2017, she was not authorized to perform the additional skill of PCR. Ms. vander Heide referred the Hearing Tribunal to Ms. Duan's registration cards for 2017 and 2018. The 2017 registration card stated that Ms. Duan's registration with the College would expire on November 30, 2017 and she was not authorized to perform dental probing, provisional coverage and restorations, or limited scaling. The 2018 registration card listed the same prohibited skills.

Ms. Duan did later obtain additional training in PCR, on January 28, 2018. Ms. vander Heide confirmed that Ms. Duan did not have this additional training and she was not authorized to perform PCR on November 6, 2017.

Ms. vander Heide next described receiving a complaint about Ms. Duan from S.H., the Human Resources manager at Practice. The complaint was received by email on November 20, 2017. In the complaint S.H. alleged that Ms. Duan did not understand her scope of practice and was therefore unsafe to work. The complaint form attached to S.H.'s email explained that on November 6, 2017 A.B., RDA observed Ms. Duan using a highspeed handpiece in a patient's mouth to adjust a temporary crown. The complaint went on to explain that A.B. reported her observations to S.H. who then went and herself observed Ms. Duan using the highspeed handpiece in the patient's mouth. The complaint also alleged that when questioned, Ms. Duan claimed to have no knowledge of her scope of practice. The complaint said that Ms. Duan was dismissed from her employment with Practice.

Ms. vander Heide then identified a letter she received dated December 4, 2017 responding to S.H.'s complaint. The letter of response was addressed to Ms. vander Heide and it stated that it was from Ms. Duan. The Hearing Tribunal accepted the letter into evidence over an objection from Mr. Wang. Mr. Wang said he was objecting because the Complaints Director was not attempting to prove the statements in Ms. Duan's letter and he could not guarantee the accuracy of the statements. He also seemed to be saying that he had written the letter on Ms. Duan's behalf. The letter was clearly relevant as it was a response on Ms. Duan's behalf to the allegations in the complaint. It was not necessary for the Complaints Director to prove the statements in the letter of response to be true. The Hearing Tribunal did not accept Mr. Wang's reasons for his objection.

The letter of response denied that Ms. Duan had used a highspeed handpiece in a patient's mouth. It stated that she had used a highspeed handpiece outside of a patient's mouth to trim temporary crowns on occasion. The letter also denied that Ms. Duan had misrepresented her qualifications to her employer. It stated that she had showed her registration card with the list of skills she could not perform to her employer during her interview. It also stated that she gave her employer a copy of her RDA license. The letter also asserted that several times during her employment she had been asked to do PCR and each time she refused as she was not permitted to perform that skill. The letter then claimed that she was "threatened and pressured by each of the dentists at Practice to perform PCR notwithstanding" her objections.

The letter of response said that on November 6, 2017 Ms. Duan was assisting S.G. who asked her to "trim PCR" for a patient. The letter said that Ms. Duan told S.G. she could not perform PCR but S.G. said she could give her permission. The letter then said:

> Under the pressure from S.G., I trimmed the temporary crown before put it on the patient's tooth, when I was polishing the temporary crown using slow speed handpiece in the patient's mouth, Human Resources manager, RDA S.H. just walked pass (sic) the room, she turned back in and told me I can't do that, I then stopped and asked S.G. to see the patient, S.G. checked the temporary crown and was satisfied and let the patient go.

The letter then described subsequent incidents in which dentists at Practice asked Ms. Duan to perform PCR over her objections. The letter concluded with Ms. Duan's account of her termination from Practice on November 16, 2017. It stated that the reason she was given for her termination was that she had been seen using the highspeed handpiece in a patient's mouth. The letter claimed that this was the first time Ms. Duan had been informed of this.

Enclosed with the letter of response was a copy of the November 16, 2017 termination letter that Ms. Duan received from Practice . The termination letter stated that Ms. Duan was observed by two different employees using a highspeed handpiece in a patient's mouth, which was not within her scope of practice. The termination letter also stated that the scope of Ms. Duan's practice is her responsibility to know, including the duties she is restricted from performing.

Also enclosed with the letter of response were portions of a Practice employee manual. It included a section entitled "Clinical Expectations" which stated "All RDA's must work within their legislated scope of practice and follow the Code of Ethics as laid out by the Alberta Dental Assistant's Association."

Ms. vander Heide then identified employee records that she obtained from S.H. Ms. vander Heide testified that these records confirmed that Ms. Duan was working at Practice on the morning of November 6, 2017 when patient H.H. came in to have a temporary crown cemented. A covering email from S.H. to Ms. vander Heide stated that H.H. was the patient who S.H. had observed Ms. Duan treating with the highspeed handpiece.

Ms. vander Heide also identified a copy of the patient chart she obtained from S.H. for patient H.H. The chart listed "Completed Procedures" for H.H., including for November 6, 2017. The list of completed procedures for November 6, 2017 was: Porcelain Crown, "+L" Commercial Laboratory Procedures, Composite Core Bonded, Specific/Emergency Exam, and X-Ray Single Film. The list of procedures for November 6, 2017 did not include polishing, which Ms. Duan's letter of response had said she was performing. Polishing was mentioned on other dates in the list of Completed Procedures.

On cross-examination, Ms. vander Heide confirmed that she had interviewed S.H. and A.B. . They both confirmed that they had observed Ms. Duan using the highspeed handpiece in the patient's mouth. In particular, A.B. had said she took a second look to be sure and that she heard the sound of the highspeed handpiece. Ms. vander Heide confirmed that she had spoken with S.G. and S.G. said she had purported to give Ms. Duan permission to work on H.H. Ms. vander Heide also confirmed that S.G. was unaware of Ms. Duan's scope of practice and it was up to Ms. Duan to let her co workers know her scope of practice.

Ms. vander Heide was also asked during cross-examination about incident reports dated November 6 and 16, 2017. She said she became aware of these in 2018 as part of an email exchange and request for documents.

The November 6, 2017 incident report was signed by A.B. and by S.H. . It stated that on November 6, 2017 Ms. Duan was "caught" using a highspeed handpiece in a patient's mouth and this was witnessed by both A.B. and S.H. . The incident report also listed duties that an RDA can perform in Alberta. The list does not include the use of a highspeed handpiece.

The November 16, 2017 incident report was also signed by A.B. and S.H. This incident report was similar to the November 6, 2017 incident report, but it added that when the patient returned to have their crown cemented, S.G. and A.B. both witnessed that the "cord", meaning gingival retraction cord had been left behind in the patient's mouth around the prepped tooth. It said that Ms. Duan was the assistant who left the cord behind after making the temporary crown. It also said that due to lack of care and working outside of her scope of practice, Ms. Duan had been dismissed from her employment.

A.B.

A.B. has been a Registered Dental Assistant since 2014. She began working at Practice in 2015 or 2016 and worked there full-time until approximately November 2018. She still works there but on a casual basis.

A.B. confirmed she is familiar with PCR, explaining that it refers to the placement of temporary crowns or bridges while waiting for permanent crowns or bridges to be made by a dental lab. She explained that RDAs can perform PCR if they have obtained additional skills training and additional authorization from the College.

A.B. described the lowspeed handpiece. It is used for polishing and the removal of excess resin from teeth, such as when debanding a patient's braces. A.B. said that RDAs can use a highspeed handpiece, but only outside a patient's mouth. The highspeed handpiece is more dangerous because the speed and the burs that are used with it can penetrate tooth enamel. A.B. also confirmed that the highspeed handpiece sprays water to reduce heat and the risk of damage. The two handpieces sound different. A.B. said that they warn patients about the sound of the highspeed handpiece.

A.B. recalled November 6, 2017. She was working that day. She said she walked into the office and as she walked past one of the operatories she saw Ms. Duan using the highspeed handpiece inside a patient's mouth. A.B. was asked how she knew it was the highspeed handpiece. She said they look different as the highspeed handpiece is longer. They also sound different, and she heard the high-pitched sound of the highspeed handpiece. She said only one handpiece can be used at a time and she could see the lowspeed handpiece sitting unused on the tray. A.B. had an unobstructed view and she confirmed there was no doubt in her mind that Ms. Duan was using the highspeed handpiece inside the patient's mouth. She said she was 100% certain.

A.B. said she then went to S.H. and reported what she had seen. She said she told S.H. that RDAs are not allowed to use the highspeed handpiece. S.H. returned with A.B. to the operatory to see for herself what Ms. Duan was doing.

On cross-examination A.B. explained that she had graduated the previous year. She knew that no RDA anywhere in Canada was permitted to use a highspeed handpiece in a patient's mouth. A.B. characterized what she observed on November 6, 2017 as a serious incident. The patient was facing away from her but tilted back. A.B. was only a few feet away and she could see what Ms. Duan was doing.

A.B. recalled another incident when she was working with S.G. and a patient came back with gingival cord in their mouth. She said they checked the computer notes and Ms. Duan was the last person to have worked on the patient. A.B. was asked if she knew whether Ms. Duan had performed PCR prior to November 6, 2017. She said she had seen Ms. Duan perform PCR. A.B. said that if Ms. Duan wasn't authorized to do PCR then a different RDA should have been scheduled to assist with that procedure. A.B. said that dentists give instructions, but it is the RDA's responsibility to tell the dentist what skills they are and are not authorized to perform.

A.B. confirmed that she signed the incident reports dated November 6 and 16, 2017. They were typed by S.H. , but A.B. confirmed they were accurate.

In response to a question from the Hearing Tribunal, A.B. clarified that she did not see what Ms. Duan was doing with the highspeed handpiece in the patient's mouth on November 6, 2017.

She said she saw Ms. Duan using the highspeed handpiece in the patient's mouth and she found out later what it was being used for.

November 19, 2019

When the hearing opened on November 19, 2019, Mr. Maxston made an application on behalf of the Complaints Director to adjourn the balance of the hearing, including the proposed testimony of S.H. and S.G. . The Hearing Tribunal decided to adjourn the hearing. We issued a written decision with reasons for granting the adjournment on January 27, 2020.

October 5, 2020

The hearing was subsequently scheduled to continue on October 5-7 and November 25-26, 2020. The Hearing Tribunal issued a further written decision directing the hearing to proceed on these dates on September 15, 2020.

On October 5, 2020 Mr. Wang appeared on Ms. Duan's behalf but Ms. Duan was not present herself. Mr. Maxston submitted that section 79(6) of the *Health Professions Act* allowed the Hearing Tribunal to proceed in Ms. Duan's absence and to determine the allegations if the Tribunal was satisfied that Ms. Duan received notice of the proceedings.

Mr. Maxston produced a copy of a March 19, 2020 letter from the Hearings Director, Ms. Collison to Ms. Duan and the enclosed Notice of Hearing for October 5 7, 2020. Mr. Maxston also submitted that the Tribunal could proceed given the Tribunal's September 15, 2020 decision that was circulated to the parties and given that Ms. Duan's representative Mr. Wang was present. Mr. Maxston said that the hearing should proceed.

Mr. Wang acknowledged the provisions of the *Health Professions Act*, but he suggested it would be unreasonable and contrary to the rule of law to proceed with the hearing before November 1, 2020.

The Hearing Tribunal decided to proceed with the hearing. Section 79(6) of the *Health Professions Act* provides that if the investigated person does not appear and there is proof they have been given a notice to attend, the Hearing Tribunal may proceed with the hearing in their absence, and act or decide on the matter in their absence. The Hearing Tribunal was satisfied that Ms. Duan had been given adequate notice of the continuation of the hearing on October 5, 2020. The Hearings Director sent a new Notice of Hearing to her for the October 5 7, 2020 dates. Ms. Duan's representative Mr. Wang was also sent a copy of the Hearing Tribunal's September 15, 2020 decision and he attended the hearing on October 5, 2020 on Ms. Duan's behalf. There was no question Ms. Duan had adequate notice of the hearing dates.

The Hearing Tribunal next addressed Mr. Wang's objection to Ms. vander Heide's presence. Mr. Wang suggested that Ms. vander Heide or Mr. Maxston had contravened the *Criminal Code of Canada* by obstructing, perverting or defeating the course of justice. He suggested that Mr. Maxston had interrupted his cross examination of A.B. excessively and this had frightened A.B. into testifying to "whatever Susan vander Heide put in her report word by word". Mr. Wang suggested this was against the law.

Mr. Maxston disagreed that he or Ms. vander Heide had obstructed justice. He also submitted that as the Complaints Director Ms. vander Heide was a party to the proceedings and entitled to be

present, even if the hearing were to be held in private. He said it was necessary for Ms. vander Heide to be present to instruct him.

The Hearing Tribunal did not find Mr. Maxston to have improperly interrupted Mr. Wang's cross-examination of A.B. or to have obstructed Ms. Duan's defence. The Tribunal determined that Ms. vander Heide would be permitted to remain in the hearing room. Ms. vander Heide is the Complaints Director and a party to the proceedings.

The Hearing Tribunal then considered an application from Mr. Maxston for S.G. to be permitted to testify remotely, by videoconference. The Hearing Tribunal determined that it would require S.G. to testify and be subject to cross-examination in-person, for reasons explained in the Tribunal's written direction issued to the parties on October 7, 2020.

Mr. Maxston then advised that S.G. was unavailable to testify in person on October 5, 2020. He later advised that the Complaints Director would dispense with calling S.G. .

S.H.

Mr. Maxston next called S.H. . S.H. had been an RDA from 1988 until approximately 2017. She was uncertain exactly when she ceased to be registered with the College but she felt it was close to three years prior to her testimony.

S.H. had also worked at Practice in human resources from September 2017 until March 2020. It was in this capacity that she submitted a complaint to the College about Ms. Duan.

S.H. described PCR to be fabricating temporary crowns and placing cord around the prepared tooth. She confirmed that some RDAs do not have the training or authorization to perform PCR. S.H. described the lowspeed handpiece as a tool with a lower rpm that RDAs can use to adjust or prepare teeth at slow speeds. She said it does not omit water.

In contrast the highspeed handpiece is what is commonly known as "the drill". It has a higher rpm, a different sound and it emits water if the water flow is turned on. The highspeed handpiece is used to cut and prepare teeth. S.H. confirmed that RDAs cannot use the highspeed handpiece in a patient's mouth at all.

S.H. said that Ms. Duan had been hired before she joined Practice . S.H. was unaware of Ms. Duan's specific authorizations when she joined Practice . S.H. was not aware on November 6, 2017 that Ms. Duan was prohibited from performing PCR.

On November 6, 2017 S.H. was in her office at Practice when A.B. came to speak with her. A.B. told S.H. that she had witnessed Ms. Duan using a highspeed handpiece in a patient's mouth. S.H. then decided that she wanted to see for herself to make sure it was true. S.H. then went directly to the operatory where Ms. Duan was working. When she got there, she observed Ms. Duan using a highspeed handpiece to adjust a temporary crown that was already cemented in a patient's mouth.

S.H. confirmed she was certain that she observed Ms. Duan using the highspeed handpiece in the patient's mouth. S.H. said she was certain it was the highspeed handpiece because she noticed the rpms, there was water coming from it and she noticed the lowspeed handpiece sitting in in the holster. S.H. said she quietly asked Ms. Duan to put the highspeed handpiece down and told her "you cannot use that."

S.H. said that following this incident she discussed it with S.G. Then S.G. , Ms. Duan and S.H. met in S.H. 's office to discuss the incident. S.G. asked Ms. Duan what she had been doing and Ms. Duan said she was doing a little adjustment.

S.H. was also asked about the November 6 and 16, 2017 incident reports. S.H. confirmed that she had submitted the incident reports. The November 16, 2017 incident report was prepared because the patient had returned with retraction cord left behind in his mouth. S.H. was advised of this by A.B. and S.G. . She added this additional information to the November 6, 2017 report and created a new report. S.H. said that retraction cord is used to move the gum tissue out of the way while an impression is made of a tooth. The cord is normally removed after making the impression. If it is left in place it can cause the gums to swell and it can cause an infection.

S.H. said she made her complaint to the College because Ms. Duan was not aware of her scope of practice. Ms. Duan didn't seem to understand that her actions were improper. It was dangerous for patients that she didn't know what she could and could not do.

S.H. was cross-examined, but her evidence of Ms. Duan's conduct went unchallenged.

On October 7, 2020 the Hearing Tribunal issued a further written direction to the parties to exchange available dates for the continuation of the hearing and to ensure any proposed witnesses would be available to testify when the hearing continued.

April 19, 2021

The hearing was next scheduled to resume on April 19-21, 2021 pursuant to an exemption for quasi-judicial hearings from public health orders then in effect due to the COVID-19 pandemic. In a written decision dated March 25, 2021, the Hearing Tribunal dismissed an application by Mr. Wang to adjourn the April dates. The Tribunal also directed Ms. Duan to commence calling her case on the April dates.

At the commencement of the hearing on April 19, 2021 Mr. Wang was present but Ms. Duan did not appear. Mr. Wang objected to the continuation of the hearing asserting that the exemption issued by the Chief Medical Officer of Health for quasi judicial hearings to proceed despite public health orders had been rescinded. The Hearings Director verified this with Alberta Health and the hearing was then adjourned again pending reinstatement of the exemption.

On May 28, 2021 the Hearing Tribunal issued a further direction to the parties to provide dates for scheduling the continuation of the hearing pursuant to a new exemption granted by the Chief Medical Officer of Health for quasi-judicial hearings. The Tribunal directed that if either party did not confirm their availability as directed then the hearing may be scheduled to resume without their input.

On July 2, 2021 the Hearing Tribunal issued a further direction to the parties after learning that Mr. Wang had withdrawn from his representation of Ms. Duan. The direction required Ms. Duan to correspond with the College as to whether she would be retaining a new representative and their availability to continue the hearing. The Tribunal also directed that if Ms. Duan did not correspond with the College the hearing may be scheduled to resume without her input.

September 27, 2021

The hearing was next scheduled to resume on September 27, 2021. Neither Ms. Duan, nor Mr. Wang attended on this date. Mr. Maxston began by confirming that Mr. Wang had withdrawn as Ms. Duan's representative on June 4, 2021 and the College had not heard from Ms. Duan or Mr. Wang since then. The Hearing Tribunal then adjourned for 15 minutes to see if Ms. Duan or a representative on her behalf would show up. When the Tribunal reconvened, no one was in attendance for Ms. Duan.

Mr. Maxston made an application to proceed with the hearing in Ms. Duan's absence pursuant to sections 79(6) and 120(3) of the *Health Professions Act*. Section 79(6) permits the Hearing Tribunal to proceed with the hearing in the absence of Ms. Duan if there is proof that Ms. Duan was given a notice to attend the hearing. Section 120(3) permits the notice of hearing to be given to Ms. Duan by registered mail at her address shown on the register or record of the Registrar.

Mr. Maxston then called the College's Hearings Director, Ms. Collison to give evidence about the notices given to Ms. Duan. Ms. Collison testified that on June 4, 2021 she received an email from Mr. Wang advising that he was withdrawing from his representation of Ms. Duan. Ms. Collison confirmed that since June 4, 2021 she has had no communications from Mr. Wang or Ms. Duan, or from anyone on Ms. Duan's behalf. On August 17, 2021 Ms. Collison sent a Notice of Hearing for the September 27, 2021 hearing date to Ms. Duan. The notice was sent by email to the email address Ms. Duan had provided to Ms. Collison and that Ms. Duan had used throughout the proceedings. The notice was also sent by registered mail to Ms. Duan's address registered with the College.

Mr. Maxston submitted that the efforts to notify Ms. Duan of the hearing date satisfied the requirements of section 79(6) and 120(3) of the *Health Professions Act*. He submitted that Ms. Duan and Mr. Wang had effectively abandoned the proceedings and the Hearing Tribunal should proceed in Ms. Duan's absence.

The Hearing Tribunal decided to proceed with the hearing in the absence of Ms. Duan. There was no question that Ms. Duan was given proper notice of the continuation of the hearing as required by sections 79(6) and 120(3) of the *Health Professions Act*. The Hearing Tribunal's directions and the Notice of Hearing were also emailed to Ms. Duan at the email address she used throughout the proceedings. The Tribunal believed Ms. Duan was aware of the continuation of the hearing on September 27, 2021.

Mr. Maxston then closed his case and made submissions on the merits of the allegations. He submitted that charge 1 alleged that Ms. Duan carried out a restricted activity she was not authorized to perform, specifically using a highspeed handpiece in a patient's mouth.

Mr. Maxston submitted that the second charge alleged that Ms. Duan performed dental-assisting services that she was not authorized to perform, specifically fabricating, fitting, trimming, or cementing temporary crowns.

Mr. Maxston explained that since Ms. Duan had effectively abandoned the hearing, the only evidence before the Hearing Tribunal in relation to the allegations was that of Ms. vander Heide, A.B. and S.H. Ms. Duan had effectively chosen not to enter any evidence or documents to support her defence. Mr. Maxston then reviewed the evidence of Ms. vander Heide, A.B. and S.H. . He also referred to the definition of "unprofessional conduct" in the *Health Professions Act* and the College's Code of Ethics and Standards of Practice. Mr. Maxston submitted that Ms. Duan's conduct was factually proven and that it amounted to unprofessional

conduct within the meaning of the *Health Professions Act*. He urged the Hearing Tribunal to find both allegations proven.

In response to a question from the Hearing Tribunal, Ms. vander Heide explained that using the highspeed handpiece in a patient's mouth is a restricted activity as defined by Schedule 7.1 to the *Government Organization Act*, RSA 2000, c. G 10, section 2(1)(a). That provision states that it is a restricted activity to cut a body tissue or to perform surgical or other invasive procedures on body tissue in or below the surface of the teeth. Ms. vander Heide said that the highspeed handpiece can cut teeth and that is why its use in a patient's mouth should be interpreted as a restricted activity that RDAs are not authorized and therefore not permitted to perform.

Ms. vander Heide also explained that performing PCR without authorization from the College breaches the College's standards of practice. The Standards of Practice prohibit RDAs from performing activities in dental assisting practice that they have not been specifically authorized to perform.

DECISION

Allegation 1 alleged that on or about November 6, 2017, Ms. Duan carried out a restricted activity she was not authorized to perform, specifically using the high speed handpiece in a patient's mouth, which contravenes section 1(1)(pp)(ii) of the *Health Professions Act*, section 4 of Schedule 7.1 to the *Government Organization Act*, section 12 of the *Dental Assistants Profession Regulation* and the College of Alberta Dental Assistants Standards of Practice section 2.9 and the College of Alberta Dental Assistants Code of Ethics articles 1.4, 2.1 and 3.1.

The evidence clearly demonstrated that on November 6, 2017, Ms. Duan was observed using a highspeed handpiece inside a patient's mouth. A.B. testified that she observed Ms. Duan using the highspeed handpiece from only a few feet away as she walked past an operatory. A.B. was a qualified RDA. She explained how she could clearly differentiate the highspeed and lowspeed handpieces and she was 100% certain Ms. Duan was using the highspeed handpiece in the patient's mouth.

A.B. then went to S.H. who followed her back to the operatory to observe what Ms. Duan was doing for herself. S.H. was also a trained dental assistant capable of differentiating the highspeed and lowspeed handpieces. S.H. was also certain she observed Ms. Duan using the highspeed handpiece in the patient's mouth. S.H. then met with Ms. Duan and S.G. . S.H. was present when S.G. asked Ms. Duan what she had been doing and Ms. Duan said she was performing an adjustment, or in other words trimming and fitting a temporary crown.

Ms. Duan called no evidence to refute A.B. and S.H. 's observations. Their evidence was uncontradicted.

Ms. vander Heide, A.B. and S.H. each testified that the highspeed handpiece can cut tooth enamel. This is an irreplaceable body tissue. Using the highspeed handpiece in the mouth also carries a grave risk of serious harm to other body tissues. The Hearing Tribunal accepts that using the highspeed handpiece in a patient's mouth in or below the surface of teeth as Ms. Duan was using it is therefore a restricted activity pursuant to section 2(1)(a) of Schedule 7.1 to the *Government Organization Act*.

Section 4(1) of Schedule 7.1 to the *Government Organization Act* prohibits any person from performing a restricted activity or a portion of it on or for another person unless the person

performing it is authorized to do so. The *Dental Assistants Profession Regulation*, AR 252/2005 at section 12 authorizes RDAs to perform some restricted activities but not the use of the highspeed handpiece. RDAs are authorized to cut body tissues or to perform surgical or other invasive procedures for the limited purposes of dental probing or for scaling teeth upon completing additional training in that skill. There was no other authority for Ms. Duan to use the highspeed handpiece inside a patient's mouth.

Ms. Duan's conduct contravened the *Government Organization Act* Schedule 7.1 as well as the College's standard of practice 2.9. Standard 2.9 provided that RDAs know the restricted activities the profession is authorized to perform and limit their own activities to those they are authorized and competent to perform and which are appropriate to their area of practice. Ms. Duan failed to limit her activities to those that she was authorized and competent to perform and that were appropriate for her area of practice.

Ms. Duan's conduct also contravened the College's Code of Ethics provisions 1.4(a) and 3.1. These require RDAs to provide only those services authorized by legislation that they are competent to perform, and to know and comply with the legislation applicable to the profession.

The Hearing Tribunal concluded that allegation 1 was factually proven. Given the grave risk of harm that Ms. Duan's conduct posed for the patient, and her failure to comply with her legal and professional obligations the Hearing Tribunal concluded that Ms. Duan's proven conduct was very serious and amounted to unprofessional conduct.

Allegation 2 was that or about November 6, 2017, Ms. Duan performed dental assisting services that were not authorized to her by the College of Alberta Dental Assistants, specifically fabricating, fitting, trimming and/or cementing temporary crowns which contravenes section 1(1)(pp)(ii) of the *Health Professions Act*, and College of Alberta Dental Assistants Standards of Practice section 2.9 and the College of Alberta Dental Assistants Code of Ethics articles 1.4, 2.1 and 3.1 and the Granting of Intra-Oral Skills Policy.

The evidence also proved this allegation. Ms. Duan had not been trained or authorized to perform PCR in November of 2017. She only obtained that skill and the authorization from the College to perform it later. In her response to the complaint, Ms. Duan acknowledged that she had been performing PCR on the patient on November 6, 2017 until she was stopped. This was consistent with S.H. 's evidence that in a meeting with S.G. , Ms. Duan and S.H. Ms. Duan said she had been performing an adjustment for the patient. It was also consistent with A.B. 's evidence that she found gingival retraction cord left in a patient's mouth on November 16, 2017 and when she checked the patient notes she determined that Ms. Duan was the last person to have treated that patient.

The November 16, 2017 Incident Report completed by S.H. and signed by S.H. and A.B. confirmed this. It stated that the same patient who Ms. Duan treated on November 6, 2017 was noted to have gingival retraction cord left around his tooth when he returned to have his crown cemented on November 16, 2017.

As above Ms. Duan elected to call no evidence to refute the allegations. The Complaints Director's evidence was therefore uncontradicted.

Performing PCR improperly, such as by leaving gingival retraction cord in place around a tooth, carries a risk of harm to the patient such as the risk of tissue damage and infection. Ms. Duan's conduct breached the College's standard of practice 2.9 in that she engaged in a skill she was not

authorized to perform. Her conduct also contravened the Code of Ethics in that Ms. Duan provided a service she was not authorized to perform.

The Hearing Tribunal concluded that allegation 2 was factually proven. Given the risk of harm that Ms. Duan's conduct posed for the patient and her failure to meet the College's professional standards the Tribunal also concluded that her conduct amounted to unprofessional conduct.

SUBMISSION ON SANCTION

The Hearing Tribunal will receive submissions on sanctions. The Tribunal will consider written submissions on sanction. If either party requests the opportunity to call evidence and make oral submissions on sanctions the Tribunal will consider whether to hold an oral hearing on sanctions. The Tribunal requests the Complaints Director to provide submissions on sanctions within 4 weeks of receiving this decision. Ms. Duan is requested to provide submissions on sanction within 1 further week. If either party is unable to meet these suggested deadlines they may write to the Hearing Tribunal requesting an extension with reasons for the request.

Signed on behalf of the Hearing Tribunal by its Chair this 7 day of March, 2022

Patty Demchuk, RDA