500 – 1765 West 8th Avenue
Vancouver BC Canada V6J 5C6

Phone 604 736 3621
Toll Free 1 800 663 9169
www.cdsbc.org

CDSBC | College of Dental Surgeons of British Columbia

Complaint Summaries

2012/13

Complaints: The Year 2012/13 in Review

The College of Dental Surgeons of BC (referred to below as CDSBC or "the College") closed 230 complaints for the fiscal year ending February 28, 2013:

- 162 were closed without any formal action required against the dentist or certified dental assistant. These are summarized in section 1.
- 45 complaints were closed on the basis of the dentist's or certified dental assistant's agreement to take steps to address concerns identified during the investigation. These are summarized in section 2.
- 23 files were referred to discipline. These are summarized in section 3.

Most complaints were made by patients or family members of patients; however, CDSBC also received complaints from dentists, other dental professionals, other health care providers and insurance companies.

Summaries of Files Closed with Action Taken to Address Concerns

Below are summaries of the complaint files closed with the registrant agreeing to take steps to address concerns raised in the investigation. These summaries are provided to educate the public, practitioners, and their staff on the types of complaints that CDSBC receives and how they are resolved. Specific and technical detail has been omitted from the individual case summaries to ensure understanding by a general audience.

Each complaint file summary contains a brief description of the nature of the complaint, information gathered during the investigation, and the agreed upon resolution. Identifying information about those involved has been removed.

Although the investigations are conducted by staff dentists (referred to as CDSBC Investigators in the summaries below), all complaints are accepted, directed, and closed under the direction of the Inquiry Committee. In each investigation, the Inquiry Committee reviewed an investigation report, decided the remedial action, and directed that the complaint file be closed pursuant to *Health Professions Act* section 36(1). Learn more about the complaints and discipline process >>

Many of the summaries mention that there will be monitoring to track compliance with the terms of the agreement. This typically refers to periodic chart reviews by CDSBC staff dentists to ensure the dentist being monitored is practising to an appropriate standard of care, but may also confirm that the registrant has

completed required courses. Depending on the issue, some of these monitoring files may remain open for several years after the complaint file is closed.

Health files
Files related to practitioner health (including addiction and mental health) are handled through the Registrar's Office, where possible, and not through the complaints/discipline process. CDSBC's wellness program ensures public protection while respecting a practitioner's personal dignity and providing for treatment and return to safe practice. Learn more about practitioner wellness >>

Notes about language

- Mentorship: this refers to a formal agreement for an experienced dentist to work with the dentist who is being monitored to improve the standard of care being provided. The agreement will specify the number of sessions or the length of time that the dentist will be mentored.
- Ethics course: this refers to the PROBE Canada (Professional, Problem-Based Ethics) program. This is an intensive multi-day ethics and boundaries course specifically designed to meet the unique needs of healthcare professionals. Intensive small group sessions target participants' unprofessional or unethical behavior, such as: boundary crossings, misrepresentations, financial improprieties, and other lapses.
- *Tough Topics in Dentistry*: this is a course offered by CDSBC to help dentists deal with the difficult situations they may encounter day-to-day. A major feature of the course teaches practitioners how to deal with requirements for informed consent (a concern identified in many of the complaint summaries). Informed consent means that the dentist: outlines all treatment options, risks, benefits and potential complications; provides a cost estimate and, if appropriate, a pre-determination from the insurer; is satisfied that the patient understands the treatment and agrees to it; and records discussions in the chart and/or a written treatment plan.
- Dental specialties (endodontic, prosthodontic, etc.): Many general dentists provide some of the services that fall within one of the 11 dental specialties. Examples include root canal treatment, orthodontics and pediatric dentistry. However, even if a general dentist performs a given treatment regularly, they may refer a patient to a certified specialist based on the dentist's assessment of a patient's individual oral healthcare needs. Read descriptions of dental specialties >>
- X-rays: for simplicity, this term is used to refer to a radiograph, the resultant image after a patient is exposed to an X-ray.

File 1	**Complaint** A patient complained about the quality of care provided by the dentist (Dentist A) after experiencing ongoing sensitivity following the replacement of an amalgam filling with composite. **Investigation** Dentist A outlined the treatment done and the steps taken to resolve the patient's ongoing sensitivity. Dentist A felt a bite adjustment would likely resolve the issue but also felt he had a duty to caution the patient about the possibility of root canal treatment if her symptoms did not resolve. The symptoms did not resolve and over the course of the treatment the relationship broke down, which led to the dismissal of the patient. The patient sought a second opinion from Dentist B, who provided a report confirming that the restoration looked sound and had good marginal and interproximal contact. While CDSBC Investigators identified no concern about the treatment or the quality of care provided, concerns were noted about diagnosis, informed consent, recordkeeping and patient communications. **Resolution** Dentist A agreed to take a recordkeeping course and to take CDSBC's *Tough Topics in Dentistry* course. He agreed that in future he would speak to patients directly about treatment-related concerns and would follow the proper patient dismissal protocols.
File 2	**Complaint** The patient complained about the quality of care provided by a dentist. **Investigation** The patient had her teeth extracted initially for the purpose of having immediate complete upper and lower dentures made. She then visited a denturist, who advised her that he could make an implant-supported appliance for far less than a dentist would charge for the same treatment. Based on this advice, the patient insisted that she have implants. The dentist proceeded to work with the denturist to implement the patient's preferred treatment despite his concern that she was not an optimal candidate for implants. The patient was not happy with the end result and made a complaint against the dentist.

	Resolution The dentist's agreement with CDSBC addressed the standard of care for implants, the scope of practice for denturists, and the fact that he must not allow a patient to dictate treatment if it is not in his/her best interest.
File 3	**Complaint** A certified dental assistant (CDA) complained that she was sexually harassed by a dentist who invited her to dinner and gave her a massage. **Investigation** The dentist admitted the allegations but felt that the interactions were consensual. The College met with the dentist and his lawyer to discuss the significant concerns arising out of the complaint, including: • the dentist's failure to independently recognize the impropriety of the incident • the power imbalance created by the employment relationship • the significant age disparity between himself and the CDA • the dentist's lack of insight into the importance of establishing and maintaining appropriate professional boundaries with his staff. **Resolution** The dentist agreed that – with the benefit of hindsight – what happened was inappropriate. He acknowledged the effects on the CDA and sent her a letter of apology. The dentist assured CDSBC this would not happen again and agreed to take an intensive and focused course identified/required by CDSBC. The course focuses on appropriate professional boundaries, inter-office communications and leadership.
Files 4 and 5	**Complaint** A patient and dentist (Dentist A) complained about numerous problems with endodontic treatment provided by the dentist (Dentist B). **Investigation** A review of the records revealed concerns with Dentist B's diagnosis and treatment planning, endodontic and operative dentistry, radiographic interpretation and recordkeeping. Dentist B acknowledged the concerns, but did not agree that his endodontic work needed to be re-done considering that many of the teeth were asymptomatic for a number of years.

	Resolution Dentist B agreed to cease providing endodontics except for emergencies to relieve a patient's pain, and agreed to a program of mentorship and monitoring.
File 6	**Complaint** A certified dental assistant complained that the dentist was not complying with the *Minimal and Moderate Sedation* and *Infection Prevention and Control Guidelines*. **Investigation** A review of the records identified a number of deficiencies within the dentist's office relating to sedation and infection control. Issues with billing and recordkeeping were also noted. **Resolution** The dentist agreed to a chart review and monitoring, and to abide by the *Minimal and Moderate Sedation* and *Infection Prevention and Control Guidelines*.
File 7	**Complaint** A patient complained about crown work done by the dentist. **Investigation** The investigation revealed that the patient had TMJ problems before the crown work was done, as well as heavily restored dentition and a clenching habit. The dentist planned to crown many of the patient's teeth to strengthen them. The patient agreed to the treatment but reported experiencing bite problems almost immediately. Several of the crowns had to be returned to the lab for adjustments while others had to be redone entirely. The investigation revealed concerns about the dentist's diagnosis and treatment planning, restorative work (crowns), obtaining/recording informed consent, and recordkeeping. The dentist underwent a chart review which showed similar problems with some patients and acceptable crown work on others. **Resolution** The dentist agreed to mentorship and monitoring.

Files 8 and 9	**Complaint** A certified dental assistant and a hygienist complained that their employer (the dentist) was misdelegating tasks to a dental assistant. **Investigation** The dentist admitted that he had delegated tasks to an assistant contrary to the Bylaws. The dentist acknowledged he did not understand the rationale for some of the rules and that he allowed himself to second-guess them as a result; however, he agreed that this was inappropriate and that he did not handle the situation with the certified dental assistant and the hygienist well. **Resolution** The dentist agreed to ensure his staff perform only the activities for which they are authorized and demonstrably competent as evidenced by certification.
File 10	**Complaint** The mother of a pediatric patient complained after the dentist was not able to make radiographs of the patient's teeth, resulting in significant decay and extensive treatment by a specialist. **Investigation** The dentist saw the pediatric patient regularly, but the patient would not allow radiographs to be taken due to dental anxiety. A thorough clinical examination did not reveal evidence of caries. An accumulation of plaque and the need to maintain proper home care between visits was reported to the patient's father. The dentist believes the caries developed after one of the patient's recall appointments was cancelled and she was not seen for an 11-month period. **Resolution** The dentist agreed to review the guidelines for prescribing dental radiographs for children and to refer the patient to a specialist if radiographs cannot be taken after two visits.
File 11	**Complaint** (health file) CDSBC received a report from the police that a dentist had been arrested under the *Mental Health Act*. **Investigation**

	Investigators obtained a report from the dentist, but he later discontinued contact with CDSBC. The dentist has not been practising for some time and does not hold registration to practice. **Resolution** The College advised the dentist that if he wishes to return to practice he must be assessed as fit to practice and deal with the concerns identified by CDSBC prior to returning to practice.
Files 12 and 24	**Complaint** A former employee of the dentist (Dentist A) complained regarding the practice of unlicensed dentistry by Dentist B, whose registration had lapsed. **Investigation** Dentist A, who owned the practice, acknowledged that Dentist B was no longer registered as a dentist, but said Dentist B was not involved in patient care. Dentist A later admitted that Dentist B had engaged in several instances of unauthorized practice and admitted that his dishonesty had jeopardized his career and put his patients at risk. Dentist B initially denied being involved in patient care, saying that her role in the office was managerial. She later admitted that she had engaged in several instances of unauthorized practice and continued to be involved in patient care even after assuring CDSBC that she was not. Dentist B acknowledged that her lapse in judgment had jeopardized her career and put patients at risk. **Resolution** Dentist A agreed to take an intensive and lengthy professional ethics course, pay a $10,000 fine and undergo a practice audit. He took responsibility for his role and agreed to a program of monitoring. Dentist B promised not to engage in the unauthorized practice of dentistry and agreed to take an intensive and lengthy professional ethics course, pay a $10,000 fine and to undergo a practice audit and a program of monitoring.
File 13	**Complaint** A patient complained about the quality of care provided by the dentist. **Investigation**

	The elderly patient presented with inflammation of the gingiva. The radiograph revealed a radiolucent area; however, the dentist felt the patient's dentures were likely causing the problem as it was identical to a radiograph taken in 2006 and no purulence or tooth mobility was noted. The dentures were adjusted and the patient was given an oral rinse and directions to control plaque. This conservative approach was in part due to the patient's age. The dentist indicated that he would have been more assertive in diagnosing the source if she had returned with more obvious problems. Concerns about recordkeeping and informed consent were noted as the dentist did not discuss the basis for his diagnosis with the patient and did not chart the test results or his observations concerning the radiographs. CDSBC was also concerned about the fact that the dentist prescribed tetracycline at the patient's insistence, even though it was not a medication that would address her symptoms. **Resolution** The dentist agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. To address the concern raised by the tetracycline prescription, the dentist received a strong reminder about not allowing patients to dictate treatment.
File 14	**Complaint** A patient complained about endodontic work done by the dentist and failing to diagnose a problem with a root canal treatment done by another dentist. **Investigation** A radiograph of the tooth showed a suspicious apical radiolucency and a short fill on the root canal which the dentist did not take into consideration before crowning the tooth. The dentist was advised that he should have ensured the patient was aware that the tooth would likely require future treatment that would necessitate the removal of the crown. **Resolution** The dentist agreed to monitoring and to take endodontic diagnosis and radiographic interpretation courses.

File 15	**Complaint** A patient complained about a wisdom tooth extraction done by the dentist. **Investigation** In the course of extracting a wisdom tooth, the tooth slipped from the forceps and was no longer visible to the dentist. The dentist made a radiograph to locate the missing tooth but because it did not appear where one would expect it to be, he failed to notice that the tooth had lodged in the submandibular tissue. The dentist assumed the patient had swallowed the tooth but did not recommend that she have radiography taken of her chest and bowel to confirm this, nor did he ensure she was aware of the possible risks of not having this done. The dentist agreed that more time and care was required in examining the radiograph. Recordkeeping concerns were noted as it was found that the dentist did not record his discussions with the patient, the surgical technique, or the amount of anesthetic given. **Resolution** The dentist acknowledged that he did not meet his responsibility to ensure the patient was aware of the need to seek further treatment and agreed to take CDSBC's dental recordkeeping course. The College was satisfied that this was an isolated and highly unusual incident and that the dentist will respond differently if he faces this situation again.
File 16	**Complaint** A patient complained about a disagreement with the dentist regarding treatment plan and cost. **Investigation** The dentist recommended that the patient have two new crowns done. She agreed although there was a subsequent dispute over timing of when treatment should be done. The dentist believed the treatment should be done right away and initiated treatment without a pre-authorization from the insurer. The dental office failed to include the lab fees in the estimate provided to the patient, which increased the amount payable by the patient. The dental office agreed to a monthly payment plan but once the patient said she was not returning, the office charged the last two payments to her credit card on the same day.

	The dental records supported the treatment rationale, but recordkeeping concerns were noted as there was no written treatment plan, no record of the diagnosis or other options, and no reference to the cost or the financial arrangement made with the patient. **Resolution** The dentist was reminded that his office has an obligation to honour the terms of any payment plans and should not estimate those terms without patient consent. He agreed to record treatment plans and cost estimates and to document that informed consent was obtained. He also agreed to review the *Dental Recordkeeping Guidelines* and take the online dental recordkeeping course.
File 17	**Complaint** An insurer complained that the dentist's office was not collecting co-payments from patients. **Investigation** The dentist admitted that his office was not collecting the co-payments, attributing this to his own inattention. The dentist had left it to his staff to deal with all financial matters and was not confirming cost estimates with the patients as part of obtaining informed consent. The dentist's receptionist did not know it was mandatory to collect co-payments and, as many of these families had very limited finances, she did not charge them. There was no evidence suggesting the oversight was intentional. Rather, it appeared to be based on a misunderstanding about insurance requirements relative to co-payments and the dentist's failure to follow-up with his staff to ensure the proper protocols were implemented. **Resolution** The dentist educated his staff, implemented a new protocol to ensure co-payments are collected and issued billing statements to the patients in question. He also contacted the insurer directly about reimbursing for any amounts he was unable to collect. The dentist agreed to take the College's *Tough Topics in Dentistry* course.
File 18	**Complaint**

	The mother of a pediatric patient complained that the dentist did not advise her of a change in the treatment plan. **Investigation** The dentist diagnosed a deep carious lesion (cavity) in the patient's tooth. He advised the mother the tooth would need to be filled but she did not make an appointment until more than two months later. When the child returned for the filling, the dentist determined that the decay had progressed and that the tooth needed to be extracted. He did not advise the mother of the change in the treatment plan because he did not want to lose the opportunity while the child was already in the dental chair. The dentist advised the child her tooth was too sick to be saved and that he would have to "wiggle it out." The treatment was supported by the records; however, there was concern that the dentist did not obtain the mother's informed consent before proceeding, or at least send his certified dental assistant to the waiting room to explain. **Resolution** The dentist agreed to take the College's *Tough Topics in Dentistry* course. The investigator also suggested that he consider issuing an apology to the mother.
Files 19 and 20	**Complaint** Patient A and Dentist A complained about the clinical treatment provided by Dentist B. **Investigation** Dentist B was newly retired. The records for Patient A, who had been under Dentist B's care for almost 30 years, revealed a number of concerns: • periodontal probing was only done irregularly and usually only on specific teeth • the records were substandard • it appeared that while Dentist B had noted a 7mm pocket on one tooth, no treatment plan was developed, nor was the patient referred to a specialist • the treatment undertaken by Dentist B after he referred Patient A to an orthodontist, but she declined to proceed with a full treatment plan.

	These concerns were discussed with Dentist B, who could not provide any explanation. In a separate complaint, Dentist A complained about Dentist B's treatment of Patient B, who had been under his care for 10 years. Patient B had recurrent decay and many of the restorations failed, which is why Dentist B determined that crowns were required. The radiographs showed open margins, which led to caries and the failure of the crowns. Two teeth had to be extracted, which resulted in the loss of the bridge. Dentist B agreed the crowns were not done as well as he would have liked, but felt the treatment circumstances were less than ideal, as Patient B attended only when there was a problem. **Resolution** Dentist B is retired and does not intend to return to dentistry but understands that if he were to apply for reinstatement, CDSBC would require that he first take a number of remedial courses including recordkeeping, periodontics, prosthodontics and orthodontics.
File 21	**Complaint** (health file) A dentist contacted the College to report that he had recently been diagnosed with Hepatitis B. **Investigation** Reports from specialists advised that the dentist's disease was mild and that his prognosis was good. The specialists also indicated that as long as the dentist uses universal precautions for infection control, he can safely practise dentistry. **Resolution** The dentist signed a letter agreeing to abide by therapy recommendations made by his doctor and to use universal precautions in all dealings with dental patients.
File 22	**Complaint** A patient complained about the quality of care provided by the dentist and that the dentist participated in a phone call while providing treatment. **Investigation** The patient's radiographs revealed extensive decay on two teeth (4.6 and 4.7). The dentist recommended the teeth be filled; during treatment he observed decay on tooth 4.8. He said he obtained the patient's consent to treat 4.8 as

	well (the patient denies this). The dentist subsequently recommended root canal treatment to tooth 4.6 as a preventive measure after noticing caries and fracture lines. The patient had to return several times to get a good result. Because the patient was experiencing ongoing discomfort, the dentist allowed time for the area to settle before the permanent crown was seated. CDSBC Investigators were concerned about the basis for the dentist's diagnosis of the need to fill tooth 4.8 and root canal treat tooth 4.6. The dentist confirmed that at one of the patient's appointments he had an earpiece in and a phone call was ongoing. **Resolution** The dentist agreed to undergo monitoring and a remedial program to address concerns about recordkeeping, informed consent, endodontic diagnosis, radiographic interpretation and patient communications.
File 23	**Complaint** Dentist A complained that Dentist B had failed to diagnose caries (cavities) and had not made radiographs of the patient over a five-year period. **Investigation** Dentist B explained he did not make radiographs so as to reduce his patients' exposure to radiation. When CDSBC Investigators showed Dentist B the radiographs taken of the patient one month after his last visit, he admitted that there was evidence of caries and agreed that a clinical examination was not sufficient to make a thorough diagnosis. Concerns were also noted about Dentist B's recordkeeping, billing protocols and the apparent lack of informed patient consent. **Resolution** Dentist B agreed to mentorship and a monitoring period of two years, as well as a remedial program to address the concerns about diagnosis and treatment planning, recordkeeping, operative dentistry, informed consent and billing.
Files 24 and 12	*See above*
File 25	**Complaint**

	A patient and her parents complained about the orthodontic treatment received from the dentist. **Investigation** A 13-year-old patient required orthodontic treatment to create space for implants to address her congenitally missing upper lateral incisors. The patient's father signed a consent form to initiate treatment, but details of the treatment plan were not contained on the form or noted in the patient chart. The dentist said he discussed the various treatment options with the parents, but there was no note of the discussions and he left it to the patient to inform the parents of her treatment progress. The investigation raised concerns about the dentist's recordkeeping and the lack of communication. **Resolution** The dentist acknowledged that he should have provided the patient's parents with updates throughout her treatment and confirmation when there was a change in the treatment plan. He agreed to complete CDSBC's *Tough Topics in Dentistry* course on informed consent, take a recordkeeping course and review the *Dental Recordkeeping Guidelines*, and to a program of monitoring.
Files 26 and 27	**Complaint** Two dentists (A and B) complained about Dentist C's quality of care, recordkeeping, diagnosis and treatment planning. **Investigation** Dentist C denied the allegations and outlined the challenging circumstances he faced at the dental clinic, which affected his treatment planning. A review of patient charts revealed a number of concerns with Dentist C's recordkeeping, restorative competency, radiographic interpretation, diagnosis and treatment planning and, in some cases, his billing practices. Dentist C was unable to satisfactorily explain the discrepancies noted. **Resolution** Dentist C agreed to monitoring and a further chart review of 20 randomly selected charts to assess his standard of care and determine whether a remedial program is required. The chart review is in process and concerns, if any, will be addressed in a separate file.

File 28	**Complaint** An insurance company complained regarding the impact of the dentist's failure to renew his registration on time. **Investigation** Because the dentist did not advise CDSBC of his new practice address, he did not receive the written notice of the renewal deadline. As a result, he failed to renew his registration before it lapsed. The dentist apologized, explained that this oversight was unintentional and re-paid the amount he had billed the insurance company during the time his registration was lapsed. While this addressed the initial complaint, the fact that he practised dentistry after his registration lapsed was a concern to CDSBC, and it exposed patients to risk of loss as his professional liability insurance would have also lapsed. **Resolution** The dentist acknowledged the concerns of his unauthorized practice of dentistry and agreed: 1) to ensure the College is informed of any change in his contact information; 2) to implement a diary system to ensure he renews his registration by the deadline every year; and 3) that he will not practise without current registration and professional liability insurance.
Files 29 and 32	**Complaint** The College opened a complaint about a dentist and certified dental assistant (CDA) after learning a patient had inhaled a crown. **Investigation** The patient inhaled the crown during a try-in, which was being performed by the CDA. While the risk of such an event is low, it can happen as part of this type of procedure. The dentist appropriately filed a critical incident report with the college and referred the patient to a lab to have a radiograph taken. The radiograph confirmed that the crown had been inhaled. It was removed later that day while the patient was placed under sedation in a hospital facility. The crown was disinfected and permanently seated without incident. The dentist was unaware that the CDA was not authorized to try-in permanent crowns, and the CDA was unaware that she was performing a restricted activity. **Resolution**

	The dentist and CDA both agreed that CDAs would only perform services outlined in CDSBC's *Guide to CDA Services* and as defined by the CDSBC Bylaws. The dentist acknowledged her responsibility to file a Critical Incident Report.
File 30	**Complaint** A parent of a pediatric patient for five years, complained about the quality of care provided by the dentist (Dentist A). **Investigation** Dentist A had been treating the 7-year-old patient since the age of 2, but was unable to establish a good rapport with him from the outset. The dentist said it was impossible for radiographs to be taken because the patient was uncooperative. As a result, he based his diagnosis on clinical examination alone. Dentist A acknowledged that he should have referred the patient to a pedodontist, which he would do if faced with a similar situation in future. A number of concerns arose out of this complaint. Records from the subsequent-treating dentist (Dentist B) confirmed the need to extract a tooth that was bothering the patient and which Dentist A had not diagnosed, due in part to his inability to take radiographs. Dentist A's records were inadequate regarding the treatment provided and informed consent discussions. In addition, Dentist A's receptionist had given dental advice to the patient's parent over the phone. Dentist A agreed this was inappropriate and that he, not his staff, should have advised the parent. **Resolution** Dentist A agreed to implement a new protocol within his office to ensure that his office follows the American Dental Association's guidelines for taking radiographs of children. He also agreed to take a recordkeeping course, complete CDSBC's *Tough Topics in Dentistry* course, take a pediatric dental course, and agreed to a program of monitoring.
File 31	**Complaint** The mother of a pediatric patient complained about the quality of care provided by the dentist (Dentist A). **Investigation**

	Dentist A had treated the patient between 2004 and 2010. Orthodontic treatment began in 2008 after numerous treatment planning discussions with the patient's mother. The dentist placed brackets in 2009. In 2010, after noting the discoloration of tooth 2.2, she referred the patient to an endodontist. At that time, the patient was referred to Dentist B (an endodontist) for root canal treatment. Dentist B confirmed the cause was likely due to a deep, subgingival developmental groove on the palatal surface of the tooth and not from the orthodontic treatment. The records provided by Dentist A did not contain sufficient detail of the treatment planning discussions. **Resolution** Dentist A agreed to review CDSBC's *Dental Recordkeeping Guidelines* and to take the online Dental Recordkeeping course.
Files 32 and 29	*See above*
File 33	**Complaint** A patient complained about a periodontist he saw for a periodontal assessment. **Investigation** The patient was referred for a complete periodontal assessment to determine his suitability as a candidate for implants. The periodontist said all new patients receive a full examination and that they are advised of this, and the cost, by the receptionist. The findings of the examination were discussed with the patient, but the periodontist did not record the patient's informed consent or the discussions he had with the patient on the chart. **Resolution** The periodontist acknowledged the inadequacy of the records and agreed to review the *Dental Recordkeeping Guidelines* and take a recordkeeping course.
File 34	**Complaint** A patient complained about the quality of care provided by the dentist (Dentist A).

	Investigation Dentist A completed restorative work on the patient without incident. When the patient returned the next day complaining of pain, she was told by Dentist A that more time was needed for the tooth to settle. The patient returned a second time and was seen by Dentist B, who suggested she use a sinus rinse to address a possible sinus infection. When Dentist A saw the patient next, there was no evidence of any infection, although he noted slight inflammation of the gums. He observed two canker sores, which he believed could be causing the discomfort, and provided a topical numbing gel to the patient. Upon investigation, an open contact was noted on the radiograph. Dentist A agreed that the radiograph showed the appearance of an open contact, but confirmed no open contact was observed on examination. This was not reflected in his chart. **Resolution** Dentist A confirmed the steps he takes to check the contacts after restorations and agreed to ensure these observations are included in the chart.
File 35	**Complaint** The College opened a complaint file about Dentist A regarding comments he made to patients about Dentist B. **Investigation** Dentist A indicated that after purchasing Dentist B's practice, he became concerned about the quality of care provided and, in accordance with his duty under the *Health Professions Act*, reported those concerns to CDSBC. Dentist A admitted that he went too far in the way he communicated his concerns to the patients. **Resolution** Dentist A agreed not to have any further communication with or about Dentist B unless it was required in the course of the legal proceedings between them. He also agreed to limit his remarks to Dentist B's former patients to the status of their oral health without including derogatory remarks.

File 36	**Complaint** A patient complained about the quality of care provided by the dentist. **Investigation** When the patient joined the dentist's practice, a full series of radiographs were made. The patient had poor home hygiene and constantly presented with interproximal food impaction. In 2010, the patient reported a gap between her front teeth, which the dentist opted to monitor instead of referring her to a periodontist at that time. When the patient returned for an emergency appointment in severe pain, he noted the gap had widened. Radiographs were made and she was immediately referred to a periodontist. The dentist did not believe it was necessary to make radiographs until that time, but CDSBC advised that it would have been prudent to make radiographs every 12 to 18 months and that he should have referred the patient to a periodontist earlier. **Resolution** The dentist agreed to a chart review, a program of monitoring, and to participate in a remedial program to address concerns, if any, arising from the chart review.
File 37	**Complaint** A patient complained about the periodontal care provided by the dentist. **Investigation** Periodontal probing was performed only four times in an eight-year period. The dentist confirmed he did not have a periodontal assessment schedule at the time, but that he did maintain the patient's periodontal status and felt she was aware of this. He agreed that his recordkeeping required improvement. **Resolution** The dentist implemented new protocols within his practice to address the areas of concern. He agreed to a chart review to assess his current periodontal diagnosis and treatment planning and to verify his new protocols. He also agreed to a program of monitoring to track the results of the chart review and develop a remedial program required.

File 38	**Complaint** A patient complained about the quality of care provided by the dentist (Dentist A) after her implants failed. **Investigation** Dentist A explained the patient arrived with a treatment plan already in mind after consulting another dentist and a denturist. She was insistent that all nine of her remaining teeth be extracted in preparation for a new implant-supported denture, which she felt would achieve a cosmetic improvement. Dentist A admits he did not explore other treatment alternatives, even though, radiographically, some of the teeth appeared healthy. Dentist A extracted the teeth uneventfully and immediately placed three implants. He believes their eventual failure was caused by overloading as well as a recurrent infection in the area, which did not resolve with antibiotics. A subsequent-treating dentist (Dentist B) felt the implants were improperly placed so that making it impossible for the new dentures to fit. He removed and replaced them, resolving the patient's discomfort and bite concerns. **Resolution** Dentist A acknowledged the unsatisfactory outcome and accepted responsibility for it. He agreed to take a number of CDSBC-approved implant placement and restorative courses, and to take a recordkeeping course, and to take CDSBC's *Tough Topics in Dentistry* course. He also agreed to a program of monitoring.
Files 39 and 40	**Complaint** Dentist A and a patient submitted complaints about the clinical treatment provided by Dentist B in relation to crown preparation and restorative treatment. **Investigation** A chart review and reports from three subsequent-treating dentists confirmed the concerns raised in the complaints. **Resolution** Dentist B agreed to mentorship and a program of monitoring.

File 41	**Complaint** The mother of a pediatric patient complained about the quality of care provided by the dentist. **Investigation** Because of an abnormal eruption pattern, the dentist referred the patient to an oral surgeon. The dentist said she also discussed referring the patient to an orthodontist after the oral surgery was done, but the parent does not recall this, and the conversation is not recorded in the chart. After the oral surgery was completed, the dentist went on leave. She did not follow up with the patient and admits that she failed to properly coordinate the treatment by arranging the orthodontic component ahead of time. **Resolution** The dentist apologized to the mother of the patient. She confirmed that of her own volunteer, she took a number of orthodontic courses as a result of this complaint and before the investigation and resolution recommendations had been formalized. She also agreed to take a recordkeeping course and to complete CDSBC's *Tough Topics in Dentistry* course.
File 42	**Complaint** A patient complained about the treatment provided by the dentist. **Investigation** The patient required full mouth reconstruction but declined a consultation with an orthodontist and endodontist. The dentist had splinted four of the crowned teeth together as a means of providing extra stability because the patient had a history of cracking and breaking teeth. The crowns were placed to protect the bone because the she believed the patient would be a good candidate for implants in the future. A chart review revealed concerns about diagnosis and treatment planning, radiographic interpretation, informed consent, recordkeeping, and the provision of fixed prosthodontic treatment. **Resolution** The dentist agreed to a remediation program overseen by a dentist mentor, a further chart review, and to a program of monitoring by CDSBC.

File 43	**Complaint** A patient complained about the quality of care provided by the dentist. **Investigation** The dentist said that he warned the patient in 2009 that she would likely lose a crown that he had placed three years earlier because there was now decay under it. He believed the decay was due to poor hygiene habits and the length of time between visits. The dentist admitted that there was evidence of decay on the radiograph made at the patient's 2007 visit. The dentist thought it was radiographic burnout and did not diagnose decay until it was more obvious in 2009. After the crown failed, the patient wrote to the dentist. The dentist understood she had gone to another dentist and did not feel he had any further responsibility, so he did not reply. **Resolution** The dentist agreed to make a radiographic interpretation course and undergo a chart review and a program of monitoring. He also agreed to respond to his patients directly and ensure all treatment options are explained – not just those he recommends. He issued a partial refund for the crown after receiving a second letter from the patient.
File 44	**Complaint** A certified dental assistant complained that the dentist did not remove the gloves he was wearing while treating a patient, before taking a phone call. **Investigation** The dentist admitted he was in a rush and had not removed his gloves before taking the phone call (thus causing a risk of transmission of infectious agents). He said the gloves were clean but he admitted that it was inappropriate for him to wear them while taking the call. His staff advised him of the problem immediately, and he scrubbed down the phone. The dentist explained that this was an isolated incident and was not representative of the office's usual practice. **Resolution** The dentist acknowledged it is his responsibility to ensure the proper infection control protocols are in place. In addition, he agreed to review CDSBC's *Infection Prevention and Control Guidelines*.

File 45	**Complaint** The Inquiry Committee directed CDSBC to open a complaint file to investigate a dentist's apparent failure to diagnose an ameloblastoma (a benign tumour of tooth development tissue). **Investigation** The dentist admitted that he had missed the lesion evident in the panoramic radiograph. He assured CDSBC that he has taken steps to ensure he reviews his radiographs more carefully and also has them reviewed by a colleague as a further safeguard. **Resolution** The dentist agreed to take a course in radiographic interpretation and to a program of monitoring.