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CDSBC | College of Dental Surgeons of British Columbia

Complaint Summaries

2013/14

Complaints: The Year 2013/14 in Review

The College of Dental Surgeons of BC (referred to below as CDSBC or "the College") closed 266 complaints for the fiscal year ending February 28, 2014:

- 61% were closed without any formal action required against the registrant (dentist, certified dental assistant, or dental therapist).
- 38% were closed on the basis of the registrant's agreement to take steps to address concerns identified during the investigation.
- Less than 1% were referred to discipline.
- 1 file was closed and transitioned to a health file mid-year.

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 after the dentist placed four porcelain crowns that cracked and needed to be repaired, and that the dentist cut the floor of her mouth during treatment, resulting in the need for two stitches. **Investigation** The patient told CDSBC Investigators that she did not appreciate the dentist's communication style, and so chose to see other dentists after the extensive restorations. These dentists saw problems with the original restorative work, including gaps and decay. They also told the patient that she was not a good candidate for the porcelain crowns she had earlier received because of her grinding habit. They instead recommended root canal treatment and gold crowns for the teeth. The original dentist told CDSBC Investigators the patient went against his treatment recommendation by choosing porcelain crowns. He said he had accepted responsibility for the unsuccessful treatment and had refunded the patient. He said that this case was not representative of his practice and agreed to have CDSBC Investigators review 10 of his patient charts. The chart review revealed that the quality of his crown and bridgework was sub-standard, as was his recordkeeping. The dentist did not agree with the assessment and asked to meet with a panel of the Inquiry Committee. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to undergo mentorship sessions, monitoring, and additional chart reviews.
File 2	**Complaint** A patient complained that the dentist did not outline all the available options before providing treatment for two teeth. **Investigation** The patient received root canal treatment, a bridge and a crown on the recommendation of his dentist. Five years later, the patient saw another dentist who recommended and provided implants. The patient believed that the first dentist should have given him this option as well.

	CDSBC Investigators reviewed reports and records from both dentists. The first dentist said that he had discussed implants with the patient, but this was not documented in the patient chart. The chart was incomplete and failed to explain the rationale for the treatment provided; it also lacked documentation about recommended treatment related to the patient's gum disease. CDSBC Investigators reviewed other patient charts, which raised concerns about the dentist's informed consent protocols, diagnosis and treatment planning, and his competency in crown and bridge work. **Resolution** The dentist signed an agreement to be mentored by another dentist to address these issues, and to be monitored by CDSBC.
File 3	**Complaint** A patient complained about several issues with her dentist: that she mistakenly used the patient's husband's chart, meaning that she might not have received the proper treatment as a result; billing for procedures that were not done; concerns with an ineffective night guard; and that the dentist did not return her phone calls. **Investigation** The dentist admitted to CDSBC Investigators that there was a mix-up with the charts (the patient and her husband have very similar names), but that the patient did receive the correct treatment. She said that she had called the patient to apologize for the chart error. She told CDSBC Investigators that this was an isolated incident that would not happen again because she had since tightened office protocols. The dentist also admitted that the bite guard she provided was not appropriate for the patient. The patient's billing concern came about when her insurer refused to cover the cost of two fillings with onlays (a type of restoration) after the patient's new dentist reported that no onlays were present. The dentist denied billing improperly. CDSBC Investigators examined the patient and confirmed that there were no onlays, either because they were never there, or because they were defective. The investigation showed that the dentist was carrying out procedures incorrectly and that her periodontal diagnosis and treatment planning were sub-standard. After a meeting with the dentist and her legal

	counsel, CDSBC Investigators were concerned about her lack of knowledge in fundamental areas of dentistry. **Resolution** The dentist signed an agreement that she would participate in a clinical prosthodontic study club and attend lectures on the topics where she has knowledge gaps. She also agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and undergo monitoring and chart reviews for at least 18 months.
File 4	**Complaint** A patient complained that the dentist did not give enough anaesthetic while doing a number of fillings and refused to stop the procedure despite the severity of the pain. She was also concerned with the results of the treatment, as she was left with a jagged tooth and a large gap that had to be repaired by another dentist. **Investigation** The dentist acknowledged to CDSBC Investigators that the topical anaesthetic provided to the patient was ineffective. He said that although he eventually did give more anaesthetic, the patient continued to experience discomfort. He said it was a trying situation for both of them. A review of the records raised concerns about the dentist's recordkeeping, patient relations, X-ray interpretation, and operative competency. **Resolution** The dentist agreed to take remedial courses as requested by CDSBC but refused to sign a formal agreement. After confirming the courses had been completed, CDSBC was satisfied that the concerns raised in the complaint had been adequately addressed and closed the file.
	Note: Files 5, 6, 8, and 9 are all related to a dentist who was abruptly fired from the practice he was employed at, which caused several complaints to be filed related to a lack of follow-up care.
Files 5, 6, 8, 9	**Complaint** Four patients made separate complaints after implants placed by the dentist failed. **Investigation**

	The dentist told CDSBC Investigators that he was abruptly fired from the practice where he was employed after the implant procedures for these four patients. He explained that because he no longer had access to the patients' records or contact information, he could not provide further follow-up care. The dentist acknowledged that the lack of care caused by his leaving the practice was particularly problematic due to the complexity of the treatment plans (some of the patients were having full mouth reconstructions). CDSBC Investigators reviewed the patients' charts and, in some cases, agreed with the dentist's treatment plan. In one case, they found that the patient's oral hygiene could have contributed to the problem. In another, CDSBC Investigators provided the dentist with advice on detecting decay and advised that he should have taken an additional X-ray from a different angle. CDSBC Investigators found that the dentist's records were inadequate and did not show that he had obtained informed consent from the patients prior to treatment. One patient said that she agreed to the implants, but that the dentist did not thoroughly discuss the possible risks and complications of the treatment. This is not informed consent. The dentist's records also lacked details on how the treatments progressed, where applicable (i.e. while he was still employed at the practice and providing follow-up care to some of the patients). **Resolution** The dentist signed an agreement to take a hands-on implant placement and treatment planning course and to complete CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 7	**Complaint** A patient complained about the dentist's quality of treatment after much of the work done in a full mouth reconstruction had to be redone within a short period of time. **Investigation** CDSBC Investigators reviewed reports and records from the dentist and three other dentists who saw the patient. The dentist who was the subject

	of the complaint said he was carrying out the treatment plan created by another dentist. Both dentists later contributed to the costs for a third dentist to repair the work. The investigation raised concerns about the treating dentist's competency in restorative clinical dentistry and prosthodontics. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, enroll in a hands-on clinical prosthodontic study club, and undergo a chart review and monitoring.
File 10	**Complaint** A patient complained that the dentist prepared three of his teeth for crowns, and billed his insurer for the work, despite having told him that he did not want this treatment. **Investigation** The dentist told CDSBC Investigators he thought the patient understood and agreed to his recommended treatment of crowns on three teeth, but admitted he did not provide a cost estimate. Only after the dentist prepared the teeth for crowns did the patient learn the cost of the crowns. He objected to further treatment and the dentist said he would not charge for the work. A new receptionist at the dental practice mistakenly billed the patient's insurance company for the dental work, and the dentist called the insurance company and arranged to have the charges reversed. He believed the matter had been resolved. Four months later the patient contacted him asking for a refund, so the dentist again contacted the insurer to arrange for the charges to be reversed. In addition to the billing mix-up, CDSBC Investigators reviewed the patient chart and found that informed consent had not been given for the treatment. **Resolution** The dentist signed an agreement to be mentored by another dentist to address the concerns about informed consent and billing practices raised in the complaint.

File 11	**Complaint** A patient complained that the dentist started an extensive course of treatment without explaining why it was necessary, and that the treatment caused chronic pain. **Investigation** The dentist told CDSBC Investigators that he had a number of treatment planning discussions with the patient and he believed that she had a good understanding of the restorative treatment and had consented to it. He believed that the patient's pain would resolve over time after he made several bite adjustments. He said that he was unable to resolve her concerns because the patient switched to another dentist after he made the first adjustment. CDSBC Investigators found recordkeeping and ethical concerns during a review of the records. The patient's chart contained no notes about the diagnosis on which his treatment was based. The dentist had also billed $600 more than the estimate he had provided, explaining that he billed for procedures based on his own (non-standard) definitions. **Resolution** The dentist signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines,* take CDSBC's *Dental Recordkeeping* course, complete an ethics course, and undergo a chart review to confirm improvements in his practice.
File 12	**Complaint** A patient complained that the dentist's treatment to replace his bridge failed and that a tooth that received root canal treatment had to be removed. **Investigation** The dentist told CDSBC Investigators that the patient had a chipped bridge that was loose and that he complained of pain in one tooth. He said the patient insisted on replacing the bridge with a new one because the cost would be covered by his insurer. He said the patient declined other treatment options despite his warning that the new bridge might not be successful. The dentist replaced the bridge and root canal-treated the tooth that was causing pain. The bridge later failed and the root canal-treated tooth needed to be extracted. Interviews with the patient and the dentist – and reports from

	two other dentists who treated the patient – raised concerns about the dentist's recordkeeping practices and his protocols for obtaining informed consent. The dentist acknowledged that he had been practising for only two years at the time, and that it would have been preferable to seek input from a more experienced dentist. **Resolution** The dentist signed an agreement to complete at least a one-year prosthodontic course with an emphasis on bite, and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 13	**Complaint** A patient complained that, partway through her bridge replacement treatment, she was transferred to a new dentist in the practice and billed $4,000 more than the original cost estimate. She was also unhappy that metal was visible on the new bridge. **Investigation** The dentist confirmed that he had taken over the patient's care when the first dentist left the practice. He said he was unaware of the cost arrangements, as they had been left to the office manager. He did not know whether the patient had been notified in advance that she was being transferred to his care. After receiving the complaint, the dentist contacted the patient and made her a new bridge. The patient was satisfied with the new bridge and told CDSBC that she wanted to withdraw her complaint. **Resolution** The dentist signed an agreement acknowledging his responsibilities to discuss treatment plans and costs with the patient, as they are important components of informed consent and must not be delegated to the office manager. He was advised to confirm complex treatment plans in writing, and to set out clear agreements with associate dentists, including who will assume patient care if the agreement dissolves.
File 14	**Complaint** A patient complained that the dentist may have diagnosed a problem with the wrong tooth after root canal treatment, and a later extraction did not

	relieve her pain. She later saw a specialist who treated the neighboring tooth and relieved the pain. **Investigation** The dentist told CDSBC Investigators that while performing the root canal he discovered the canals were heavily calcified and that the tooth needed to be extracted instead. The dentist admitted that he might not have explained this to the patient. The dentist damaged the tooth during treatment but did not tell the patient because he had already decided to extract it. He said he did not refer her to a specialist because he did not believe the tooth could be treated. The patient later saw a specialist and learned that her pain was made worse because the dentist did not treat the neighboring tooth prior to placing a bridge. The specialist provided root canal treatment to that tooth and relieved the patient's pain. The investigation raised a number of concerns about the dentist's informed consent protocols, recordkeeping, treatment planning, endodontic diagnosis and prosthodontics. **Resolution** The dentist signed an agreement to take a number of remedial courses in the identified areas of concern, followed by a chart review.
File 15	**Complaint** The parents of a young patient complained that the dentist provided several fillings that later fell out, requiring another dentist to re-do the treatment with the patient under sedation. **Investigation** The dentist told CDSBC Investigators that another practitioner had diagnosed the patient as having eight cavities, and that while it is not her normal practice, she began treatment without getting the original X-rays or taking new ones that would confirm the diagnosis. She said that she explained the treatment options and risks to the patient's parents, but there was no record of this in the chart and the parents deny it happened. The dentist believed the fillings failed because the decay had progressed. However, the dentist who re-did the fillings raised concerns about the quality of the original fillings.

	A review of the dentist's records revealed concerns about a lack of informed consent protocols, interpretation and quality of X-rays, supervised neglect, and recordkeeping. **Resolution** The dentist signed an agreement to be mentored by another dentist, followed by a chart review and 24 months of monitoring.
File 16	**Complaint** The patient complained that after receiving three implants, he experienced electric shock-like symptoms, because one of the implants was improperly placed. **Investigation** The dentist said that the post-surgical X-ray indicated that one implant was close to the nerve, but because the patient was not experiencing pain or dysfunction, he did not think there was a problem. The patient did not return for the recommended follow-up visits, and the dentist was unaware of the symptoms until the patient returned two years later on the advice of his family doctor. The dentist agreed to the patient's request for a referral to an oral surgeon to have the implant removed, but he did not make a diagnosis to confirm that this was the best course of action. The oral surgeon removed the implant, but the patient's symptoms returned three days later. The patient then sought treatment from another dentist, who used 3D imaging to confirm that the implant had originally been placed too close to the nerve canal and that had caused his ongoing pain. The investigation showed the dentist had not met the expected standard of care for informed consent, recordkeeping and implant surgery. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, to join a clinical, hands-on implant restorative study club, and to be monitored by CDSBC, including chart reviews.
File 17	**Complaint** The patient complained that the dentist misdiagnosed a tooth fracture caused by a vehicle collision. He claimed that, had he received a proper

	diagnosis at the outset, he would have been eligible for a dental implant covered by ICBC. The dentist provided root canal treatment and placed crowns on two teeth. The crowns later failed, and the teeth had to be extracted. **Investigation** The dentist provided CDSBC Investigators with X-rays taken over several years. While the fracture line was very difficult to see in the initial X-ray, it was clearly visible in the later X-rays. The dentist said she thought the fracture line was a pencil mark. The X-rays also showed that one of the crowns had a gap that allowed decay to develop under it. The patient chart did not include a record that the patient had provided informed consent. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to join a clinical prosthodontic study club. The dentist also agreed to be mentored with a focus on operative and endodontic diagnosis, treatment planning, and X-ray interpretation, followed by monitoring.
File 18	**Complaint** A certified dental assistant (CDA) complained that she was fired after raising a concern that the dentist was inappropriately assigning tasks to the receptionist that should have been done only by a CDA. **Investigation** The dentist told CDSBC Investigators that she had delegated the tasks to the receptionist but was not aware that it was inappropriate to do so. While she said she was aware of CDSBC's *A Guide to CDA Services,* she was unable to explain why she did not follow it. She explained that the CDA was fired because of performance concerns and not because she raised this issue with the dentist. CDSBC Investigators reminded the dentist of her responsibility to ensure that only qualified and certified staff perform the duties of a CDA. **Resolution** The dentist had closed her office and was not practising due to illness, but signed an agreement requiring her to follow CDSBC's *A Guide to CDA*

	Services to properly delegate duties as a condition should she ever wish to return to practice.
File 19	**Complaint** A long-term patient complained after the dentist dismissed her as a patient and would not answer her question about a $250 “office sedation fee” that she had been charged. **Investigation** The dentist said the patient was dismissed because she was often disrespectful to the office staff. The dentist sent the patient a letter of dismissal, but failed to offer emergency care for a period of 60 days as required by CDSBC. The dentist said the sedation fee was for the scheduling and coordination of sedation services. Given that the sedation fees had been paid for separately by her provincial health coverage (MSP), the patient’s question was reasonable. **Resolution** The dentist signed an agreement acknowledging that he must provide emergency dental care for a period of 60 days after dismissing a patient, and that all procedures must be described accurately to ensure that the patient understands them and can provide informed consent.
File 20	**Complaint** A patient complained about the dentist’s competency after he could not complete a root canal treatment and did not tell her that he made a hole in the tooth. The patient also complained that the dentist made unprofessional comments to her during treatment. **Investigation** The dentist said he spent three hours on the root canal treatment before finding that he could not complete it because he suspected there was a fourth canal further complicating the procedure. The dentist denied that he perforated the tooth during the root canal treatment. The patient saw a specialist who confirmed the fourth canal, but advised that because of the hole in the tooth, it would need to be removed and replaced with an implant. An oral surgeon who later extracted the tooth also confirmed the hole was caused by the root canal treatment.

	The dentist did not directly address the allegation that he had made inappropriate comments to the patient, but acknowledged that some people do not appreciate his “loud personality.” The patient chart lacked detail and did not record any informed consent discussions. **Resolution** The dentist signed an agreement to undergo an extensive remedial program to address concerns about his diagnosis and treatment planning, root canal treatment, recordkeeping, informed consent protocols, and interactions with patients. The agreement included a 24-month monitoring period with random chart reviews.
File 21	**Complaint** CDSBC opened a complaint file against a dentist after it received an application for reinstatement from a former certified dental assistant (CDA) indicating that she had performed CDA duties when she was not authorized to do so, while under his mentorship. **Investigation** The dentist acknowledged that he had relied on the CDA to guide him through the mentorship process, and did not understand his role when he assessed her competency in performing various skills. The CDA confirmed that she also did not understand the mentorship program and accidentally misinformed the dentist about his role. **Resolution** The dentist received a letter reminding him of his responsibility as a mentor to understand the process and follow the agreement. He apologized and confirmed that he now understood his responsibilities as a mentor, and would ensure his future involvement in the program meets CDSBC’s expectations.
File 22	**Complaint** The patient complained about the quality of care provided by the dentist when his lack of follow up after treatment began led to pain and the loss of a tooth.

	Investigation The patient saw the dentist with a request to have a bridge made. The dentist told the patient that he needed gum grafting first, which he performed. The patient returned to the office six months later and was still in pain from the grafting. The dentist started a root canal treatment on a tooth, but stopped before finishing. He advised the patient that he could not save the tooth and it should be removed. CDSBC Investigators found there was no basis for the grafting procedure and that the dentist failed to treat a large cavity that was visible on the X-rays. They also found that the patient was confused about the treatment and had not been advised of other options. The dentist stated that this case was not representative of his overall practice, but he was unable to explain his poor quality of care. **Resolution** The dentist signed an agreement to undergo an extensive remedial program to address the concerns about his diagnosis and treatment planning, recordkeeping, informed consent protocols, and X-ray interpretation. He also agreed to monitoring and random chart reviews.
File 23	**Complaint** A patient complained about the look and quality of the veneers that the dentist placed on her front teeth when they broke apart within a year of being placed. **Investigation** Because the patient did not speak English, the dentist relied on his certified dental assistant (CDA) and the principal dentist to act as interpreters. The dentist said he was instructed to do a “quick fix” and noted that the veneers were intended to be temporary. Despite the patient’s dissatisfaction, photos show a good result was achieved. However, CDSBC Investigators found that the patient chart lacked detail and did not confirm any informed consent discussions. **Resolution** The dentist signed an agreement to take CDSBC’s *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.

File 24	**Complaint** A patient complained that she received too much anaesthetic when having a single filling placed by the dentist. She said she was in severe pain when it wore off. **Investigation** The dentist said he had provided the same amount of anaesthetic he normally uses for that type of procedure. When the patient called him in pain, he explained that some pain after treatment is normal and that it would likely resolve on its own. He offered to prescribe pain medication. When he did not hear back from the patient, he assumed she was fine. The patient went to another dentist for a concern about a different tooth. The second dentist extracted the tooth, which resolved her pain. CDSBC Investigators found that there was no evidence of sub-standard treatment by the first dentist. However, they found that the patient chart was missing relevant information such as the amount of anaesthetic given, notes about phone calls with the patient, and the prescription offered. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to undergo chart reviews.
File 25	**Complaint** A patient complained that the dentist gave treatment without explaining its rationale or costs. **Investigation** The patient saw the dentist for a check-up and cleaning. The dentist took X-rays that showed a filling needed to be replaced, and he provided the treatment at the next appointment. The dentist told CDSBC Investigators that he explained the treatment to the patient, though the patient did not recall this. The patient returned repeatedly, sometimes twice in one day, to have the filling adjusted. The dentist said that at each visit, the patient would ask questions about the treatment, which he would answer – only to have the patient return later with the same questions. Although the patient was an adult, he may have been cognitively impaired, and so the dentist

	requested that he return with his father. From that point on the dentist discussed the treatment with them both. Problems developed with the tooth four months after the initial treatment. The dentist removed the tooth because the patient could not afford root canal treatment. CDSBC Investigators found that while there were no problems with the treatment, there was inadequate recordkeeping. The patient chart confirmed the patient's many visits, but lacked the patient's medical history and detail about informed consent discussions. CDSBC Investigators felt that the patient may not have been able to provide informed consent at all, given the difficulty he had in understanding the treatment – despite the dentist's multiple attempts – and that the dentist should have recognized this. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to undergo a chart review.
File 26	**Complaint** A patient complained that the dentist provided restorative treatment without his consent and billed him for it. **Investigation** The patient came in for an emergency appointment on a busy day just before Christmas. A piece of his tooth had broken off and he wanted it smoothed. The patient said that the dentist did not discuss any options with him before restoring the tooth with three pins and a new filling. The dentist stated that he explained the treatment options to the patient, and that he recommended restoring the tooth to avoid problems with the tooth over the holidays. This discussion was not noted in the chart, and the dentist admitted he did not provide the patient with a cost estimate for treatment. The patient's medical history and other necessary information on a new patient form were missing. The dentist was advised that informed consent requires him to ensure the patient knows what treatment is being proposed, including the benefits, risks and potential complications, and is given a fee estimate, all of which

	should be recorded in the chart. An appropriate medical history must also be taken. **Resolution** The dentist signed an agreement acknowledging his responsibilities and agreeing to take the *Tough Topics in Dentistry* course and review CDSBC's *Dental Recordkeeping Guidelines*.
File 27	**Complaint** The parent of a nine-year-old patient complained that the on-call dentist failed to come to the hospital to provide emergency care after the child fell and knocked out two of his teeth and fractured another. **Investigation** The on-call dentist said that he was contacted by the hospital physician, who explained that the child had suffered a fall and knocked out his two upper front teeth and fractured a third. Over the phone, the dentist explained how to re-implant the teeth and said the physician – who admitted he had never done the procedure before – seemed comfortable to go ahead with treatment. The on-call dentist said he was expecting the physician to call him after the child had been sedated, but he did not hear anything further. He denied that he had declined to attend, stating that he assumed everything was under control. The physician explained to CDSBC Investigators that the father asked him to call the patient's regular dentist, rather than the on-call dentist. The child's regular dentist came immediately and took over his care. Key concerns were raised during the investigation. The dentist should not have made a diagnosis and treatment recommendation for a traumatic injury over the phone, and he should have attended to the patient in the hospital and followed up with the physician. **Resolution** CDSBC provided the *Dental Emergency Resource Kit* to the dentist, which includes tips for running an on-call group that would be helpful for the community in which the dentist practises. The dentist signed an agreement not to diagnose an emergency situation without attending to the patient in person, and to ensure appropriate emergency service is provided when he is the on-call dentist.

File 28	**Complaint** A patient complained about the quality of care that she received from the dentist over the course of her orthodontic treatment, saying that the dentist continually delayed, cancelled and rescheduled her appointments. The patient also complained that the dentist did not have the expertise to handle her care, did not provide her with other treatment options, left her alone with the dentist's husband, and delayed transferring her records to her new dentist. **Investigation** CDSBC Investigators reviewed reports and records from the original dentist and another dentist who later saw the patient. The patient's case was very complex, and the dentist should have considered referring her to a specialist. The dentist's treatment plan was improper and a correct course of action would have required removing several teeth and possibly jaw surgery. From a review of the records, it was clear that the dentist began treatment without providing the patient with proper treatment options. The dentist's pattern of continually cancelling or rescheduling appointments was reflected in the patient chart. At one appointment, the dentist left the patient with her husband – who was not qualified to be involved in any aspect of patient care – to remove the patient's oral appliance, and did not recognize that this was inappropriate. When the patient eventually decided to continue orthodontic treatment with another dentist, there were numerous issues and delays with her request to have her records transferred. Overall, several concerns were identified, including: lack of understanding of orthodontic principles, diagnosis and treatment planning protocols; informed consent; misdelegation of duties; recordkeeping; access to records; and patient communication. **Resolution** The dentist is no longer practising dentistry. She signed an agreement that if she wants to return to practice, she will need to complete a number of remedial courses before practising orthodontics again. She also agreed to review CDSBC's *Guide to CDA Services* and *Dental Recordkeeping*

	Guidelines and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 29	**Complaint** A patient complained that a dentist refused to replace a filling at no charge and was rude. **Investigation** The dentist filled a large cavity for the patient. Six months later the patient returned and said that the filling had fallen out. The patient said that he was originally told there would be no cost for the replacement. However, once the dentist examined the patient, he noted that the problem was actually with a different tooth, and not the one he had recently restored. The dentist said he tried to explain this to the patient, who became angry and shouted loudly as he left the office, accusing the dentist of avoiding his responsibility. The dentist told CDSBC Investigators that he was frustrated by the patient's conduct, but did not feel that he himself was rude. The patient chart lacked detail and there was no pre-treatment X-ray. The dentist said he did not take one because he thought the patient would have declined due to the cost. The patient chart also lacked information about the rationale for diagnosis and treatment, and informed consent. **Resolution** The dentist was advised that he should have strongly recommended a pre-treatment X-ray in the case of such a large cavity, and then recorded the patient's refusal in the chart. He signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course.
File 30	**Complaint** A patient complained that the dentist provided treatment without discussing it with him or obtaining his consent. **Investigation** The principal dentist in the practice completed an initial examination and created a treatment plan for the patient, then referred the patient to the second dentist.

	The second dentist then conducted his own patient exam, and changed the treatment plan based on his findings. He said that these changes were discussed with and agreed to by the patient before he proceeded. A review of the patient chart did not contain any notes about the informed consent discussions. It also revealed a concern that the dentist had carried out root canal treatment without first doing enough testing. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to enroll in a hands-on endodontic study club. The dentist also agreed to monitoring and a chart review.
File 31	**Complaint** The father of a six-year-old patient complained that his child developed a staphylococcus (staph) infection after treatment, which caused blisters and bleeding on her face and hand. The parent alleged that the dental practice was not sterile. He said the office did not address the concern in a meaningful way and advised him to find a new dentist. **Investigation** The dentist said he extracted the child's tooth without incident. The patient's father later called him to say that the child had developed a staph infection and suggested that the dental practice was not sterile. The dentist told him that his office observes infection prevention and control protocols and that the infection was likely caused by the child accidentally biting her lip while anaesthetized. CDSBC Investigators reviewed the records and found that the infection was likely herpetic (viral), and not a staph infection (bacterial) as alleged in the complaint. CDSBC Investigators found that the patient chart raised concerns about the dentist's recordkeeping. There was a lack of pre-treatment records to provide sufficient rationale for the diagnosis, and there was no indication that other treatment options were presented and discussed with the child's father before extracting the tooth. **Resolution** The dentist signed an agreement to review the radiographic guidelines for infants and children and the *Dental Recordkeeping Guidelines*, take CDSBC's *Dental Recordkeeping* course, and to undergo a chart review.

File 32	**Complaint** An elderly patient complained when the dentist placed a crown that was a different material from what she was expecting. **Investigation** The patient said that the dentist had previously told her that a gold crown would outlast a porcelain one, and so she told the front desk staff that is what she wanted. Despite this, the dentist placed a porcelain crown. The dentist told CDSBC Investigators that he did not specifically discuss the crown material with the patient and he presumed that she would want a porcelain crown for aesthetic reasons. He also thought she would trust his professional judgment in choosing the appropriate material. CDSBC Investigators' review of the patient chart raised recordkeeping concerns. It lacked detail about the rationale for the diagnosis, other treatment options, and informed consent discussions. CDSBC Investigators reminded the dentist that patients must always be given the full range of options along with the associated costs and benefits of each so that they can then make an informed choice. The dentist was confrontational when he met with CDSBC Investigators and questioned the basis for the concerns and recommendations. **Resolution** The dentist signed an agreement acknowledging the informed consent and recordkeeping concerns, and agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 33	**Complaint** A patient complained that when she went to the dentist for a crown and to have a gap closed between her two front teeth, the dentist instead began a treatment plan involving three veneers and a crown that caused chronic inflammation and bleeding of her gums. When the patient complained to the dentist, she was blamed for the breakdown of the dentist/patient relationship. **Investigation** The dentist told CDSBC Investigators that she provided treatment according to the patient's wishes. There was no evidence that the patient was advised of potential complications, or provided with other treatment

	options. The dentist did not appear to have considered the long-term effects of the restorations, which resulted in chronic inflammation. The patient was later treated by four other dentists, each of whom had concerns about the original treatment plan. **Resolution** The dentist had already enrolled in several prosthodontic study clubs to improve her skills in this area. She was reminded that her communications with patients should be respectful, professional and empathetic, and signed an agreement to take CDSBC's *Tough Topics in Dentistry* course. She also agreed to undergo chart reviews.
File 34	**Complaint** A patient complained that the dentist did not recommend root canal treatment for his tooth and, as a result, it cracked and had to be removed less than a year later. **Investigation** The dentist took X-rays and said he would provide root canal treatment for the tooth at the next appointment, to which the patient agreed. The patient cancelled two follow-up appointments at the last minute, and so never did receive the treatment from the dentist. The follow-up telephone reminder was not recorded in the patient chart. CDSBC Investigators examined the patient record. The X-ray showed deep decay on the tooth, raising concerns that root canal treatment may not have been the best treatment option. The records were incomplete and did not outline whether any other treatment options (such as extracting the tooth, as was later necessary) were presented to the patient. The complaint raised informed consent, recordkeeping and root canal treatment diagnosis and treatment planning concerns. **Resolution** The dentist signed an agreement to enroll in hands-on endodontic courses, review the *Dental Recordkeeping Guidelines*, and take CDSBC's *Dental Recordkeeping* course. The dentist also agreed to monitoring and a chart review.

File 35	**Complaint** A patient complained that the bridge placed by the dentist left a large gap that affected her ability to speak properly. The dentist did not fix the issue in the year following placement, and refused to refund the cost of the bridge or participate in mediation. **Investigation** The patient reported that the dentist extracted four of the patient's teeth and made a bridge. The dentist placed the bridge with temporary cement in case it needed to be adjusted. There was a large gap between the bridge and the patient's gum, which made a whistling sound. When the patient returned to the dentist asking him to fix the gap, he could not remove the bridge and sent her home with advice to shake it loose and return. He also suggested she use chewing gum to fill the gap. The patient was treated by another dentist, who provided CDSBC Investigators with photographs that showed the bridge had obvious gaps when placed by the first dentist. The gaps meant that food was getting stuck, which would lead to cavities and seriously damage the patient's gums under the bridge. The bridge was bulky, ill-fitting, and affected the patient's speech and ability to chew. The patient and her new dentist both confirmed that the bridge had never been removed or adjusted since it was initially placed by the dentist. The original dentist denied to CDSBC Investigators that the bridge had gaps when it was placed. The dentist eventually admitted that the treatment outcome was not ideal, but said that it was an isolated incident. **Resolution** The dentist signed an agreement not to provide crown and bridgework, and to take a remedial program if he wished to resume such work in the future. He also agreed to undergo a chart review and to take CDSBC's *Dental Recordkeeping* course.
File 36	**Complaint** A patient complained that during root canal treatment, the tooth fractured and had to be removed, and that the dentist restored another tooth without her consent.

	Investigation The dentist diagnosed that a tooth needed root canal treatment. The patient was nervous about the procedure and agreed to proceed with it under sedation. During treatment, the dentist noticed a cavity on another tooth and decided to restore it as the patient was already sedated. She thought this was in the patient's best interest and it would eliminate the need for the patient to undergo a separate procedure later. CDSBC Investigators were concerned about the basis of the dentist's initial diagnosis for the root canal treatment, as it appeared that insufficient testing was done. During the investigation, the dentist joined a hands-on study club to improve her root canal treatment skill, and agreed to a chart review by CDSBC Investigators. All six charts reviewed showed satisfactory results. **Resolution** The dentist signed an agreement acknowledging CDSBC's concerns about her decision to restore the second tooth without consent, and that she should have discussed this possibility with the patient before treatment or have the patient appoint someone to consent on her behalf.
File 37	**Complaint** The patient complained that the dentist carried out unnecessary treatment on asymptomatic teeth, and charged her more than double the initial estimate. **Investigation** The patient originally saw the dentist about a cracked molar tooth and her desire to have some fillings replaced. She said that even though she did not have symptoms, the dentist recommended root canal treatment and crowns for these teeth, and provided a quote of $13,000. She said she did not learn that the actual cost was $30,000 until half way through the treatment. The dentist disputed the patient's version of events and stated that the patient had consented to the $30,000 treatment plan and did not question the cost or complain while the treatment was being carried out.

	Within a year after treatment, the teeth had to be re-treated, and one tooth had to be removed. The patient saw a new dentist who commented on the large number of root canal-treated and crowned teeth that she had, which made her question whether any of the treatment had been necessary in the first place. CDSBC Investigators found that the patient chart did not include a signed treatment plan, and it appeared that the dentist had not provided a written estimate to the patient. The patient's X-rays did not support the dentist's diagnosis, and a review of five random charts showed a pattern that the dentist's rationale for root canal treatment diagnosis did not meet standards. **Resolution** The dentist initially defended his treatment approach as being preventative but later signed an agreement to take remedial courses to improve his recordkeeping, informed consent protocols, endodontic diagnosis and treatment planning. He also agreed to monitoring and a chart review.
Files 38 and 39	**Complaint** The patient complained about the standard of care provided by two dentists (Dentist A and Dentist B) over the course of five years, saying that she experienced problems at every step of the complex treatment plan, and felt abandoned when the problems were not addressed, despite assurances that the work would be redone or replaced. **Investigation** The patient had injured her jaw and teeth in an accident. The resulting treatment plan was complex and involved implants, crowns, restorations and bone grafting. When CDSBC Investigators asked for the patient's records, the dentists could not locate them. Dentist A said that when he and Dentist B dissolved their partnership, Dentist B took all the patient records. Dentist B denied this claim, saying that he left the records behind. The two dentists did not agree about which of them had performed the treatment. Without the patient records, this could not be confirmed.

	The Investigators did obtain the patient's insurance record and the office's daily schedule, but neither was helpful to the investigation, as they provided conflicting and insufficient information about the treatment provided. **Resolution** Both dentists signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course. They also agreed to ensure the safe keeping of patient files, accurate billing, and to record who provides treatment to a patient. Dentist A's agreement also required that he take a surgical implant course, and participate in a chart review.
File 40	**Complaint** The patient complained about the quality of the dentist's bridgework. The dentist made two failed attempts at replacing the 24-year-old bridge, but neither replacement was sized correctly, which caused problems with the patient's bite. **Investigation** The dentist created an initial replacement bridge for the patient, but it was too large. The dentist made adjustments, but they did not resolve the patient's concerns, and she continued to bite her cheek and tongue. The second replacement bridge was short and stubby and also failed. The dentist believed the patient's discomfort was due to factors other than the bridge. The patient sought treatment from another dentist, who was able to successfully resolve her concerns by creating a third replacement bridge. The second dentist reported that the two failed bridges were not modelled after the patient's original bridge. CDSBC Investigators reviewed the original dentist's records and found that the patient chart did not include notes on diagnosis and treatment planning discussions or informed consent. **Resolution** The dentist signed an agreement to enroll in a hands-on prosthodontic study club to improve her skills and take CDSBC's *Dental Recordkeeping* course.

File 41	**Complaint** The patient complained that replacement bridges provided by the dentist did not fit properly, causing bite issues and severe jaw pain that she was unable to resolve. The patient saw a specialist who recommended fixing the problems by replacing the bridge at further cost to the patient. **Investigation** The dentist confirmed that she had replaced the patient's 30-year-old bridge. When the first replacement bridge was uncomfortable, the dentist replaced it a second time with a replica of the patient's original bridge. The dentist said the patient left satisfied. The dentist said she did not hear from the patient again until two years later, when he returned and asked for a full refund after seeing a specialist who had recommended replacing the bridge at an additional cost of $6,000. The dentist was not aware that the patient had experienced further difficulties and had not been contacted by any of the other dentists involved in the patient's care. CDSBC Investigators found that the patient chart generally lacked detail and that it did not record the patient's open bite and overbite. CDSBC advised the dentist that she should have referred the patient to a prosthodontist at the outset. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to enroll in a hands-on prosthodontic study club (with an emphasis on occlusion/bite). She also agreed to monitoring and a chart review.
File 42	**Complaint** A patient complained about the quality of a new bridge, and that the dentist was not able to resolve the bite and speech problems she experienced. She also reported that the dentist did not pay for specialist fees as he had promised. **Investigation** The patient had problems chewing and speaking after the dentist cemented in the new bridge. The dentist made numerous adjustments that did not solve the patient's problems. He expressed regret at the

	outcome of her treatment and eventually referred her to a specialist, and said that he would cover the fees. The patient saw the specialist twice and he was able to adjust the bridge to improve her situation. The patient reported the dentist did not reimburse her for the two specialist visits until after the complaint was made. A chart review by CDSBC Investigators revealed concerns about the dentist's recordkeeping as well as his understanding of fixed prosthodontics and occlusion (bite). The dentist should have realized the effect that the bridge was having on the patient earlier, as it seemed likely that the problems with the bridge were related to the positioning of her jaw. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and attend a hands-on fixed prosthodontic study club. He also agreed to monitoring and a chart review.
File 43	**Complaint** A patient complained that after the dentist replaced the clips on his implant-supported denture, it was uncomfortable and fell out while eating. **Investigation** The initial denture fit well and the patient was happy with it. The dentist noted that the force from the patient's strong oral/facial muscles made the case challenging and caused the denture to wear out. When the patient returned for a clip replacement, the dentist adjusted the denture, which caused problems with its fit. When the denture eventually popped out, the patient was upset at the prospect of paying additional lab fees. The dentist/patient relationship deteriorated after that. CDSBC Investigators found that the patient's issues were not referenced in the patient chart until they became problems. The chart did not include any of the informed consent discussions the dentist said he had with the patient. The dentist agreed that his records were lacking and confirmed that he had already taken steps to improve them. Despite the recordkeeping and informed consent concerns, CDSBC Investigators did note that the rationale for the treatment was sound and a good outcome was achieved.

	Resolution The dentist signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 44	**Complaint** A patient complained that the dentist was unable to resolve pain caused by a bridge he placed, even after a number of adjustments. She also complained that he initially offered to pay for a consultation with another dentist, but later refused. **Investigation** The dentist placed a bridge for the patient and made a number of adjustments when she complained that it was uncomfortable. The patient's issues persisted, so the dentist replaced the bridge at no cost. When the patient did not experience any improvements with the second bridge, the dentist offered to pay for a consult with another dentist. The dentist had intended to reimburse the new dentist's office directly for the consultation. When the patient returned asking for a $300 reimbursement, and refused to provide the name of the new dentist, the dentist explained that he would not pay the fee without some confirmation from the dentist the patient consulted. CDSBC Investigators found that the patient chart lacked detail and did not include any record of informed consent discussions with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 45	**Complaint** A patient complained that the dentist did not tell her that he had accidentally made a hole in her tooth during a root canal treatment. As a result, she experienced ongoing pain and discomfort until the tooth was removed by another dentist. **Investigation** The dentist replaced a crown for the patient. She later returned with pain and sensitivity. The dentist recommended waiting to see if it would resolve on its own because he had not noted any decay on the tooth. When it did

	not resolve, he provided root canal treatment, during which a hole was accidentally made in the tooth. The dentist did not tell the patient what had happened at the time, and the patient said the dentist did not outline any other treatment options, or advise of risks and possible complications. The patient continued to experience pain and discomfort and saw another dentist, who noted the hole in the tooth. Because the tooth could not be restored, the dentist removed it. CDSBC Investigators reviewed the original dentist's records and found that the dentist had overfilled two of the root canals in the tooth. The records raised concerns about X-ray interpretation and root canal treatment diagnosis and treatment planning as well as recordkeeping and informed consent. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* and *Dental Recordkeeping* courses, and to review the *Dental Recordkeeping Guidelines*. He also agreed to join an endodontic study club or take a related course (either of which must be approved by CDSBC), and undergo monitoring and a chart review.
File 46	**Complaint** A patient complained of ongoing pain after the dentist placed a crown, which he was unable to resolve for her through adjustments and root canal treatment to two teeth. **Investigation** The patient saw the dentist for a routine check-up, with no complaints of pain. The dentist recommended a crown for one molar and the patient agreed. After the dentist placed the crown, the patient began to have pain in that area. The pain was not resolved with adjustments to the patient's bite, so the dentist performed root canals on that tooth and one next to it. The patient continued to experience throbbing pain and the dentist eventually referred her to a specialist. The specialist re-treated both of the teeth, one of which was eventually extracted as it continued to bother the patient. CDSBC Investigators found that the X-ray taken prior to the dentist's treatment did not show the entire tooth. The dentist acknowledged that

	limited testing was done to confirm the need for root canal treatment of the teeth. The patient chart lacked detail, especially regarding informed consent and discussions of treatment options. The chart review also raised concerns about the dentist's root canal treatment diagnosis and treatment planning. **Resolution** The dentist signed an agreement to complete a hands-on root canal treatment course, take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. He also agreed to monitoring and a chart review.
File 47	**Complaint** A patient complained about the dentist providing root canal treatment and a crown on a tooth that he later learned could not be saved. **Investigation** The dentist said that because the patient wanted to save the tooth, he had provided the root canal treatment and crown. The patient confirmed that he had initially agreed with the treatment plan, but could not recall if he was given any other options at the time. Two years later, the patient's new dentist advised that the tooth would have to be extracted within the next four years, causing the patient to question the rationale for the initial treatment. CDSBC Investigators found that the dentist's records supported the treatment rationale and the root canal treatment was well done. In fact, the treatment lasted for six years. However, the chart lacked detail and did not confirm that the patient had provided informed consent. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.

File 48	**Complaint** A patient complained that she was billed twice as much for an examination and X-ray as the dental office's receptionist had estimated for her earlier in the same day. **Investigation** The patient came to the office with a toothache. The receptionist told her that it would cost $60-65 for an examination and an X-ray, and the patient made an appointment to see the dentist later that day. The dentist did an oral examination and took an X-ray as requested by the patient. He also performed additional testing to confirm his diagnosis of a bacterial infection. He did not advise the patient about the need for extra testing or what the costs would be. He was unaware that the receptionist had provided the initial estimate to the patient. The patient's final bill was twice the amount that the receptionist had estimated. The dentist was advised by CDSBC Investigators to improve communication in his office. They also recommended that the receptionist should not provide specific estimates to patients, and that any broad estimates given should be recorded in patient charts and communicated to the dentist prior to treatment, so that the dentist can have the necessary conversation with the patient to outline treatment options, costs, and benefits, based on the actual diagnosis. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course and to take steps to improve communications within his office.
File 49	**Complaint** An elderly patient complained that the upper and lower dentures provided by the dentist kept falling out. **Investigation** The dentist said that the patient had several issues that would have affected the treatment outcome, such as a previous stroke, heavy smoking, and medications that created a dry mouth. The dentist recommended placing two implants to anchor the dentures, but this option could not be acted upon because of the cost and the

	patient's smoking habit. Instead, conventional upper and lower dentures were made for the patient. The dentist did not record his discussions about potential complications in the patient chart. The patient said that the dentist assured her he could achieve a good result, but despite her repeated visits to the office, her dentures continued to fall out. **Resolution** The dentist signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines* and take CDSBC's *Tough Topics in Dentistry* course.
File 50	**Complaint** A patient complained about the quality of four implants she received from the dentist, saying that they were improperly placed, which caused problems with a denture that fit over them, and that they ultimately failed. **Investigation** The dentist said that the patient's implant surgery and healing process had gone as planned. A denturist made a denture to go on top of the implants. The denture did not fit properly and the patient felt that this was because of poor placement of the implants. After seeing the denturist, the patient returned to the dentist frustrated by the poor fit. The dentist said that she did not express any other problems. The patient subsequently visited two other dentists who confirmed that all four implants had failed. CDSBC Investigators consulted with a specialist who confirmed that the dentist's rationale for the treatment plan was supported in the patient chart. However, the chart lacked information about how the treatment was carried out and questions remained about quality of care. **Resolution** The dentist signed an agreement to take a hands-on implant diagnosis, treatment planning, and placement course.

File 51	**Complaint** A patient complained that the dentist did not inform her that his restorative work might not match the colour of her teeth, and that instead of addressing her concerns, he dismissed her as a patient. **Investigation** The dentist provided a porcelain crown on one tooth and treated a second tooth with composite material. The remaining teeth were bleached. The dentist believed he had the patient's consent before he began treatment. The patient said that she would not have chosen this treatment if she had known that she risked her teeth having different textures and mismatched colouring. The dentist said he would not have permanently cemented the crown if he knew that the patient was unhappy with the colour, but the patient felt that when she raised the concerns, the dentist failed to address them in a meaningful way. Instead, he sent her a letter dismissing her as a patient. CDSBC Investigators found that the patient chart did not note that the patient provided informed consent. **Resolution** The dentist acknowledged the need to have — and record — informed consent discussions and he was advised to manage patient expectations by communicating the potential shortcomings of a treatment. He signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course.
File 52	**Complaint** A patient complained that the dentist extracted a tooth without her permission, that he did not take a pre-treatment X-ray, and that he refused to provide her dental records. **Investigation** The patient saw the dentist to have a filling replaced. The dentist told CDSBC Investigators that he noted a badly decayed tooth and discussed various treatment options with the patient. He said there were concerns that the patient's insurance would not cover root canal treatment, so the patient agreed to have the tooth extracted for financial reasons. While the dentist said it was badly decayed, the patient thought it was healthy and told CDSBC Investigators that it had not been bothering her.

	At the same appointment, the dentist replaced the filling and polished a rough spot on a tooth at no cost to the patient. A few weeks later, the patient returned with her husband, who demanded his wife's records. The dentist did not release them, as the request came from the husband, and not from the patient. CDSBC Investigators found that the patient chart lacked detail and that no pre-treatment X-ray was taken of the extracted tooth, making it difficult to confirm proper diagnosis. The dentist also did not record any of the informed consent discussions in the patient chart. The dentist acknowledged that the patient has a right to a copy of her records and that separate arrangements should have been made to accommodate the request. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. He also agreed to take pre-treatment X-rays, especially prior to an extraction.
File 53	**Complaint** A patient complained that she received a bill that was higher than estimated and which exceeded her annual insurance limit, despite having previously discussed this with the dentist. **Investigation** The patient felt that she should have been given the option to defer treatment for two months when her annual insurance limit would reset. The dentist said that she did not want to delay the treatment of two large cavities as she believed more extensive work would be required if they waited. CDSBC Investigators found that the records supported the dentist's treatment rationale. The patient was not given a proper estimate of the cost of treatment beforehand. The dentist confirmed that her office agreed to check the patient's annual limits, but did not obtain (or offer to obtain) a pre-authorization that would show how much coverage remained for that calendar year. The patient said that the dentist did not acknowledge the mix-up and told her that it was her own responsibility to know her insurance limits.

	The dentist's records lacked detail and did not show that any other treatment options had been discussed with the patient. **Resolution** The dentist signed an agreement acknowledging the concerns and to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to review the *Dental Recordkeeping Guidelines*. The dentist indicated she may yet refund the patient. She was advised the College could not intervene in that regard but that if she reimburses the patient, she must also reimburse the insurer.
File 54	**Complaint** A patient complained that the dentist failed to diagnose an abscess at the root of her tooth, which later had to be root canal-treated. **Investigation** The dentist decided to monitor the abscess in the tooth because the patient was not experiencing symptoms, and it appeared to resolve by the patient's next appointment. The patient later returned when the same tooth broke, at which time the dentist recommended crowning it. Because the dentist had not noted the abscess in the chart, she did not re-evaluate the area. Six months later, the patient was seen by another dentist at the practice who noted that the abscess was still present and clearly visible on the X-rays. That dentist recommended root canal treatment. The dentist did cover the cost of the root canal treatment for the patient, but the investigation raised concerns about the dentist's recordkeeping, X-ray interpretation, and root canal treatment diagnosis and treatment planning. **Resolution** The dentist signed an agreement to take CDSBC-approved courses in X-ray interpretation and root canal treatment diagnosis, as well as CDSBC's *Dental Recordkeeping* course.
File 55	**Complaint** A dental insurer complained that the dentist grossly overbilled for root canal treatment for a patient with an unlimited insurance plan.

	Investigation The dentist agreed that the amount he charged to the insurer was far in excess of what was normal, but said that the root canal treatment was so complex that it had to be performed over three appointments. Billing issues were handled by the front desk staff and the dentist did not advise the patient how much her insurer was being charged for the procedure. The dentist later agreed that the amount ($4,500) was excessive and reimbursed the insurer. In addition to the ethical concerns raised by this complaint, a number of concerns about the dentist's competency with root canal treatment were also noted. **Resolution** The dentist acknowledged the ethical concerns and recognized the importance of ensuring that his informed consent discussions confirm the cost of the treatment. He signed an agreement to enroll in an educational root canal treatment course or study club, followed by a 24-month monitoring period that would include chart reviews.
File 56	**Complaint** A patient complained that a replacement bridge provided by the dentist caused discomfort and bite issues, and that it would now be difficult to have a new bridge made because her teeth were compromised by the treatment. **Investigation** A review of the patient's X-rays raised numerous concerns about the root canal treatment that the dentist provided before inserting the bridge. After the bridge was inserted, the patient experienced pain and discomfort. The dentist ground down her teeth in an unsuccessful effort to resolve her concerns. The patient was shocked at the small amount of tooth structure that was left and got a second opinion. This dentist noted that her teeth had been badly compromised and that it would now be very difficult to make a new bridge.

	The investigation also revealed that the dentist had not planned to address gaps under the bridge that would lead to decay. Concerns about crown design and recordkeeping were also noted. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and join a prosthodontic study club. She also agreed to mentorship and monitoring to ensure that the concerns have been addressed successfully.
File 57	**Complaint** A patient complained that he was unhappy with a dental prosthesis he received from the dentist because it did not look like his original teeth, and that he no longer trusted the dentist to address his concerns. **Investigation** The dentist said that he and the patient had discussed affordable treatment options at length. The dentist also told the patient that a porcelain bridge would likely fail because of his extreme grinding habit. The patient agreed to proceed with implants and a prosthesis. The informed consent discussions that the dentist said happened were not recorded in the patient chart. The dentist felt a very good result was achieved at a cost that the patient could afford, but acknowledged that the patient had aesthetic concerns. However, he was confident that they could be addressed with a few minor adjustments, at no cost, if the patient returned for follow-up treatment. The patient saw a second dentist who commented favourably on the outcome and acknowledged that the patient's aesthetic concerns were a personal preference and could be addressed if the patient would return to the original dentist for adjustments. It appeared to CDSBC Investigators that regardless of the length of time the dentist spent with the patient, the patient's expectations were not well managed. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* and *Dental Recordkeeping* courses, and to review the *Dental Recordkeeping Guidelines*.

File 58	**Complaint** A patient complained that the dentist refused to remove the residual cement on a recent crown unless he came in – and paid for – a new patient examination. The patient was told the office would contact him and when they did not, he made multiple phone calls to the practice that were not returned. **Investigation** The patient went to see the dentist because his gums were bleeding. The dentist checked the patient's crown (which had been placed by a different dentist who had since left the practice), and suggested that removing the residual cement might resolve the patient's discomfort. The dentist noted poor dental hygiene and the patient admitted he had not had a cleaning in over eight months. The dentist recommended, and the patient agreed to, a new patient exam at a later date. The dentist instructed the front desk staff to set up the new patient exam, but the patient was upset when the receptionist told him the cost. He called the office multiple times and left messages. The chart entries surrounding the patient's calls contained little detail. His calls were not returned because the office manager felt his messages were threatening, but she did not tell the dentist what was happening. He agreed that his staff should have let him know. It was clear to CDSBC Investigators that the patient believed he was being charged unfairly for removing the cement and did not know what a new patient exam was. **Resolution** The dentist was reminded of the guidelines on patient dismissal and signed an agreement to improve his office protocols to ensure that this situation does not happen again, and to take CDSBC's *Dental Recordkeeping* course.
File 59	**Complaint** Dentist A complained that Dentist B had billed a patient for a wisdom tooth extraction when the tooth had not, in fact, been extracted, and refused to forward him the patient's dental records. **Investigation** Dentist B maintained that he had extracted the wisdom tooth, despite an X-ray that clearly showed that it was still intact. When CDSBC

	Investigators reviewed the panoramic X-ray taken by Dentist A with Dentist B, he claimed that the tooth must have regenerated (this is not possible). Dentist B admitted there was no scientific basis for this theory, but then produced another patient chart to illustrate that it had happened before. Dentist B later admitted that he was unsuccessful in extracting the teeth in both cases and had been too embarrassed to admit it to the patients. In addition to the patient communication and ethical concerns, a review of the patient chart revealed that it lacked detail and that no pre- or post-operative X-rays had been taken. **Resolution** Dentist B agreed that he would no longer remove wisdom teeth or impacted teeth. He also signed an agreement to take CDSBC's *Tough Topics in Dentistry* and *Dental Recordkeeping* courses, as well as an ethics course.
File 60	**Complaint** A patient complained after a specialist determined that her lower jaw had fractured when her dentist removed a molar, which caused ongoing pain, infection, and numbness. **Investigation** The dentist said he did not anticipate increased risk from this extraction as he had done many similar to it throughout his career. However, in reviewing the dentist's records, CDSBC Investigators found that the pre-operative X-rays were not sufficient to properly identify the risks. The patient had a small jaw and the position of the tooth, the bone volume, and the location of the nerve canal all increased the risk involved in the procedure. Proper X-rays that included the whole tooth and the surrounding area would have shown these issues more clearly. It was also noted that specialty care was not mentioned to the patient before the surgery. **Resolution** The dentist signed an agreement to address the concerns through monitoring, a chart review, and to complete remedial work to improve his recordkeeping and informed consent protocols.

File 61	**Complaint** A patient complained that the dentist's placement of her implant made it impossible to achieve comfortable placement of the crown. **Investigation** The records provided to CDSBC Investigators by the dentist showed that the implant was successfully placed in a restorable position. The dentist said he consulted with the dentist who was making the crown restoration. They proposed making and adjusting a temporary crown to address the patient's comfort concerns, before proceeding with a permanent crown. The patient refused to proceed with any further treatment that had a cost associated with it. Both dentists gave full refunds to the patient so that she could continue care under the dentist of her choice. CDSBC Investigators found that the patient chart included a generic consent form signed by the patient but did not include a treatment plan or fee estimate and did not record any informed consent discussions. **Resolution** The dentist, who was not practising in British Columbia at the time the complaint was resolved, signed an agreement to review the *Dental Recordkeeping Guidelines* and to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses as a condition of his return to practice in the province.
File 62	**Complaint** A patient complained that the dentist was not available to provide post-surgical care for the severe discomfort she experienced after receiving a partial upper denture. **Investigation** The dentist's office did not make a follow-up call to the patient after surgery, and the patient said that the dentist was not available to adjust the partial upper denture for her over the three-day weekend that followed. The patient sought treatment elsewhere because she was in severe discomfort, which included vomiting and gagging. The dentist told CDSBC Investigators he felt bad about what the patient experienced. He said that his contact information was on the office's answering machine and that he would have been available to help the patient over the weekend had she called. He noted that discomfort is

	common after this type of procedure and felt that he would have been able to resolve her concerns. CDSBC Investigators were concerned about the lack of post-surgical follow-up, as well as the dentist's delay in responding to the complaint. **Resolution** The dentist signed an agreement to respond promptly to his patients, colleagues, and CDSBC, and to be more proactive in post-surgical follow-ups with patients.
File 63	**Complaint** A patient complained of ongoing tooth sensitivity after the dentist replaced six of her fillings with composite material. **Investigation** The patient was aware of the risk of tooth sensitivity when she chose the composite option, but chose it for aesthetic reasons. The fillings were replaced over two appointments. After the first appointment, the patient returned three times for bite adjustments to deal with discomfort and pain when chewing. The adjustments provided only temporary relief. Despite the unresolved discomfort, they proceeded with the second appointment. When the patient returned in discomfort a month later, the dentist made further adjustments and removed two fillings (replacing them with temporary fillings). After a small improvement, the symptoms returned; at that point the patient chose to see another dentist. CDSBC Investigators found that the dentist took reasonable and well-intentioned steps to resolve the patient's post-operative problems. While the patient confirmed that she consented to the treatment, the records provided by the dentist were inadequate and did not capture this discussion, and did not include any diagnosis or treatment planning notes. **Resolution** The dentist signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course.

File 64	**Complaint** The parents of a patient complained about the orthodontic care provided by Dentist A after they learned that they would have to pay for further orthodontic treatment to correct a tooth that was not properly aligned in the initial treatment. **Investigation** Dentist A retired and Dentist B took over the practice and became responsible for monitoring the patient. When the patient returned to the practice in deteriorated oral health, Dentist B noted that one tooth had not been properly aligned during the initial treatment so he recommended additional orthodontic treatment. Dentist A believed that a good result was achieved for the patient at the end of the initial treatment; however, CDSBC Investigators felt that he could have done more to better position the tooth. Dentist A said that he believed the risks of attempting to reposition the tooth outweighed the benefits, and thought that the problem was caused by the patient not wearing the retainer he had provided. The patient's parents took exception to the dentist blaming their daughter for the tooth not being aligned. **Resolution** Because Dentist A had retired and was no longer practising, no action was taken. However, he was advised that he would be required to take a remedial course if he ever wished to reapply to practise.
File 65	**Complaint** A mother complained on behalf of her teenaged daughter that the dentist failed to diagnose and treat a large cavity that caused her pain. **Investigation** The teenaged patient came to the dentist complaining of pain in the area of her lower wisdom tooth. An X-ray showed no sign of infection in the wisdom teeth, so the dentist recommended they be monitored. The dentist said she told the patient about a large cavity on a nearby tooth that needed root canal-treatment and a crown. The dentist did not record this discussion in the patient chart or follow up with the patient's mother, who did not accompany her daughter to dental appointments. The dentist was unaware that the patient's mother

	requested a copy of the X-ray from the dental office staff and took it to an oral surgeon who removed the patient's wisdom teeth. Later, the patient returned to the dentist still complaining of pain. The dentist root canal-treated the tooth earlier discussed, which resolved the patient's pain. CDSBC Investigators found that the records adequately documented the treatment provided, but did not include any information about diagnosis, treatment planning, and informed consent discussions with the patient or follow up with the patient's mother. **Resolution** The dentist signed an agreement to improve her office's follow-up protocols, review the *Dental Recordkeeping Guidelines*, and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 66	**This complaint was addressed as a health file.**
File 67	**Complaint** A patient complained about an extensive treatment plan she received from the dentist at a new patient examination after a previous dentist provided a much more conservative treatment plan. **Investigation** The patient had seen a different dentist a year earlier and no concerns were identified, so she was surprised by her new dentist's treatment plan, which included dozens of fillings and several root canal treatments. The dentist told CDSBC Investigators that this was a proactive approach based on a worst-case scenario; however, the patient said he did not explain this until after she told him she had sought a second opinion. When CDSBC Investigators reviewed the patient records with the dentist, he was unable to identify the areas of decay on many of the teeth he had included in the treatment plan. He was also unable to support the diagnosis for the root canal treatment he had recommended. The complaint raised concerns about the dentist's X-ray interpretation, diagnosis and treatment planning.

	Resolution The dentist signed an agreement to mentorship and monitoring. He also agreed not to perform any invasive dental procedures except under the supervision of a dentist approved by CDSBC.
File 68	**Complaint** A patient complained that the dentist did not explain her complex treatment plan for full reconstruction work or its costs. She also felt that the dentist was unable to address her concerns when complications arose. **Investigation** The dentist told CDSBC Investigators that he believed the patient understood and agreed to the treatment, but that she insisted on a type of prosthesis that was five times more expensive than the original cost estimate he provided. The dentist said he tried to address the patient's concerns during treatment, but acknowledged the patient/dentist relationship deteriorated to the point that he refunded her deposit and suggested she see another dentist. The patient was upset that she would now require more expensive care from a specialist and felt that after two years of treatment she was in a worse position than when she started. The dentist said he also offered to pay for her to see a specialist for treatment. The investigation raised concerns about the dentist's competency in providing complex restorative treatment, as well as recordkeeping, X-ray interpretation, ethics, and patient communication. **Resolution** The dentist agreed not to perform any invasive dental procedures on a patient except under the supervision of a CDSBC-approved dentist, and signed an agreement to mentorship and monitoring.
File 69	**Complaint** A patient complained that the dentist did not give her sufficient information for her to provide full informed consent to treatment and costs, and that the dentist harassed her by showing up at her place of employment to serve her with a Small Claims Court notice.

	Investigation The long-time patient saw the dentist and requested to have her old amalgam fillings replaced before her dental insurance plan coverage ended the following month. She signed a general consent form confirming she would be responsible for any costs not covered by the insurer, but said she believed that most, if not all, would be covered. The patient said she would not have proceeded if she had known what the final cost would be. The dentist said there was no time to obtain pre-authorization from the insurer because of the request to complete the treatment before the insurance ended. The dentist's records were inadequate and did not include a written treatment plan, cost estimate, or any notations of informed consent discussions. The dentist said that while he had served the patient with a Small Claims Court notice, he did not feel he had behaved inappropriately in doing so. **Resolution** The dentist was advised that it would have been better to mail the court documents rather than deliver them at the patient's place of work. He signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 70	**Complaint** A patient complained that the dentist failed to diagnose decay in a tooth that later caused her pain and required root canal treatment. **Investigation** The dentist told CDSBC Investigators that he did in fact diagnose the decay at the new patient exam and discussed various treatment options with the patient, including root canal treatment, removing the tooth, or monitoring it. Because the patient was not experiencing any symptoms or pain, he said she agreed with the option to take no action and to monitor the tooth. When the patient returned months later in pain, she was seen by another dentist in the office, who confirmed the decay and recommended she see a specialist in root canal treatment. The patient later met with the first dentist to discuss her concern and he offered to pay for the required

	treatment within 90 days. The patient said that he failed to keep this promise when she submitted her two receipts; however, the office said that she had only paid a deposit to the specialist, and they would not reimburse her until she provided confirmation that she had undergone the procedure. The dentist's records were inadequate and did not contain sufficient detail about what was discussed with the patient at her first visit to support his explanation. **Resolution** The dentist has since moved to another province and is no longer a registrant of CDSBC. Should he ever wish to return to practice in BC, the Inquiry Committee required that the dentist review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course.
File 71	**Complaint** A son complained that the dentist cut his elderly mother's tongue during an appointment, and questioned whether her subsequent oral cancer diagnosis was linked to the injury. **Investigation** A week after the appointment, the patient's son called to report that his mother's tongue was sore. The dentist suggested that she come back in to the practice. The patient refused to return and consulted another dentist who referred her to a specialist who discovered a tumour on her tongue. The tumour was in a hard-to-see area and matched the colour of the healthy surrounding tissue. The specialist also noted that this kind of tumour grows from the inside out making it difficult to detect in the early stages. The son questioned whether the dentist's treatment was linked to the cancer diagnosis. The dentist told CDSBC Investigators that she did not cut the patient's tongue during treatment or detect anything unusual during her oral examination. There was no evidence to suggest any link between the treatment and the patient's subsequent cancer diagnosis; however, the investigation did find that the dentist's records did not contain sufficient detail to meet the expected recordkeeping standards.

	Resolution The dentist signed an agreement to review the *Dental Recordkeeping Guidelines*, take CDSBC's *Dental Recordkeeping* course, and undergo a chart review.
File 72	**Complaint** A patient complained that the dentist's lack of research before using a new anaesthetic resulted in her suffering a severe allergic reaction requiring hospitalization, and that the dentist did not follow up with her after the incident. **Investigation** The patient had been treated by the dentist before and he was aware of her allergies to penicillin, morphine and sulphites. The dentist did not dispute the events as described by the patient, saying that he had used a new type of anaesthetic because he wanted it to last throughout the treatment. He assumed that the chance of an allergic reaction was remote given that the patient had previously tolerated other anaesthetics that contained the same chemical compound. He acknowledged that he should not have made this assumption. The dentist said that he did follow up later that same day, and that his office also called the patient twice more, but there was no response. The patient said she did not receive these calls, although they are recorded in the patient chart. **Resolution** The dentist confirmed that he has implemented new office protocols to prevent this from happening again and signed an agreement to thoroughly research any drug administered or prescribed to a patient with a known allergy.
File 73	**Complaint** A patient complained that she was in continued pain after the dentist provided root canal treatment, which was later found to be incomplete. **Investigation** The patient returned to see the dentist several times after the root canal treatment because of ongoing discomfort and pain. The dentist thought that the source was a nearby tooth and was related to the patient's grinding habit, so they agreed to monitor the second tooth.

	The patient sought a second opinion from a specialist, who indicated that the root canal treatment on the original tooth was inadequate and should be redone. CDSBC Investigators reviewed the dentist's records and found that he had failed to confirm the initial diagnosis for root canal treatment by not taking an X-ray that showed the root of the tooth. In general, the patient chart lacked detail and did not refer to the diagnostic tests undertaken or to a discussion of treatment options with the patient. This raised concerns about informed consent, recordkeeping, and root canal treatment diagnosis and treatment planning. **Resolution** The dentist signed an agreement to take courses to improve his root canal treatment, review the *Dental Recordkeeping Guidelines*, take CDSBC's *Dental Recordkeeping* course, and undergo monitoring.
File 74 and File 75	**Complaint** A patient complained after her corneas were scratched during a permanent makeup cosmetic procedure done by a certified dental assistant (CDA) in a dentist's office. The cosmetic services were listed on the dentist's website, which the patient felt made the business trustworthy. **Investigation** The dentist confirmed that she rented office space to her CDA, who is also a certified cosmetic technician, on weeknights and Saturdays when the dental office is closed. The CDA used the space to run her cosmetic business. The cosmetic services offered by the CDA were not affiliated with the dental practice but were listed on the dentist's website. During a cosmetic procedure for permanent eyeliner, the patient's corneas were scratched, causing traumatic symptoms that affected her vision in both eyes. She said she felt that because the cosmetic services had been advertised on the dentist's website, a certain credibility was implied. The dentist and the CDA agreed that it could be confusing to the public to list these services on the dentist's website as they were not affiliated with the dental practice.

	Resolution Both the dentist and the CDA confirmed that the cosmetic services business had a separate telephone number, business license and liability insurance. The dentist signed an agreement to remove references to the cosmetic services from her website and to ensure that the public is aware that they are separate and distinct businesses. The CDA signed an agreement that the cosmetic services business would remain separate and distinct from her practice as a CDA.
File 76	**Complaint** A patient complained when his tooth fractured just a few months after being root canal treated by the dentist. **Investigation** The patient came to the dentist for emergency root canal treatment on a tooth. The new patient examination conducted by the dentist revealed the need for an extensive treatment plan. The patient consented to the treatment plan and made an appointment to begin the restorative work. At the next appointment, the scheduled work was deferred in favour of root canal treatment on two other teeth that were causing the patient discomfort. The dentist recommended crowns for the teeth that had received root canals and sent pre-approvals to the insurer; however, the patient declined the crowns in favour of proceeding with the original restorative treatment plan first. The remaining work was completed. When one of the treated teeth fractured a few months later, the dentist removed the broken piece and explained the treatment options. The dentist said the dentist-patient relationship deteriorated when the patient wanted the dentist to crown the teeth free of charge. The dentist put a temporary crown on the tooth, referred the patient to a specialist, and dismissed him as a patient. The investigation found that the work was done well and that the records were extensive and fully supported the treatment proposed. A recurring charting error (incorrect tooth number) and an issue with the procedure codes being used for billing were noted during the investigation.

	Resolution The dentist took steps to remedy the billing issues with his office manager, who was responsible for billing, and agreed to undergo a chart review to confirm that the appropriate codes were being used.
File 77	**Complaint** The patient complained about the quality of root canal treatment provided by the dentist. She said that the dentist proceeded despite her mouth not being completely frozen by the anaesthetic, that he left a file tip in one of her tooth canals, and that he did not provide appropriate follow-up care. **Investigation** The dentist told CDSBC Investigators that while the patient required extra anaesthetic before the root canal treatment, he would not have proceeded if he had known that she was not completely frozen. He confirmed that the root canals in the tooth being treated were calcified and that a file tip separated in the canal during treatment (this is a known risk). He said he advised the patient of the separated file immediately. He told the patient to expect some discomfort after the procedure, but agreed he could have suggested that she take pain medication and informed her of how he could be reached over the weekend. The patient returned in pain a few days after the treatment and the dentist recommended that she see a specialist. She declined because of the cost and opted to have the tooth extracted instead. CDSBC Investigators were concerned that the dentist took on this potentially complicated case (due to the calcified canals) rather than referring it to an endodontist. **Resolution** The dentist signed an agreement to address the concerns by taking a root canal treatment diagnosis and treatment planning course and CDSBC's *Avoiding Complaints* course. He also agreed to advise patients that his emergency contact information is on the office's answering machine.
File 78	**Complaint** A patient complained after he experienced unresolved paresthesia (extended numbness and prickling/burning sensation) after two separate treatments provided by the dentist several years apart.

	Investigation The patient first experienced paresthesia after the dentist placed an implant. The symptoms seemed to resolve over time, but returned seven years later after the dentist provided several restorations. The dentist's reports and records confirmed to CDSBC Investigators that the paresthesia was a result of the implant procedure. The dentist said that he had used a longer implant to ensure stability and durability because of the patient's strong bite. The dentist noted that the standards for implant placement had changed considerably since that time, and that he would not have proceeded with treatment in the same way today. He has since taken a series of courses to improve his skills in implant placement and crown design. CDSBC Investigators found that the records were lacking in detail and did not note informed consent discussions. The dentist admitted that his recordkeeping protocols were lacking at the time, but confirmed that he has since taken CDSBC's *Dental Recordkeeping* course, both online and in person, and has made changes to his recordkeeping protocols. The dentist agreed with CDSBC Investigators that the sensations the patient was experiencing suggested that the nerve was intact. He advised the patient to consult an oral surgeon about the possibility of reversing the condition by having the implant removed. **Resolution** The dentist signed an agreement acknowledging the concerns arising from this complaint and confirming the courses that he had proactively taken to address them.
File 79	This file required public notification. Read the publication notice: Anonymous Certified Dental Assistant (CDA) >>
File 80	**Complaint** A patient complained that the dentist proceeded with an extensive treatment plan without his consent. The patient said he had told the dentist that due to a divorce he could not afford any treatment not covered by his plan. The patient claimed that he did consent to have one tooth

	crowned, but not to root canal treatment, and additional crowns and bridgework that resulted in a $3,000 bill. **Investigation** The dentist claimed that the patient consented to the treatment and understood what the cost would be. Although the dentist said that he had addressed the patient's cost concerns by offering that his portion of the cost could be paid in instalments, CDSBC Investigators found no record of the reported discussions, and no signed treatment plan or consent form. CDSBC Investigators reviewed the patient X-rays and found they did not support the dentist's diagnosis, which raised additional concerns about the dentist's X-ray interpretation and root canal treatment diagnosis. **Resolution** The dentist signed an agreement for a remedial plan that included taking courses in the areas of X-ray interpretation, root canal treatment diagnosis and treatment planning, and informed consent. He also agreed to monitoring and chart review.
File 81	**Complaint** A dentist wrote a research article for a local newspaper that contained controversial and unverifiable opinions about the disadvantages of dentures. As part of the article, the dentist listed credentials for himself that are prohibited for use on promotional materials by CDSBC Bylaws because they are not obtained through an accredited program. **Investigation** Regarding the merits of the article, the dentist provided CDSBC with the research and scientific evidence that he used. CDSBC Investigators reminded the dentist that the bylaws (in place at the time) do not permit him to reference credentials not obtained through accredited programs in his advertising. He told CDSBC Investigators that he refused to remove them because in 2005 he had been told by the College that they were permitted. He did not recognize the subsequent direction of the Ethics Committee as valid, and refused to sign an agreement to abide by CDSBC's Bylaws and guidelines for promotional activities.

	The matter was referred to a panel of the Inquiry Committee. The chair of the panel had a discussion with the dentist about the appropriate forums to display his credentials, but the dentist still would not sign an agreement. **Resolution** While the Inquiry Committee Panel was satisfied that no risk was posed to the public because of the article, it told the dentist to cite his sources clearly when authoring articles in the future to ensure that the public is not misled. The chair of the panel sent a letter to the dentist clarifying the remaining concerns and stating the expectation that he abide by the bylaws and guidelines for promotional activities as they currently stand.
File 82	**Complaint** CDSBC opened an investigation into the quality of root canal treatment provided by the dentist based on concerns that were noted during a separate investigation. **Investigation** CDSBC received opinions from two endodontists – one chosen by the College and one chosen by the dentist. Both specialists reviewed the X-rays and the patient's tooth and agreed that one canal was underfilled and another was overfilled, and the tooth would require re-treatment. **Resolution** The dentist signed an agreement to improve her root canal treatment skills by taking an endodontics course or enrolling in a CDSBC-approved clinical study club. She also agreed to monitoring and a chart review to assess her root canal treatments.
File 83	**Complaint** A complaint file was opened when, through the course of a separate investigation, CDSBC discovered that the dentist's X-rays were not of diagnostic quality. The dentist also failed to inform a patient of three existing cavities. **Investigation** The dentist explained that he saw the cavities and decided to monitor those areas, but he did not advise the patient of this. He confirmed that he has since switched to digital X-rays that are of diagnostic quality.

	Resolution The dentist signed an agreement to fully inform his patients of their oral health status and treatment options in future, even if no treatment is recommended.
File 84	**Complaint** A patient complained that her dental health had deteriorated under the care of her former dentist after her new dentist diagnosed a number of cavities and failing restorations that she claimed the original dentist had not told her about. **Investigation** The dentist's records showed that he had, in fact, diagnosed the same issues and recommended the same treatment to the patient that her new dentist had proposed. The dentist's records confirmed that the patient often refused X-rays and deferred recommended exams or treatments; however, his records were lacking in other areas. The patient told CDSBC Investigators that the dentist had never used the word "cavity," instead telling her that there was "softness" in her teeth. She said that she would not have hesitated to undergo treatment had he used "cavity" to convey the seriousness of the issue. **Resolution** The dentist acknowledged the need to be clear with his patients so that they can make informed decisions. He signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and attend CDSBC's *Avoiding Complaints* presentation.
File 85	**Complaint** Dentist A complained that Dentist B gave his patient a negative second opinion about her current treatment plan, without consulting with her dental care providers or obtaining dental records. Based on Dentist B's opinion, the patient demanded a refund from Dentist A, sought treatment elsewhere, and complained to the College. **Investigation** The patient was frustrated by an ongoing treatment plan that included replacing her bridge for the third time. She asked Dentist B for a second opinion about other treatment options. Dentist B examined her but did not review her records or contact Dentist A before suggesting that she reconsider the treatment plan since the bridge had already failed twice.

	Because it seemed to be a complex case, Dentist B also suggested she consult a prosthodontist. Dentist B told CDSBC Investigators that he intended his opinion to be objective and did not feel that he was critical of the patient's existing dental work. He said he did not tell her to ask for a refund from Dentist A. Despite this intent, it was clear to CDSBC Investigators that the patient interpreted Dentist B's second opinion to unfairly reflect negatively on Dentist A. As a result, she abandoned the treatment before it was complete and filed a complaint. **Resolution** Dentist B signed an agreement to consult with a patient's other dentist before providing a second opinion.
File 86	**Complaint** A patient complained about her dental bridge, which had to be replaced three times. **Investigation** The dentist told CDSBC Investigators that he had taken over the patient's care when her regular dentist went on medical leave. He followed the existing treatment plan and replaced the bridge. He failed to independently assess why the original bridge failed, and he did not take pre-treatment study models, or discuss other treatment options with the patient. The records showed that this was a complex case, but there were no notes about consulting with a specialist. The patient then sought a second opinion and continued her treatment with a prosthodontist. **Resolution** The dentist signed an agreement to take a treatment planning course for complex prosthodontic cases. The dentist also recognized that he has an obligation to assess the patient and the existing plan and apply professional judgment as to its continued efficacy. The dentist confirmed that the patient received a refund for her dental costs.

File 87	**Complaint** A health authority raised a number of concerns about the dentist's infection control procedures at his dental practices in BC and Alberta. **Investigation** The dentist informed CDSBC that he had sold his BC dental clinic and was no longer practising dentistry for health reasons. **Resolution** The dentist signed an undertaking confirming his withdrawal from practice and promising that he would seek the College's consent before applying for reinstatement. If he applies for reinstatement, he will need to sign an agreement with CDSBC to address the serious infection control concerns and agree to monitoring. The College liaised with relevant health authorities to assess and manage potential risk from infection control concerns
File 88	**Complaint** A patient complained that the dentist extracted the wrong tooth during an emergency visit to his dental office **Investigation** The patient was in pain and saw the dentist for an emergency visit. The dentist diagnosed the source of her pain to be a tooth that had previously received root canal treatment. He did not feel comfortable re-treating the tooth because the X-ray did not reveal any obvious problems with the tooth. Instead, the dentist referred the patient to an endodontist. The patient's pain worsened and she returned for a second emergency visit the next day. The dentist initially agreed to re-treat the tooth, but because the patient experienced extreme pain during treatment, he instead extracted the tooth with her consent. The patient experienced post-operative pain and alleged that the dentist had extracted the wrong tooth. The records confirmed to CDSBC Investigators that the dentist extracted the correct tooth. However, he should not have allowed the patient to dictate the course of treatment, particularly after he had initially told her he was not comfortable doing so, and because of a concern that the X-ray was not of diagnostic quality.

	CDSBC Investigators recognized the challenges presented by the emergency situation, but were concerned that no other treatment options were discussed, including the option of referring the patient to the hospital for more effective pain management until she could be see a specialist. **Resolution** The dentist signed an agreement to inform patients of all treatment options available and to ensure all X-rays are of diagnostic quality.
File 89	**Complaint** An adult patient and his mother complained that the dentist discharged him while he was still bleeding after having his four wisdom teeth extracted, and that the dentist did not respond to emergency calls when the bleeding worsened. **Investigation** The dentist told CDSBC Investigators that the surgery was done according to the patient's initial consultation with another dentist. He said that there were no complications and the patient was not actively bleeding at the time he was discharged, though he noted minor bleeding is not unusual. The patient received written and verbal post-operative care instructions from the dentist and the certified dental assistant. When the bleeding worsened, the patient went to the hospital where the on-call dentist determined that a loose suture caused the bleeding. The treating dentist said he had not received an emergency call. When he learned the next day that the patient had been hospitalized, he immediately contacted the patient's mother. She declined to bring the patient in for a follow-up examination. CDSBC Investigators found that the treating dentist's records did not include any informed consent discussions. He said that the referring dentist usually provides a signed consent form, but there was no record of it. This information should have been confirmed prior to treatment. **Resolution** The dentist was advised not to rely on the referring dentist for patient consent and was reminded that the diagnosis and consent should be discussed prior to treatment and noted in the patient chart.

	The dentist signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines*, and take the *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 90	**Complaint** CDSBC opened an investigation into a certified dental assistant's (CDA's) conduct after she was the subject of two complaints in two years. **Investigation** CDSBC met with the CDA to discuss ways she could improve her interpersonal relationships to avoid complaints in the future. She acknowledged that her confrontational communication style often caused conflicts to escalate. She accepted a recommended list of communications courses, but demonstrated a lack of insight into the impact of her behaviour and a lack of respect for CDSBC as her regulator. **Resolution** The CDA received a letter expressing the concerns about her conduct and apparent lack of insight. She remained certified, but was no longer working as a CDA and confirmed that she did not intend to return to the profession.
File 91	**Complaint** A mother complained on behalf of her daughter after the dentist nicked her cheek during treatment and did not acknowledge or immediately apologize for the incident. **Investigation** The dentist agreed that the hand piece had slipped during the treatment, but said that he did not realized the patient's cheek had been cut. The photographs provided by the complainant showed a very obvious nick in her cheek that was consistent with a burr injury. The dentist said he has since apologized to the patient and her mother, and arranged to have her referred to a dermatologist. **Resolution** The dentist sent a letter of apology to his patient and her mother. He also signed an agreement to inform patients right away when things go wrong, to provide the best care for his patients, and to treat them with courtesy and respect.

File 92	**Complaint** A patient complained that the dentist had been too rough during a cleaning appointment after he experienced prolonged tooth sensitivity and bleeding from his gums. **Investigation** The new patient saw the dentist for a check-up and cleaning appointment. He had not been seen by a dentist in the previous two years. The dentist's examination revealed poor oral hygiene including swollen gums, plaque, and tartar build-up. During the cleaning, the dentist asked whether the patient had any medical conditions that might explain the bleeding from his gums. The patient said he had no such medical conditions. After treatment, the dentist warned the patient that he may experience some discomfort. He recommended the patient come back in 10 days, but he did not return. CDSBC Investigators reviewed a photo of the patient's gums that showed that they were very red and swollen, and did not look like healthy tissue that had just been cleaned. It seemed that the patient's poor oral hygiene during the preceding two years was a contributing factor to his experience. The dentist's records documented his interaction with the patient, but CDSBC Investigators were concerned that dentist had the patient sign a generic consent form before being examined and any treatment needs identified. Consent has to be specific to the diagnosis and treatment chosen after all options and costs/benefits have been discussed. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* and *Dental Recordkeeping* courses to improve his protocols in these areas.
File 93	**Complaint** A patient's father complained about the dentist's lack of care and concern when his four-year-old son swallowed a dental burr during treatment. **Investigation** As two teeth were being filled, the patient suddenly bit down, dislodging the burr from the dentist's handpiece. The certified dental assistant tried

	unsuccessfully to retrieve it using a suction tool. The dentist sat the patient up. Because he was not coughing and had no breathing difficulties, the dentist believed the burr had been swallowed and would pass within a day or two. A few hours later, the boy was taken to the emergency ward with stomach pain. An X-ray revealed the lodged burr. Another X-ray was taken a few days later to confirm that the burr had passed through his digestive system. The dentist followed up with the family after the incident and then again to apologize after hearing about the hospital visit. The dentist was advised by CDSBC Investigators that he should have immediately referred the patient to the hospital for X-rays to confirm the burr had not been inhaled into the lungs. Concerns were also raised in that the dentist did not take any pre-treatment X-rays or consider referring the patient to a pediatric specialist. **Resolution** The dentist signed an agreement to take a number of remedial courses to address these concerns and to undergo a chart review.
File 94	**Complaint** CDSBC opened an investigation after a pharmacist reported that a dentist was self-prescribing multiple medications. **Investigation** BC's pharmacy database confirmed the dentist's self-prescriptions. The dentist explained to CDSBC Investigators that his physician had initially prescribed the medications for him five years ago, and he thought that he could self-prescribe as long as the drug was not restricted. **Resolution** The dentist was reminded that dentists may only prescribe drugs to patients in connection with dental treatment and signed an agreement not to self-prescribe.
File 95	**Complaint** Patients complained to the College that Dentist A was encouraging them to file complaints with the College against Dentist B, their former dentist and the now-retired owner of the dental practice that Dentist A had

	recently taken over. The College opened this complaint file to investigate Dentist A's actions. **Investigation** Dentist A confirmed that he had directly expressed concerns to some patients about the quality of care that they had received under Dentist B. He did not contact Dentist B directly to discuss his concerns with him. **Resolution** Dentist A signed an agreement to refrain from making critical remarks to patients about treatment received from another dentist without knowing the facts, and agreed that in the future he would consult the other dentist directly about any concerns. If concerns are not resolved after knowing all the facts, a referral to the College complaint resolution process may then be the most appropriate route to follow.