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

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

CDSBC | College of Dental Surgeons of British Columbia

Complaint Summaries

2015/16

Complaints: The Year 2015/16 in Review

The College of Dental Surgeons of BC (referred to below as CDSBC or "the College") closed 326 complaints for the fiscal year ending February 29, 2016:

- 64% were closed without any formal action required against the registrant (dentist, certified dental assistant, or dental therapist).
- 35% were closed on the basis of the registrant's agreement to take steps to address concerns identified during the investigation.
- 1% were referred to discipline.

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.
- Study club: a hands on, peer reviewed mentorship and learning group.

File 1	**Complaint** The parents of a teenaged patient complained about the dentist's rationale for a lengthy and expensive proposed orthodontic treatment after a specialist provided treatment using a more conventional (and less expensive) treatment plan that achieved a good result. **Investigation** The patient was referred to the dentist for an orthodontic consultation by the patient's regular dentist. The patient's parents told CDSBC Investigators that they presumed the dentist being referred to was a certified specialist, but this was not the case. During the consultation, which the parents attended, the dentist obtained diagnostic records including a CBCT Scan. The dentist advised the parents that their son's face was not forming correctly and that he would require major intervention. The dentist proposed a treatment plan that would last over four years and cost about $20,000. The patient's parents sought a second opinion from a certified specialist in orthodontics. The specialist recommended a conventional orthodontic treatment plan. The patient and his parents accepted the plan and the specialist proceeded. Post-treatment records provided to CDSBC Investigators showed that the specialist achieved a good orthodontic result. The positive results of this conventional approach, which cost much less than the earlier proposal, caused the parents to question the rationale for the first treatment plan proposed and they reported the matter to the College. The dentist told CDSBC Investigators that he had outlined an extensive treatment plan to address the patient's postural imbalance, difficulty with standing, and noticeable displacement of his neck, torso and pelvis. CDSBC Investigators found that the records provided by the dentist did not support the treatment plan. This raised concerns about informed consent and diagnosis and treatment planning. The dentist insisted his treatment plan was appropriate and the matter was referred to a Panel of the Inquiry Committee. The Panel asked for a random chart review, the result of which revealed a pattern of problems relating to the dentist's orthodontic diagnosis and treatment planning and orthodontic treatment.

	Resolution The dentist signed an agreement to receive mentorship covering orthodontic diagnosis and treatment planning and orthodontic treatment, followed by monitoring and chart reviews. He also agreed to join an orthodontic study club, through which hands-on, peer reviewed training is offered.
File 2	**Complaint** A patient complained that the dentist was rude and unprofessional, as he left the operatory for half an hour to take a phone call during root canal treatment. The patient also complained about the quality of treatment, after she experienced post-operative pain. The pain was not relieved until a specialist re-treated the tooth, identifying a canal that was missed by the dentist. **Investigation** The dentist told CDSBC Investigators that he saw the patient for emergency root canal treatment for the tooth. He said that he will sometimes leave the operatory to take a call while a tooth is being irrigated (about five minutes). In this case, he denied he was gone for more than a few minutes and noted that a CDA was present at all times. The dentist said that he was not aware that the patient was in discomfort, although he knew she did not like the rubber dam or the bite block. In consideration of this, the dentist gave the patient a 50% discount as a professional courtesy. The dentist did not see the patient again and was unaware of her post-operative symptoms or that she was later referred to a specialist for treatment. The dentist said the X-rays he reviewed did not show evidence of a second canal, nor did he find one during the treatment itself. CDSBC Investigators found that the dentist's recordkeeping did not meet the expected standards, as the patient's condition on presentation was not noted, nor was the diagnosis or any informed consent discussions. The dentist explained that this was due in part to the dissolution of his business arrangement which was a very stressful time in the office. The dentist told CDSBC Investigators that he did discuss the treatment with the patient beforehand. **Resolution** The dentist signed an agreement that included mentoring and monitoring to address the recordkeeping, informed consent, and endodontic diagnosis and treatment concerns.

File 3	**Complaint** Three members of a family complained that the dentist was providing only limited cleanings and was taking advantage of their dental plan. **Investigation** A family of three saw the dentist for recall examinations and cleaning appointments. The family told CDSBC Investigators that the cleaning was very superficial and done in under 15 minutes. The family was concerned that the dentist billed for restorations done to remove dark stains, which they believed was part of the hygiene appointment. The patients questioned the number of restorations billed given their brief appointments. The family told CDSBC Investigators that when they raised their concerns with the dentist, she explained that the cleaning was billed but would be completed at no charge at their next appointment. The dentist told CDSBC Investigators that the cleaning appointments were billed for but not completed. She also acknowledged other concerns with her billing practices that were found during the investigation of this complaint. CDSBC Investigators determined 11 restorations and several units of scaling for each family member were billed for but did not correspond with the time required and, in some cases, did not correspond with the teeth numbers and types of restorations done. The dentist later told CDSBC Investigators that she had reimbursed the insurer for several units of scaling that was not completed because the patients did not return. **Resolution** The dentist signed an agreement to take a restorative course and spend ten half day sessions with a mentor to improve her diagnosis and treatment planning protocols. She agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and to take an ethics course. She also agreed to undergo a chart review following the completion of the courses and mentorship.
File 4	**Complaint** The parents of two children complained about the suitability of the dentist's orthodontic treatment after receiving additional opinions from two certified specialists (one of whom then began treating both children).

	Investigation The dentist explained to CDSBC Investigators the basis for his diagnosis for both children. He indicated that the parents had consented to proceed. The records provided showed that the dentist had not explained all of the treatment options to the parents, as a consequence of which they were unable to provide informed consent. CDSBC Investigators were concerned with the dentist's orthodontic diagnosis and treatment planning. They found that the treatment plan for one of the patients appeared to be a poor choice, as problems appeared after 10 months of treatment that were not present before it began. They were also concerned that the parents were not fully informed about potential problems with the use of ceramic brackets. The dentist told CDSBC Investigators that he had refunded most of the fees to the parents due to their dissatisfaction. **Resolution** The dentist signed an agreement to participate in an orthodontic study club for at least two years, and to undergo a chart review after one year.
File 5 & File 6	*These two complaints, from two different patients, were made against the same dentist and investigated over the same period of time. The resolution addresses both complaints.* **Complaint – File 5** A patient complained after she experienced post-operative symptoms including a chronic pain disorder, tooth sensitivity and a heart spasm which she attributed to the eight root canal treatments done by the dentist. The patient also complained that the treatment might not have been necessary in the first place. **Investigation – File 5** The dentist told CDSBC Investigators that he did not believe the post-operative symptoms the patient was reporting were related to the root canal treatments, even though the X-rays clearly did not support this opinion. The dentist instead suggested that the patient's facial pain may have been a side effect of the drug Lipitor. CDSBC Investigators found that while the dentist was aware of the patient's grinding habit, he had not included temporomandibular disorders (TMD) as a potential source of her discomfort.

The dentist attempted to re-treat three of the teeth, but he failed to address the patient's pain. All eight teeth were then re-treated by a specialist.

Complaint – File 6
A patient complained about five root canal treatments provided by the dentist that caused on-going pain.

Investigation – File 6
The patient told CDSBC Investigators that he experienced progressively worsening dental pain for six years following the treatment. The patient said that when he reported his symptoms to the dentist, he was assured everything was fine and that the pain would resolve on its own over time. The patient told CDSBC Investigators that since the pain did not go away he went to an endodontic specialist, who re-treated two teeth and found a canal that had been missed by the other dentist in one of them. Two days later, the patient said he was pain free.

The dentist told CDSBC Investigators that he was unaware that the patient had experienced post-operative problems until he received a report from the specialist. The dentist apologized for missing a canal in one tooth. While the missed canal was noted in the chart, it was unclear if the patient had been advised of it at the time, or if he had been offered a referral to a specialist.

Investigation – Files 5 & 6
CDSBC Investigators were concerned with whether the dentist had obtained the patients' informed consent, as it was unclear if either patient had been made aware of the risks and potential complications associated with the treatment. CDSBC Investigators also found that the X-rays taken by the dentist did not support the diagnosis made and that the chart was lacking in other important details.

Resolution – Files 5 & 6
The dentist signed an agreement to take an intensive three-day endodontic course, an X-ray interpretation course, CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to join a study club. The dentist also agreed to undergo two chart reviews after the successful completion of the courses.

File 7	**Complaint** A father complained about the orthodontic treatment his daughter received under the care of the general dentist after the appliances provided by the dentist repeatedly broke and the outcome was not as expected. The father obtained a second opinion from an orthodontic specialist who found that the treatment approach was inappropriate. **Investigation** The general dentist told CDSBC Investigators that he provided orthodontics as part of his practice and that he had taken continuing education in this area. The dentist confirmed that the patient did repeatedly have appliances break and need replacing during the year of treatment. The dentist felt that the treatment goals were attainable had he continued to be involved in her care. CDSBC Investigators reviewed the records and found concerns with the dentist's understanding of orthodontic diagnosis and treatment planning. The dentist later acknowledged his lack of foundational understanding and said he would be willing to take whatever courses were recommended to improve his skills. **Resolution** The dentist signed an agreement to receive mentorship at his practice for eight one-day sessions. The dentist also agreed to participate in a clinical orthodontic study club and to undergo chart reviews during a two year monitoring period.
File 8	**Complaint** A patient complained after being treated by an endodontic specialist for dental root amputation. The patient said that the tooth needed to be extracted a month after treatment, and that the specialist failed to manage ongoing post-operative pain and to properly address an infection, and only reluctantly prescribed antibiotics. **Investigation** The specialist saw the patient on referral from her general dentist. The specialist told CDSBC Investigators that the root of the patient's tooth appeared to have a vertical fracture, but that it was difficult to assess the extent of it without a surgical exploration. He told CDSBC Investigators that he presented the patient two options: extraction of the tooth; or exploratory surgery to determine if root amputation was possible. The patient opted for

root amputation, as she understood that if the other two roots were not cracked that the tooth could be saved.

The patient developed an abscess which needed to be treated before surgery could proceed. The specialist told CDSBC Investigators that he opened and drained the abscess and though he told the patient he would not normally prescribe antibiotics in these circumstances, he later agreed to do so after further discussion with her. The specialist told CDSBC Investigators that he saw the patient for appropriate follow-up appointments before proceeding with the surgery. During surgery, the root was amputated once it was confirmed that the other two were intact.

The specialist told CDSBC Investigators that the patient experienced normal bruising, swelling, and post-operative pain, but that the tooth had a good prognosis and he felt her symptoms would resolve over time.

Despite this, the patient cancelled her last follow-up appointment and went to an oral surgeon who extracted the tooth. Both the oral surgeon and the patient's general dentist told CDSBC Investigators that there was no sign of infection at this time and agreed that it appeared the tooth had a good prognosis. They said it was the patient who asked to have the tooth extracted, because of ongoing pain.

CDSBC Investigators found that the evidence did not suggest any concern with the specialist's diagnosis and treatment planning and that it appeared that the patient had consented to the treatment.

However, CDSBC Investigators noted that the specialist's recordkeeping needed improvement. CDSBC Investigators were also concerned that the CDA had gone over the CBCT scan with the patient to show her the root of the tooth, and that a receptionist had reportedly advised the patient that the specialist does not typically prescribe antibiotics. Discussions with patients about X-ray interpretation and antibiotic use should only be handled by the dentist/specialist.

Resolution
The specialist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to speak with his staff about tasks that are not within the scope of practice for a CDA or dental receptionist.

File 9	**Complaint** A patient complained after suffering nerve damage that led to tinnitus (ringing of the ears) and chronic facial pain following a tooth extraction by the dentist. The patient also complained that the risks and complications of treatment were not explained beforehand. **Investigation** The patient told CDSBC Investigators that the dentist had recommended the extraction of a tooth because of bone loss in the area and because the tooth could interfere with the patient's bridge if left in place. The patient said that the dentist explained that the tooth would have to be sectioned and removed in parts due to the curved roots of the tooth. The patient agreed to the treatment. During the treatment, the dentist was able to section the crown of the tooth but he was unable to remove the roots because they kept breaking. The patient was referred to an oral surgeon who noted the root tips were "intricately" involved with the nerve bundle. The root tips were extracted by the oral surgeon, but the patient suffered nerve damage which led to tinnitus and chronic facial pain. The patient told CDSBC Investigators that these potential complications were never mentioned by the dentist beforehand, and that no other treatment options were discussed. The dentist told CDSBC Investigators that he explained the potential risks to the patient and that the patient had signed a consent form to this effect. The dentist did not see the patient again after the referral to the oral surgeon. In a review of the records, CDSBC Investigators found that the extracted tooth had been shifting as the result of a missing tooth in the same area. CDSBC Investigators said it appeared that the gap between the teeth could be maintained with proper hygiene and gum care without risk to the existing bridge and without needing to remove the tooth. The dentist told CDSBC Investigators that he only provided two treatment options: extraction or to do nothing. He did not consider two surgical gum procedures suggested by CDSBC Investigators, explaining that he does not do these procedures. CDSBC Investigators found that the records included a consent form signed by the patient, but that there was no indication that the risks of the procedure were discussed with the patient, that any other treatment options were

	provided, or that the dentist recognized how close the tooth's roots were to the nerve bundle. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, join a periodontal study club, and take a comprehensive oral surgery diagnosis and treatment planning course. The dentist also agreed to undergo three chart reviews at regular intervals following successful completion of the courses.
File 10	**Complaint** A patient complained that a new bridge placed by the dentist continually fell off and that an orthotic appliance he provided was extremely painful. **Investigation** The patient had been in a car accident where she sustained significant injuries, including fractured upper bridgework, TMD issues, and other complex medical concerns including damage to her phrenic nerve that created breathing spasms. The dentist told CDSBC Investigators that the patient's case was complex and that a number of treatment options had been discussed, including implants. The dentist said that the patient did not want implants, however, and chose a less than ideal treatment option. The dentist said that he believed that the treatment plan, involving placing a new bridge, would be workable, but that the patient's failure to comply with appliance wear contributed to its eventual failure. He said this problem was compounded by the patient's decision to see several other dentists to have the bridge re-cemented when it fell out. The dentist said that these dentists expressed concern to the patient about the long span of the bridge and whether it was sufficiently supported. The dentist said he was never contacted by these dentists, but because these opinions were instead shared with the patient, she lost trust in him and the dentist/patient relationship deteriorated. The patient underwent treatment with another dentist that included implants, which stabilized her bite and resolved her pain issues. CDSBC Investigators reviewed the records and found they supported the dentist's response, as they showed that several treatment options were discussed and that the patient consented to proceed with the option of her

	choice. The dentist agreed with CDSBC Investigators that the teeth supporting the bridge were not perfect, but he felt they were still fully functional, even though the patient did need to have the bridge re-cemented several times. **Resolution** The dentist signed an agreement to participate in a mentorship with a certified prosthodontics specialist to conduct a case review of the patient's situation.
File 11	**Complaint** Parents complained on behalf of their son about orthodontic treatment provided by the dentist that later needed to be re-treated by a specialist. **Investigation** The patient's parents told CDSBC Investigators that they were assured by the dentist that she could provide orthodontic treatment with the same result as a specialist. A year after debanding, the patient required re-treatment by an orthodontist. The parents' were concerned with the additional time, trauma, and cost this would require. CDSBC Investigators reviewed the orthodontic treatment provided by the dentist and found concerns. CDSBC Investigators had to explain to the dentist that using elastic on both sides, rather than just the right side, had resulted in overtreatment on the left side. This overtreatment required further treatment to return the left teeth back to the proper position. The dentist acknowledged the concerns raised and indicated that she no longer treats comprehensive orthodontic cases in her practice, referring those cases to local orthodontists instead. **Resolution** The dentist signed an agreement to not offer comprehensive orthodontics; and should she wish to return to offering comprehensive orthodontic treatment, she agreed to undertake additional education in orthodontics approved by the College.
File 12	**Complaint** An insurer complained about a dentist's billing protocols when an audit of procedure codes found that he billed for osseous surgery (removing or shaping damaged bone around a tooth) 100 times more frequently than the next highest user of this code. The insurer also noted that the dentist submitted documentation that contained inappropriate and negative comments about the insurer, and that he had sent letters to his patients urging

	them to revoke their consent to release their charts and encouraging them to sue the insurer. **Investigation** CDSBC Investigators reviewed the dentist's billing protocols in 18 randomly selected patient charts and found concerns with how he was billing certain procedure codes and delegating some of the treatment to hygienists. The chart review also revealed several standard of care issues related to the dentist's prosthodontic treatment, and a lack of detail regarding the diagnoses related to the treatments being provided. The dentist explained his interpretation of the procedures to CDSBC Investigators and said he felt it was appropriate, and pointed out that the descriptors for one particular procedure differed between the insurer and the British Columbia Dental Association's *Fee Guide*. The dentist admitted that he had written inappropriate comments to the insurer out of frustration. He agreed to issue an apology to the insurer directly. The dentist also acknowledged that patients have a right to consent to the release of their records and that his letters to them were not appropriate. **Resolution** The dentist signed an agreement to bill accurately and only for treatment provided, and to promptly identify and address any sub-standard treatment that was noted during the investigation of the complaint. He also agreed to take an ethics course, a course in the use of the iTero system (an intraoral scanner), and to join a clinical hands-on prosthodontics study club.
File 13	**Complaint** A patient complained that she required additional care and treatment from another practitioner after seeing the dentist to have her silver amalgam fillings removed. **Investigation** The patient saw the dentist when her regular dentist declined to replace all of the patient's silver amalgam fillings. The patient told CDSBC Investigators that while an extensive treatment plan was developed, she was not given a written treatment plan nor advised of the risks associated with the treatment. She said the treatment affected her bite and caused a "traumatic occlusion (bite)." The patient said that the dentist splinted two crowns together, which caused an infection to develop as she could no longer floss that area.

	The dentist told CDSBC Investigators that the patient sought her out because she takes a holistic approach to dentistry and works very closely with her patients to develop a treatment plan. The dentist said she proposed a full pre-treatment evaluation, but because the patient was in a rush to begin, she opted not to take X-rays or make pre-treatment models. The dentist told CDSBC Investigators that she allowed the treatment to progress at a pace comfortable for the patient. She acknowledged that she did not provide the patient with a written treatment plan listing the options, and the risks and benefits of treatment. CDSBC Investigators found that the only treatment plan in the chart was handwritten by the patient. CDSBC Investigators, following a review of the records, were concerned with the dentist's diagnosis and treatment planning protocols, in addition to prosthodontics, recordkeeping and informed consent practices. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to participate in sessions with a mentor to address prosthodontic diagnosis and treatment planning, that includes a case review specific to this patient. The dentist also agreed to undergo a chart review.
File 14	**Complaint** A patient complained about the root canal treatment provided by the dentist after she later had to have the tooth re-treated and a new crown placed. **Investigation** The patient told CDSBC Investigators that she continued to experience discomfort in a tooth after root canal treatment and the placement of a crown. She said the crown did not fit and sat well above the gum line. The patient said that when she reported her concerns to the dentist, he told her not to worry, and that the discomfort would resolve when the swelling went down. The dentist told CDSBC Investigators that he saw the patient for an emergency appointment as she was in pain. The dentist said he diagnosed the need for root canal treatment followed by a crown. He said he stayed late so that the treatment could be done that day to relieve the patient's discomfort. The dentist said that the patient was afraid and emotional, which caused him to have to stop the procedure repeatedly so that she could collect

	herself. As a result, the procedure took longer and did not end until 7pm that evening, by which time the dentist was very tired. The dentist denied telling the patient that her symptoms would resolve when the tissue healed. He told CDSBC Investigators that he felt the patient's discomfort was caused by two other teeth so he referred her to an endodontic specialist for assessment. The dentist said that the specialist did not feel root canal treatment was needed on these teeth, however, and the patient said that they were not bothering her. The patient switched dental providers and ten months later saw her new dentist. The new dentist noted that the earlier root canal was not fully filled and that the crown had a gap that was allowing food to get caught and caused chronic gingivitis. This dentist recommended that the root canal treatment be redone, and a new crown placed. The patient returned to the dentist who originally treated her. He agreed to cover the cost of re-treating the root canal but not the crown, which he blamed on the lab. CDSBC Investigators reviewed the records and agreed that the root canals had not been filled properly and needed re-treatment, and that the gap on the crown was visible on the X-rays. CDSBS Investigators found that while the dentist appeared to recognize the deficiencies in treatment, he did not take responsibility for them by immediately offering to re-treat the tooth and replace the crown. **Resolution** The dentist signed an agreement to take either a hands-on educational endodontic course or to enroll in an endodontic study club. The dentist also agreed to take a hands-on educational course in prosthodontics, and to take CDSBC's *Dental Recordkeeping* course, followed by a chart review.
File 15	**Complaint** A patient complained about post-operative problems with six teeth that were given root canal treatment by the dentist over a four-year period. Her problems were eventually resolved by another dentist who re-treated many of the teeth after finding that the canals were not filled properly and that there was chronic infection.

	Investigation The dentist told CDSBC Investigators that when he first saw the patient he provided fillings for several teeth with cavities. He said that some of these teeth needed root canal treatment when symptoms developed after the restorations were placed. The dentist said that he had tried to address the post-operative symptoms that the patient had reported to him by adjusting her bite and prescribing antibiotics. The dentist told CDSBC Investigators that he was not given an opportunity to fully address the patient's concerns before she went to see another dentist. The second dentist found that the canals were not adequately filled, and a canal on one tooth was missed, along with chronic infections. All six teeth originally treated needed to be re-treated or removed. CDSBC Investigators reviewed the dentist's records and found that there was no comprehensive written treatment plan and that the endodontic diagnosis was not supported, as very little diagnostic testing was documented. **Resolution** The dentist signed an agreement to take a clinical, hands-on endodontic course as well as CDSBC's *Dental Recordkeeping* course, and to undergo a chart review upon completion of the courses.
File 16	**Complaint** A patient complained that root canal treatment provided by the dentist caused his existing bridge to fail and that the temporary bridge provided caused harm to his gum tissue. He also complained that the dentist did not provide him with a written treatment plan and estimate as requested. **Investigation** The dentist told CDSBC Investigators that despite the patient's many issues with his teeth he had resisted a comprehensive treatment plan. Instead, the patient tended to see the dentist only when treatment was urgently required. The dentist told CDSBC Investigators that the patient provided his consent for the root canal treatment. The dentist said that he did not provide a post as part of treatment because he did not want to risk damaging the patient's existing bridge, which was already showing signs of failure.

	The dentist told CDSBC Investigators that due to the patient's financial circumstances, he required all treatment to be pre-approved by his dental insurer. The dentist said that the insurer twice declined to cover the cost of replacing the bridge. The dentist said that other treatment options were then discussed with the patient at length, including implants, crowns, an overdenture (replacement teeth retained by implants), and a partial denture. The dentist told CDSBC Investigators that because this was a complex case, he presented it to his study club mentor. He said he did not refer the patient to a specialist due to the patient's cost concerns. The dentist said it was not possible to provide the patient with an immediate treatment plan and estimate because he did not wish to rush into a treatment plan prematurely. He said that diagnostic records, including a CT scan, needed to be obtained so that each treatment option could be properly assessed. CDSBC Investigators found that the records supported the dentist's comments and that it was clear he was in constant communication with the patient throughout the treatment planning. CDSBC Investigators found that the records did not reference one of the treatment consultations, and that one of the proposed treatment options was not included. The dentist acknowledged this and indicated that he now has an assistant take notes during treatment consultations to ensure sufficient detail is captured in the chart. The dentist told CDSBC Investigators that he had many lengthy discussions with the patient. Because some of them occurred in the reception area after the consultation, these discussions were often not included in the chart. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 17	**Complaint** The College opened a complaint file against the dentist as the result of reviewing a patient's records during the course of a separate investigation that involved a different dentist. The patient's records included two X-rays taken a year apart, both showing that the patient's bridge was failing and that there was a large cavity. CDSBC Investigators were concerned that there was nothing in the chart to indicate that the dentist had reviewed the X-rays or advised the patient of the concerns.

	Investigation The patient told CDSBC Investigators that he was not advised of the concerns with the bridge or the cavity. The dentist said that the patient came to him because of issues with the bridge and so they must have been aware of the concerns. CDSBC Investigators found multiple concerns with the dentist's recordkeeping: an incorrect chart entry made by the hygienist was present (meant for another patient); the first chart entry that recorded any concerns about the bridge was over two months later; and the most recent gum probing was eight years prior. **Resolution** The dentist signed an agreement that he and his staff will complete CDSBC's *Dental Recordkeeping* course.
File 18	**Complaint** A patient complained that a crown placed by the dentist repeatedly fell out, and that the last time the dentist re-cemented it, it fell out an hour later. **Investigation** The dentist told CDSBC Investigators that he had initially placed a temporary crown which did fall out a number of times. He said that because of previous treatment to the tooth he recommended placing a post, but that the patient declined because she wanted minimally invasive dentistry. CDSBC Investigators reviewed the records and found that a post was not an option that would have assisted in retaining the crown. CDSBC Investigators determined that the dentist did not have a sufficient understanding of crown preparation to ensure that they would stay in place properly. **Resolution** The dentist signed an agreement to be mentored by another dentist focusing on crown preparation to ensure proper retention, and to join a hands-on prosthodontics study club. He also agreed to undergo a chart review after a year of participation in the study club.
File 19	**Complaint** A patient complained about the dentist offering an orthodontic treatment that he was not qualified to deliver.

Investigation
The patient told CDSBC Investigators that she saw the dentist because enamel appeared to be breaking off of her front teeth. She said that the dentist recommended orthodontic treatment involving the use of Invisalign removable appliances. The patient said she agreed to treatment and that impressions were taken. She said that she was told to expect a call within a month.

The patient told CDSBC Investigators that when she did not receive a call, she began calling the dentist's office every few weeks to ask for an update. She said that none of her calls were returned. The patient said she made an appointment to see the dentist, and that at the appointment he told her the impressions needed to be redone. The patient said that she was offered a 20% discount and so she agreed to continue with treatment. The patient said that new impressions were taken, but she did not hear from the dentist again.

The patient said that she continued to place calls to the dental office but that none were returned. She said she eventually reached the receptionist who explained that there was a delay because the dentist needed to get certified to offer Invisalign. The patient went to another dentist who addressed her concern with a bonding procedure.

In meeting with CDSBC Investigators, the dentist acknowledged the patient's concerns and apologized for the delay in following up. The dentist explained that several long-term staff members had left the practice, which had an impact on efficiency. The dentist told CDSBC Investigators that he had recommended a removable aligner system for the patient and that he was qualified to provide that treatment. He also indicated that he no longer offers orthodontic treatment.

CDSBC Investigators reviewed the records and found they did not support the treatment rationale. There were no study models, X-rays, or other records normally associated with orthodontic treatment plans. The chart did confirm the patient's many phone calls and her appointment with the dentist, but no other details were noted.

Given the concerns about the dentist's orthodontic diagnosis and treatment planning, CDSBC Investigators conducted a chart review which raised further concerns about the dentist's lack of diagnostic records, and informed consent

	protocols. CDSBC Investigators were also concerned by the dentist's failure to respond to the patient and to the College's initial requests for information. **Resolution** The dentist signed an agreement to take an ethics course, and to undergo mentorship to address the concerns raised in the complaint.
File 20	**Complaint** A patient complained that the dentist did not diagnose the cause of pain in a tooth that he had previously root canal treated. The patient sought a second opinion and was advised that one canal was not filled properly and another had been missed. The second dentist re-treated the tooth and resolved the patient's symptoms. **Investigation** The dentist told CDSBC Investigators that the root canal treatment was uneventful. Five months later, the patient returned to have the tooth crowned. The dentist said that it was only after this treatment that the patient reported discomfort and pain. The dentist said he adjusted the patient's bite and it alleviated some of the pain. He said that he felt it best to wait a few weeks to see if the patient's symptoms would resolve on their own. The dentist told CDSBC Investigators that he was not advised by the patient that she went to see another dentist to have the tooth re-treated, and that he would have offered to pay for it had he known. The dentist agreed with CDSBC Investigators' findings that the X-rays showed decay on the tooth that should have been removed prior to root canal treatment. He also agreed that one of the canals had not been filled properly, that another had been missed, and that this should have been reported to the patient at the time. **Resolution** The dentist signed an agreement to take a hands-on endodontic course to improve his skills in this area.
File 21	**Complaint** A patient complained after being told by the receptionist that her tooth was going to be extracted at her next appointment, rather than root canal treated as earlier discussed with the dentist. She also complained that when she

	called to confirm the appointment, the receptionist informed her it had been cancelled. **Investigation** The dentist told CDSBC Investigators that the patient had, in fact, been scheduled to have the tooth root canal treated, and that he had performed a drain procedure on the tooth to relieve her discomfort. The dentist said he prescribed two medications to relieve the patient's pain. The dentist said that the patient returned to the office without an appointment to ask for another prescription. The dentist said that it was a very busy day and that he was booked with other patients, but he did issue a prescription. He said he asked his receptionist to tell the patient that he would not issue any further prescriptions until he examined the patient to assess whether to complete the root canal treatment or whether the tooth needed to be extracted. The dentist explained that the receptionist instead told the patient that the tooth was going to be extracted. When the patient became upset, the receptionist noted this in the chart and then canceled the patient's next appointment. The receptionist did not inform the dentist of this at the time and he only became aware of the situation when he received the complaint. The dentist said that he contacted the patient to explain the misunderstanding and invited her to return for treatment, but learned she had it completed by another dentist. CDSBC Investigators found no standard of care concerns with the diagnosis or the limited treatment done, but did find that the dentist's records needed more detail about diagnosis and treatment planning. The dentist acknowledged his obligation to ensure his staff are trained to deal with patients professionally and with empathy, even if they are upset. **Resolution** The dentist signed an agreement to take the CDSBC's *Dental Recordkeeping* course.

File 22	**Complaint** A patient complained that a bridge placed by the dentist caused her teeth to decay under it and required a costly implant-supported prosthesis to replace it. **Investigation** The patient told CDSBC Investigators that the dentist did not inform her of other treatment options, nor that the bridge was intended to be a temporary fix. She said that as a senior on a limited income, she would not have spent $7,000 on treatment only to have to take out a loan for $10,000 to cover the cost of the later treatment. The dentist told CDSBC Investigators that the treatment was not ideal but that it was what the patient wanted at the time. CDSBC Investigators found that the records provided by the dentist lacked detail, X-rays were not of diagnostic quality and there were signs of decay that should have been noted. The patient's new dentist told CDSBC Investigators that when he saw the patient about 7 months after the bridge had been placed, he noted decay, improperly sealed margins, an unsalvageable tooth, and an ill-fitting partial lower denture with visible reline, and a broken clip. CDSBC Investigators were concerned with the dentist's diagnosis and treatment planning protocols as well as recordkeeping, X-ray interpretation and technique. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, a radiographic interpretation course, and participate in a mentorship that would include a case review and evaluation of treatment planning and execution of the patient's case, followed by a chart review.
File 23	**Complaint** A dental insurance company complained about the dentist's billing irregularities after he failed to cooperate with their investigation. **Investigation** A routine audit alerted the dental insurer to billing irregularities at three clinics the dentist operates.

	The dentist provided CDSBC Investigators with a report and records acknowledging the billing problems, but indicated that he never intended to defraud the insurer. CDSBC Investigators reviewed the records and found additional concerns beyond the dentist's billing practices, including recordkeeping and prosthodontic treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and an ethics course, and to join a prosthodontic study club. He also agreed to bill only for treatment that has been provided, ensure that any treatment provided, or use of the VELscope diagnostic tool, is billed by the dentist providing the treatment or conducting the examination. The dentist also agreed to undergo a series of chart reviews.
File 24 *Also see related: File 30*	**Complaint** The father of an adult patient complained about the quality of restorative treatment the dentist provided to his son. Some of the fillings failed within a year of being placed, and a subsequent treating dentist recommended that the teeth be re-treated due to gaps between the restorations and recurrent decay. **Investigation** The dentist told CDSBC Investigators that when she saw the patient, he had cavities in teeth throughout the four quadrants of his mouth. She said that she developed a treatment plan to restore teeth in each quadrant over the course of several appointments. The dentist told CDSBC Investigators that the patient had dental anxiety and was given oral sedation prior to the treatment. The dentist said that the treatment was uneventful. She said that she received no complaints about the treatment until a year later when the patient's father received the recommendation from the patient's new dentist to re-treat a number of the restorations. The dentist told CDSBC Investigators that she agreed to re-do the work herself, but that she would not pay to have another dentist do it. She initially disagreed that the gaps and decay were related to the treatment she had provided, and instead questioned what the patient might have done in the year since she had seen him that could have caused the issues. CDSBC Investigators reviewed the records were concerned with the dentist's informed consent and recordkeeping protocols, and with the way she

	recorded the oral sedation and monitored the patient's vital signs. They were concerned with the dentist's poor composite technique and believed that it was likely the cause of the gaps and decay. CDSBC Investigators discussed these concerns with the dentist, with a plan to develop an educational program that would require the dentist to take remedial continuing education courses. However, the dentist told CDSBC Investigators that she would be retiring from the profession very soon, and that she was no longer providing any treatment, other than extractions or dentures at a low cost clinic. **Resolution** The dentist signed an agreement to resign from the practice of dentistry by a specific date, and to take continuing education courses in the areas identified should she ever wish to apply to return to practice.
File 25	**Complaint** A patient complained that the dentist should not have crowned two teeth because she had significant infection in the surrounding gums. **Investigation** The patient told CDSBC Investigators that she was initially seen by an associate dentist at the clinic and advised of the gum infection. She said that she then saw the principal dentist who told her she required two replacement crowns on the teeth where there was infection. The patient said that after treatment she was sensitive to hot and cold and felt pain when chewing with the crowned teeth. The patient told CDSBC Investigators that the dentist told her that there was nothing wrong with the crown and that her infected gums were causing the sensitivity. CDSBC Investigators reviewed the records and while there were no concerns with the crown itself, they disagreed with the dentist's decision to place the crown on the tooth, due to the level of gum infection. CDSBC Investigators saw a significant periodontal defect in the X-rays, which indicated that the tooth was a poor candidate for a crown. CDSBC Investigators also found that the dentist's records did not include information about any informed consent discussion relating to the placement of the crown in the presence of the untreated gum disease.

	Resolution The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course, an X-ray interpretation course, a prosthodontics diagnosis and treatment planning course, and to receive mentorship in this area.
File 26	**Complaint** The patient complained about intense tingling in his tooth after the dentist placed a crown on it. **Investigation** The patient told CDSBC Investigators that the crown never worked properly. He said he felt intense tingling every time food or liquid touched it. He said that the dentist told him that the tingling would settle down after a few months. The patient said the sensation never went away. Nine months later he had the tooth extracted by an oral surgeon. CDSBC Investigators reviewed the records and found that the number of X-rays taken was inadequate considering the patient had been seen at the practice for 13 years. They also reviewed records that showed the tooth was severely structurally compromised prior to the crown being placed, and that no cause for this condition was noted in the charts. In addition to the concerns with the dentist's X-ray prescription and interpretation and diagnosis and treatment planning, CDSBC Investigators were also concerned with his informed consent protocols and his diagnostic protocol for root fractures. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course, to review the UBC Faculty of Dentistry recommendations for the prescribing of radiographs and the UBC Faculty of Dentistry Management of Caries 2013/2014 publication. He also agreed to enter into a mentorship agreement for six half-day sessions to review informed consent, diagnosis and treatment planning of severely compromised teeth, periodontal diagnosis and treatment planning, and diagnostic protocol for root fractures, and to undergo a chart review after the mentorship is complete.
File 27	**Complaint** The patient complained about pain and discomfort after the dentist replaced four front teeth. He also complained that the dentist changed the treatment plan without his consent.

Investigation
The patient told CDSBC Investigators that he believed, based on the consultation that he had with the dentist, that he would be receiving standalone individual replacement teeth. The dentist provided four upper incisor (front teeth) crowns and ceramic veneers on the adjacent cuspid teeth (eye/canine teeth). The patient said that the dentist changed the treatment plan without discussing it with him and instead placed a metal backing to splint the crowned teeth together. The patient said he continued to experience pain and discomfort years after treatment and eventually saw a prosthodontist (specialist) who suggested that the original treatment plan should not have been changed to the one provided. The patient said that the specialist suggested the crowns on the front upper teeth were too thick and bulky, which was affecting his bite and causing him to clench and grind.

The dentist told CDSBC Investigators that when he first saw the patient, he had broken down front incisors and significant erosion on the lower incisors. He said the case was difficult due to the patient's deep bite, teeth grinding, and teeth that were previously root canal treated. The dentist told CDSBC Investigators that there was so little structure left to the lateral incisors after they were prepared for treatment that he was sure they would fail on their own. He said that the metal backing was the only safe option for the patient, though he did acknowledge that he did not consult the patient about his decision to splint the crowns together.

The dentist said that because the patient only attended sporadically, two years had passed before a guard was fitted for the patient to protect the porcelain crowns. The dentist said that in the following two years the patient attended hygiene appointments and that he had exposed dentin bonded due to the sensitivity he was experiencing. The dentist told CDSBC Investigators that the patient then inquired about converting the restored teeth to single unit crowns. The dentist, after consulting with his lab, told the patient that this option would not hold up to the force of his bite and his history of grinding. The dentist said he told the patient that the metal backing was still the best option.

CDSBC Investigators reviewed all of the records and information and were concerned with the dentist's recordkeeping and his diagnosis and treatment planning of prosthodontic cases related to the patient's bite.

Resolution
The dentist signed an agreement to be mentored by a prosthodontics

	specialist to conduct a review specific to this case, and take CDSBC's *Dental Recordkeeping* course.
File 28	**Complaint** A patient complained that the dentist took too long to refer her to a gum specialist. When she finally saw the specialist she learned she had severe periodontitis and was at risk of losing eight or nine teeth. **Investigation** The dentist told CDSBC Investigators that the patient's periodontal status was a concern well before he became involved in her care, but that an earlier diagnosis might not have been made because the patient refused to have X-rays taken or an examination done. When the dentist became involved in her care, she allowed X-rays to be taken, and the dentist said that he then informed the patient of her periodontal status and recommended she be referred to a specialist for further consultation. The dentist told CDSBC Investigators that he did not make the appointment for the patient but instead gave her a referral form. He admitted that no follow up was done, and the patient was not seen again until a year later. The patient's periodontal condition had further deteriorated. The dentist said that the patient was taking medication for treatment of an infectious disease at this time and he questioned whether the medication affected the gums. The dentist said that the patient was given an oral rinse and reported some improvement. The dentist told CDSBC Investigators that he did not see the patient again for another year, at which time she was diagnosed with periodontal disease and referred to a specialist once again. The patient attended this referral and was told she was at risk of losing some of her teeth due to deep pockets in the gums and the teeth being loose. The specialist proposed a new treatment plan. The dentist acknowledged to CDSBC Investigators that it would have been advisable to have followed up with the patient after the first referral was made. The dentist also acknowledged concerns identified by CDSBC Investigators related to his recordkeeping, informed consent protocols, and periodontal diagnosis and treatment planning.

	Resolution The dentist signed an agreement to take a periodontal diagnosis and treatment planning course and CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. He also agreed to follow up on referred patients and to undergo a chart review following the successful completion of the courses.
File 29	**Complaint** A patient complained about the standard of care she had received during 20 years under the care of her dentist after she obtained a second opinion that indicated she was at risk of losing some of her teeth and would require urgent treatment. **Investigation** The dentist told CDSBC Investigators that he became involved in the patient's care in 1995. He said that she had a history of a high rate of cavities, teeth grinding, and poor oral hygiene. The dentist said that he had provided many restorations for the patient over the years and that he took a conservative approach to the patient's care. He said he focused on educating the patient about better oral hygiene in an attempt to manage the high rate of persistent cavities. The dentist admitted that, with the benefit of hindsight, it would have been better to have provided the patient with a comprehensive treatment plan to ensure she understood the compromised status of her teeth. The dentist agreed that this is likely what led to the patient's surprise when she obtained a second opinion from another dentist who provided her with such a treatment plan. CDSBC Investigators found no standard of care issues regarding the quality of the dentistry done, but they were concerned with the dentist's recordkeeping and informed consent protocols. CDSBC Investigators found that the chart did not contain sufficient details of the discussions the dentist said he had with the patient about her oral health. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to develop a comprehensive treatment plan for all patients.

File 30 *Also see related: File 24*	**Complaint** A patient complained that a bridge placed by the dentist did not fit and caused infection. The patient also complained that he had to pay to have a crown replaced after it was accidentally swallowed during an appointment to re-cement it. **Investigation** The patient told CDSBC Investigators that he initially saw the dentist to have a pre-existing bridge reattached. Based on the dentist's advice, the patient said he agreed to have the supporting tooth root canal treated and a post placed to help secure the bridge. The bridge did not fit, and an infection developed within a year. The patient saw another dentist who extracted the tooth and found that the post placed by the original dentist had punctured the root. The patient felt that the dentist should be responsible for the cost of replacing the swallowed crown. The dentist met with CDSBC Investigators and denied puncturing the root of the tooth with the post. On the matter of the crown, the dentist said that the loose crown was very old and that she repeatedly advised the patient not to swallow it when it fell off, but that he swallowed it anyway. The dentist said that she offered to replace the crown, charging only the lab costs, but that the patient declined because he did not think he should have to pay anything. CDSBC Investigators reviewed the records and found concerns with the dentist's endodontic and prosthodontics treatment as well as her failure to manage the infection and place the post to prevent it from perforating the root. CDSBC Investigators were also concerned that the dentist did not take precautions after the crown was swallowed by the patient, such as arranging for him to receive a chest X-ray to confirm he had not aspirated (inhaled) the crown. CDSBC Investigators discussed these concerns with the dentist, with a plan to develop an educational program that would require the dentist to take remedial continuing education courses. However, the dentist told CDSBC Investigators that she would be retiring from the profession very soon, and that she was no longer providing any treatment, other than extractions or dentures at a low cost clinic.

	Resolution The dentist signed an agreement to resign from the practice of dentistry by a specific date and to take continuing education courses in the areas identified should she ever wish to apply to return to practice.
File 31	**Complaint** A patient complained about the dentist taking unnecessary X-rays, providing extra treatment, not obtaining his informed consent, and the payment plan. **Investigation** The patient told CDSBC Investigators that he questioned why the dentist took X-rays when his general dentist had taken some just three weeks earlier. The patient also wanted to understand the basis for extra treatment that was done during surgery while under IV sedation. The patient was concerned that he was asked to sign a consent form for that treatment when he was still recovering from the procedure. The patient was also concerned about the agreed to payment plan. The patient said that he was asked to provide post-dated cheques and that the dentist threatened to refer the account to a collections agency after one of his cheques bounced. The dentist told CDSBC Investigators that the patient was seen for a new patient examination. The dentist said that he took a full mouth series of X-rays because the patient did not tell him that he had recently seen another dentist and had X-rays taken. He said the patient had wanted an assessment of what treatment was needed, now that he had a dental plan to help pay for it. The dentist told CDSBC Investigators that an extensive treatment was needed and that he made several treatment plans, but they were not agreed to by the patient. The final treatment plan was made based on the patient's financial limitations and his request to do only what was necessary. During the course of the treatment however, additional treatment was deemed necessary and was done, which increased the costs. The patient did not dispute that the treatment was needed, but told CDSBC Investigators that because the cost was not anticipated, it created a hardship for him. The dentist told CDSBC Investigators that the patient agreed to pay $200 per month and that it is his office's policy to require post-dated cheques. The dentist said that when one cheque bounced, the patient was advised to replace it to avoid collection proceedings.

	CDSBC Investigators found that the treatment done was supported by the records and was done to the expected standards. They were concerned, however, with the dentist's recordkeeping and informed consent protocols, and with billing that did not match the treatment estimate or the chart. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to undergo a chart review upon completion of the courses. He also agreed to inform patients of treatment options, possible complications and obtain their informed consent prior to beginning a complex procedure under sedation, and agreed that chart entries and associated billing codes will accurately reflect the services provided.
File 32	**Complaint** A patient complained that the dentist was unable to resolve problems with the dentures he had made for her, that he refused to replace them, and later dismissed her as a patient. **Investigation** The patient told CDSBC Investigators that the dentist had provided complete upper and lower dentures, but that they were uncomfortable and did not fit properly. She said that this caused blisters and sores on her gums. The patient later saw another dentist who indicated that the dentures were not well made and recommended that the patient receive a full refund. The patient said she later had the dentures remade by a denturist to her satisfaction. The original dentist told CDSBC Investigators that he had given the patient the option of seeing a prosthodontist (specialist) for her dentures, but that she declined. The dentist said that the dentures were designed to compensate for adequate retention, lip posture, bite and smile line. The dentist said that he did offer a $250 refund, but that the patient declined. CDSBC Investigators reviewed the records and found concerns with the dentist's prosthodontics diagnosis and treatment planning and prosthetic evaluation. They proposed that the dentist be mentored by a specialist to conduct a case review and to focus on prosthodontics diagnosis and treatment planning. The dentist was agreeable to this; however, before the agreement could be signed, the dentist went on a leave of absence due to an unrelated health matter.

	Resolution The dentist was informed that, should he wish to return to practice, he will need to complete the education and mentorship requirements as set out in the proposed agreement.
File 33 *Also see related: File 86*	**Complaint** A patient complained that the dentist recommended and provided unnecessary treatment that caused her pain and discomfort and exhausted her insurance coverage. All of the treatment had to be redone or adjusted by another dentist to relieve the patient's pain and sensitivity. **Investigation** The patient told CDSBC Investigators that she saw the dentist to have two teeth filled with composite restoration material so that they would match her other teeth and improve her smile. The patient said that the dentist recommended additional treatment, including placing several new fillings and replacing several old ones. The patient said that all of these teeth were fine before the dentist treated them, but afterwards she experienced pain and discomfort. In every case, the treatment had to be re-done or adjusted. The patient said that while the dentist told her there would be no charge, she was billed again and her insurance limits were exhausted. The patient said that the pain and tooth sensitivity did not resolve over time and that the dentist dismissed her as a patient. The patient said that she then saw other dentists and learned that root canal treatment was now required on several of the teeth that the dentist had treated, because of multiple gaps (open margins) in restorations and deficient restorations. The patient said she could not afford to be re-treated by a new dentist until her insurance limits renewed. The dentist told CDSBC Investigators that the rationale for the treatment he provided was that there was deep decay that, in some instances, reached into the pulp of the tooth. CDSBC Investigators reviewed the X-rays, and found they did not support this rationale, raising concerns about the dentist's X-ray interpretation and diagnosis and treatment planning. CDSBC Investigators reviewed reports and records received from three of the patient's subsequent treating dentists, which confirmed that root canal

	treatment was necessary for several of the teeth treated by the dentist. The records also confirmed the gaps and deficient restorations. The dentist told CDSBC Investigators that this was an isolated incident and he voluntarily agreed to a chart review. The chart review noted many of the same concerns. **Resolution** The dentist signed an agreement to voluntarily withdraw from practice and cease providing any dentistry while undergoing a remediation program. He agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, an X-ray interpretation course, and an ethics course. He also agreed to participate in two mentorships focused on recordkeeping, informed consent, materials science, diagnosis and treatment planning, and preclinical operative and restorative treatment. The dentist also agreed to a 30 month monitoring period during which he will undergo five chart reviews following his successful completion of the courses and return to practice.
File 34	**Complaint** A patient complained that the dentist failed to deliver on his promise to pay for the costs of a specialist providing endodontic re-treatment of two teeth. **Investigation** The patient told CDSBC Investigators that root canal treatment was provided by the dentist for two teeth. A file tip separated in one tooth, while a calcified canal was not accessed by the dentist in the other. The patient said that the dentist referred her to an endodontist (specialist) and told her and the specialist that he would cover the cost of any necessary re-treatment. The patient said that the specialist's fees were expensive and that dentist declined to assist her with the costs as he had promised. CDSBC Investigators reviewed the records and found that there was no documentation of symptoms and tests to support a diagnosis for endodontic treatment. The record also does not confirm that the patient was offered a referral to an endodontist. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and an endodontic course in diagnosis and treatment planning; document all endodontic diagnostic tests; establish and document a firm diagnosis; and follow through on written and verbal promises to patients.

File 35 *Also see related: File 56*	**Complaint** Dentist A reported concerns with the treatment provided by Dentist B after he had to redo much of the treatment. **Investigation** Dentist A told CDSBC Investigators that he saw the patient, a longtime patient of Dentist B, about a failed bridge. Dentist A noted that there were gaps on the patient's crowns and several teeth had failed root canal treatment, with insufficient fill and some with lesions at the root. He had to redo much of the treatment that had been provided. Dentist B told CDSBC Investigators that while the patient had been under his care for 16 years, he was only seen sporadically, usually in emergency situations. Dentist B believed the bridge had failed due to changes in the patient's mouth as a result of his very poor oral hygiene and irregular dental care. The patient told CDSBC Investigators that he had a fear of dentists at the time which contributed to his situation, but that he believed that was not an excuse for Dentist B's lack of quality treatment, which had to be redone at considerable expense to him. CDSBC Investigators reviewed the patient's dental records and found significant concerns with the treatment provided by Dentist B. Nine of the 10 teeth that had been root canal treated did not meet the accepted standards. CDSBC Investigators found short fills, no rationale for some of the treatment, and the use of an unacceptable filling material. The crowns were over-contoured in some areas and had at the margins gaps in others. The bridge work and post placement also had large gaps. CDSBC Investigators conducted a chart review to determine if the concerns were isolated to the patient's case or part of a broader pattern of practice. Similar concerns with the dentist's fixed prosthodontics and endodontic treatment were noted in the six charts reviewed. **Resolution** Dentist B signed an agreement to undergo an extensive educational program that includes two mentorships. In the meantime, the dentist agreed to immediately use an acceptable filling material and agreed not to provide root canal treatment or fixed prosthodontics dentistry, unless under the supervision of a mentor.

	The first mentorship will focus on prosthodontic diagnosis and treatment planning, recordkeeping, informed consent and X-ray interpretation. The second mentorship will be with an endodontist and will focus on endodontic diagnosis and treatment planning, recordkeeping, and endodontic treatment. The dentist will continue to be monitored through chart reviews following completion of the mentorships.
File 36	**Complaint** The patient complained that the dentist repeatedly failed to manage her pain following removal of a tooth, placement of a dental implant and a sinus lift and bone graft **Investigation** The patient told CDSBC Investigators that she was in pain during the procedure, but that the dentist did not respond when she told him so. The dentist said that he used more anaesthetic than usual during the procedure and doubted that the patient could have been in pain. The patient said that after the procedure she had difficulty seeing out of her right eye, and had persistent pain and swelling in the face, but the dentist told her to wait until her follow-up appointment the next week. At that appointment, an infection was observed, so the dentist prescribed antibiotics and removed the implant and bone graft the next day. She said that the anaesthetic did not work and she was again in pain during the procedure, and in the days following, the pain and swelling continued and spread to the area around her eye. The dentist told her to go to the emergency room if the pain worsened. A CT scan at the hospital showed an abscess and complete blockage and bone graft material within the right sinus and she was scheduled for immediate surgery. Reports from the hospital specialist suggested that the severe inflammation from the dental procedure had caused the eye issue. CDSBC Investigators felt that the dentist should have been aware of the possibility of an orbital complication caused from local anaesthetic infiltrating the orbital branch of the facial nerve. The investigation indicated the dentist did not recognize and manage the patient's pain complaints and infection following the procedure and raised concerns with the dentist's: • informed consent protocols (provided treatments were not identified in the consent form), • recordkeeping (lacked detail, clinical findings not documented)

	• diagnosis and treatment planning, • implant surgery, • dental extraction techniques, and • patient communication. During the investigation, the patient said that she was misled into thinking that the dentist was a specialist because of the name of his facility, and would not have chosen him had she known sooner that he was not. **Resolution** The dentist signed an agreement to do a case review with a College-approved mentor, review the *Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course. The dentist was also directed to comply with the College's Bylaws regarding promotional activity by promptly changing the name of his facility so as not to confuse or mislead the public.
File 37 & File 38	**Complaint** A patient complained that Dentist A did not diagnose the source of pain in her tooth and, as a result, she had to eventually have it extracted (File 37). The patient also complained about root canal treatment provided by Dentist B, which was the source of this pain (File 38). **Investigation** Dentist B told CDSBC Investigators that when she saw the patient, the tooth was severely decayed and the dental pulp was dead, causing her pain. Dentist B also noted problems with the crown on the tooth which had created a deep cavity. Dentist B recommended root canal treatment and the patient agreed. Dentist B said that the treatment was carried out uneventfully but that she did not see the patient again, as she was instead treated by Dentist A, an associate in the same practice whose work schedule was more compatible with the patient's availability. Dentist B was unaware of the problems and did not have an opportunity to address the patient's post-operative difficulties or be further involved in her care. The patient told Dentist A about the pain in the area following the treatment, but Dentist A felt the pain was instead related to the patient's TMJ. The patient said that after repeatedly visiting Dentist A complaining of pain, she saw other dentists, two of whom were specialists, and all determined the pain stemmed from the root canal treated tooth. An endodontist found that one of the canals

	was not sufficiently filled and that there was infection. The endodontist recommended re-treatment, but took two months to send her report to Dentist A. By the time the recommendation was received, the patient was very frustrated and had already had the tooth extracted by another dentist, which resolved her pain. The dentist who extracted the tooth told CDSBC Investigators that the abscess from the tooth had traveled into the patient's maxillary sinus. The patient believed that an earlier diagnosis of the pain source could have saved her tooth. Dentist A told CDSBC Investigators that she saw the patient at appointments three and six months after the root canal treatment by Dentist B. She said that the patient reported discomfort and pain and that she referred her to a dentist knowledgeable of TMJ, as she felt this was the source of the pain. Dentist A said that he did not receive reports from the other dentists involved in the patient's care in a timely manner, so she was unable to assist the patient and provide options for treating the tooth. **Resolution** Dentist A signed an agreement acknowledging the concerns with the failure to accurately diagnose the source of the patient's pain and agreed to take a course on pain and diagnosis. The dentist also acknowledged the need to improve her communications with patients. Dentist B signed an agreement to take a hands-on root canal treatment course.
File 39	**Complaint** A patient complained about on-going pain and sensitivity after the dentist provided root canal treatment to a tooth. The patient also complained that a partial denture provided by the dentist was unusable. **Investigation** The patient told CDSBC Investigators that the tooth was still sensitive and causing pain a year after the root canal treatment. He also said that another tooth that was treated by the dentist now had pain and sensitivity, though it was fine before treatment. The patient said that he could not eat with the partial denture in, so he did not use it. CDSBC Investigators noted that it did not appear this concern was brought to the dentist's attention so that it could be addressed.

	The dentist told CDSBC Investigators that the patient was new to her practice and wanted treatment for a missing tooth. The dentist said she took four X-rays and, following an examination, advised the patient of the various treatment options to address his many dental issues. This included root canal treatment and a crown for one tooth, and a partial denture to replace the missing tooth. The dentist says she discussed each treatment option with the patient in detail and obtained pre-authorizations from his insurer. The dentist said that the patient never indicated any post-operative problems with pain or tooth sensitivity at several follow-up appointments. The patient told CDSBC Investigators that, now two years since the treatment, he has not experienced significant discomfort to warrant further treatment. He said that one of the treated teeth was extracted about a year later. CDSBC Investigators reviewed the records and found that they supported the treatment plan, but that the chart did not reference the partial denture nor confirm the basis for the diagnosis that led to the recommended treatment. The dentist acknowledged the shortcomings with her recordkeeping and agreed that more detail is necessary, including the reasons for the treatment options being recommended. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to encourage her staff to take it.
File 40	**Complaint** A patient complained that the dentist provided gum grafting that increased the pain she was in and that she later learned was unnecessary. **Investigation** The patient told CDSBC Investigators that she was referred to the dentist by her regular dentist to address a burning sensation with her gums. She said she had two gum grafting surgeries which significantly increased the pain she was experiencing. She said she was later referred to another dentist who advised her she had a medical condition and did not need to have the two surgeries done. The dentist told CDSBC Investigators that the patient consented to the surgeries. He agreed that burning is not a symptom typically associated with a periodontal (gum) condition. He said that she experienced some delayed

	healing, which he felt was due to a fingernail biting habit, but that she did fully heal. The dentist said he prescribed medication when she reported post-operative pain, and recommended she return to her regular dentist for further care. The dentist said that he later recalled a conversation with the referring dentist in which the patient's habit of scratching her gums was discussed. The patient admitted to the habit, which dated back to a number of medical problems. The dentist did not note this discussion in the chart and said he did not recall it until after the two surgeries. CDSBC Investigators reviewed the records provided by the patient's general dentist. The records revealed a long history of medical problems dating back more than twenty years. The patient had been seen by multiple other specialists who had difficulty diagnosing her pain. The patient was eventually referred to a psychiatrist and prescribed medications to address her symptoms. The investigation revealed concerns with the dentist's diagnosis and treatment planning, recordkeeping and informed consent protocols. **Resolution** The dentist signed an agreement to do a case review with an oral medicine specialist, and to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 41	**Complaint** A patient complained about the quality of treatment and the billing for two root canal treatments and three implants placed by the dentist. **Investigation** The patient told CDSBC Investigators that he agreed to have three implants placed by the dentist in a study club environment. He said that one of the implants failed twice, but that the dentist would only issue a refund if he signed a release, which he refused to do. The patient said that two teeth were root canal treated, but that the dentist was unable to complete one of them. The patient was referred to a specialist and had to pay to have the procedure completed again. The patient told CDSBC Investigators that he was not given a receipt for the implants and had difficulty obtaining financial records from the dentist. When he did receive them, they did not match his insurer records.

	This caused him to suspect that the dentist was billing for treatment that was not provided. The dentist told CDSBC Investigators that the patient wanted to replace three missing teeth with implants, but had expressed concern about the cost. The patient agreed to have the procedures done at a reduced cost as part of the dentist's study club, under the supervision of the study club mentor. The dentist confirmed that one of the implants had to be replaced, which necessitated bone grafting. After being replaced, the implant came out when the dentist attempted to restore it with a crown. The dentist told CDSBC Investigators that she offered a full refund to the patient, but that he refused to sign a release. The dentist said she tried to follow up with the patient and eventually mailed the release to him. CDSBC Investigators found the records provided by the dentist to be incomplete and confusing. Some of the treatment was not referenced at all. The dentist told CDSBC Investigators that some of the treatment had been done in another office where she worked as an associate. These records did contain the missing treatment, but the chart did not reference any informed consent discussions. There were multiple estimates, but they were not broken out, so it was impossible to determine what was included. CDSBC Investigators reviewed the financial ledger. While it suggested that the patient had been billed appropriately, CDSBC Investigators were concerned that the dentist did not issue a receipt. The dentist explained that she could not issue a receipt because the treatment had been done through the study club, and the fees applied to those expenses. CDSBC Investigators advised the dentist that it is not the role of the study club to maintain the financial records of the treating dentist and that patients are entitled to know what they have paid for. **Resolution** The dentist signed an agreement to take the CDSBC's *Dental Recordkeeping* course and to participate in a mentorship arrangement to include a review and evaluation of the patient's case.
File 42	**Complaint** A patient complained about the quality of care she received from the dentist during root canal treatment and re-treatment of the same tooth.

	Investigation The patient told CDSBC Investigators that the dentist provided root canal treatment and a crown for a tooth. She said that she continued to feel pain but did not return to the dentist until three years later, at which time the tooth was re-treated. The patient moved away but continued to experience pain. After another three years, she went to a new dentist who said he had concerns about the root canal treatment provided by the previous dentist. The dentist told CDSBC Investigators that the patient only attended in emergency situations. He confirmed that he provided the treatment and re-treatment, the latter being done at no charge to the patient. He said that three years later he received a request from her new dentist for her records. CDSBC Investigators reviewed the records and found issues with the root canal treatment provided, including a separated file tip, canals that were over-filled, a fourth canal that was not treated at all, and a lesion at the root. They were also concerned that the crown had been placed on restorative material instead of sound tooth structure. The dentist's records were also concerning as they contained minimal notes about diagnosis and treatment planning and his interactions with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, a two day hands-on endodontics course covering diagnosis and treatment planning protocols, and to participate in a case review with a mentor to evaluate the patient's case with a focus on endodontics and prosthodontics.
File 43	**Complaint** A patient complained that the dentist: did not inform her about the treatment being done, placed instruments on her chest, dismissed her as a patient before the treatment was complete, and that she experienced post-operative pain. **Investigation** The patient told CDSBC Investigators that she had numerous concerns about her dental experience with the dentist. The patient said that she was given sedation medications by the receptionist upon arrival. She said that she did not know what treatment was being done under sedation, and that when she tried to ask the dentist, he told her not to speak. She said that she felt

	uncomfortable when the dentist placed dental tools on her chest. The patient said that she experienced post-operative pain and infection which required antibiotics and numerous prescriptions of Percocet, and that the dentist dismissed her as a patient before her treatment was complete. The dentist told CDSBC Investigators that he did explain to the patient the basis for the proposed treatment of root canal treatment for two teeth. CDSBC Investigators found that this was supported by the records, which included a consent form for dental treatment and sedation signed by the patient. CDSBC Investigators noted, however, that none of the dentist's informed consent discussions with the patient were referenced in the chart. It did not appear that the patient's medical history had been updated or that the dentist had taken into consideration the numerous other medications she was taking and how they might interact with what he prescribed. The dentist told CDSBC Investigators that he prescribed Percocet for the patient four times because she insisted on it. He said that he did not feel there was a dental basis for it, which is what led him to dismiss her from the practice. The dentist admitted that his staff had given sedation medications to patients but that he realizes this was inappropriate and this no longer occurs at his office. CDSBC Investigators found that while there were no concerns with the root canal treatment completed, there were issues with the dentist's recordkeeping protocols, as well as sedation, pharmacology, and the questionable practice of placing dental instruments on a patient's chest during treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, a course in pharmacology, and to review the sedation guidelines. He also agreed to discontinue the practice of placing dental instruments on patient's chests.
File 44	**Complaint** A patient complained that the sedation wore off during the surgical removal of three teeth. **Investigation** The patient told CDSBC Investigators that she had no memory of the first tooth being removed, but that she was awake for the last two extractions. She

	said the dentist forced her back into the dental chair and completed the treatment, even though she was in pain and moving around in the chair. The patient said she suffered bruising and trauma and that the experience affected her sleep and ability to function normally, and resulted in a significant increase in her dental anxiety. The dentist told CDSBC Investigators that he only treated the patient twice, once at an appointment where two teeth were extracted, and again at the appointment in question where three teeth were extracted. The dentist said mild sedation was used at both appointments and that the patient behaved "loudly and violently" both times. The dentist said that the patient had a significant medical history and takes medications to manage Obsessive Compulsive Disorder (OCD), Oppositional Defiant Disorder (ODD), bipolar disorder, and anxiety. The dentist felt the dosages of the medications the patient was taking to manage these conditions was mild and noted that she was in good physical health. As a result, the dentist said that he did not anticipate any negative drug interactions. CDSBC Investigators noted one of the medications the patient was taking metabolized through the same pathway as the sedation agent, which could impact the effectiveness of the sedation. The dentist said that the patient did move around a lot in the chair and that his staff ensured she was protected by keeping her hands and arms away from the surgical area. The dentist said no undue force was used, as this would only make the situation worse. The dentist denied the allegation that the sedation only lasted for 10 minutes, and noted that while most patients have no memory of the treatment, some do. He suggested that this appears to have been the case with this patient. CDSBC Investigators found that the rationale for the treatment was fully supported by the records and that there was no concern with the dentist's surgical skills. There was, however, concern about the dentist's sedation protocols and whether he took into consideration the patient's complex medical history and medications, especially since the dentist had never encountered a patient with ODD before. CDSBC Investigators advised that the patient's medical history needed additional research and that the dentist should have further considered the possibility of negative drug interactions.

	Resolution The dentist signed an agreement to participate in a case review with a mentor specific to this patient, which will include a complete evaluation of treatment planning, surgery and sedation protocols.
File 45	**Complaint** A patient complained about the quality of the root canal treatment provided by the dentist and wanted a refund after his tooth fractured. **Investigation** The dentist told CDSBC Investigators that he discussed treatment options with the patient. These options included extracting the tooth or having it root canal treated and then covered with a crown. The dentist said that the patient wanted to save the tooth and chose to undergo root canal treatment. However, the patient did not return to have the crown placed. The dentist explained that without a crown, the tooth was at greater risk of fracture, which it eventually did. In response to the patient's complaint, the dentist gave a complete refund, resolving the concerns to his satisfaction. The patient told CDSBC Investigators that he no longer wished to pursue the complaint. CDSBC Investigators reviewed the records provided by the dentist. While there were no concerns about the standard of care, the chart did not contain sufficient detail of the treatment options or the dentist's 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 46	**Complaint** Dentist A complained about the dentistry of Dentist B during a six-month period where he was an associate at the practice. **Investigation** Dentist A told CDSBC Investigators that Dentist B had suffered a stroke, which may have been a contributing factor to what he felt was sub-standard dentistry. Dentist B confirmed he did suffer a minor stroke, but that he received medical clearance to return to practice. Dentist A provided the charts

	of 13 patients for CDSBC Investigators to review. Dentist B admitted to some shortfalls and disputed others. CDSBC Investigators reviewed the records and found concerns with the adequacy of Dentist B's recordkeeping and informed consent discussions, as well as his operative/restorative competencies. Dentist B acknowledged the concerns and confirmed he had taken an operative/restorative course and CDSBC's *Dental Recordkeeping* course as a means of addressing them. **Resolution** Dentist B signed an agreement to take CDSBC's *Tough Topics in Dentistry* course, and to a 12 month monitoring period during which two chart reviews will be conducted.
File 47	**Complaint** A patient complained that the dentist placed crowns on her teeth leaving gaps which led to discomfort. **Investigation** The patient told CDSBC Investigators that she had several crowns placed by the dentist. Soon afterwards she noticed there were spaces in which food was collecting, which caused discomfort and her gums to inflame. The patient said the dentist dismissed her concerns by suggesting her teeth were shifting or that the patient had caused the gaps by using a toothpick. The patient told CDSBC Investigators that the gaps were there when the crowns were first seated, and she saw another dentist who agreed there were gaps. The dentist told CDSBC Investigators that the contacts were perfect (i.e. no gaps) when she cemented several crowns for the patient. The dentist said that she is always very careful to ensure a good fit and closed gaps before cementation. She said that it is her practice to take post-operative X-rays at the patient's recall visit. The dentist said she found the gaps highly unusual, as they were closed when the crowns were delivered. She told CDSBC Investigators that she had earlier replaced several crowns for the patient for the same reason. She said she was unsure why the gaps were re-opening and said she told the patient it may be due to her grinding habit and suggested she wear a night-guard.

	The dentist told CDSBC Investigators that she agreed to cover the costs of having the patient's new dentist replace the crowns, which satisfied the patient. CDSBC Investigators reviewed the records and confirmed the gaps, but found that the dentist's prosthodontics work otherwise generally appeared to be good. They noted problems with other teeth which the dentist had root canal treated, including some short fills and some over-fills. They were also concerned that the chart did not contain sufficient detail relating to root canal treatment diagnosis. There was no endodontic testing recorded nor reference to any discussions with the patient about the short and over-fills. The chart was also missing reference to the need for a night guard to address the patient's grinding habits. The dentist acknowledged the recordkeeping concerns and took CDSBC's *Dental Recordkeeping* course, but she disputed the concern with her root canal treatment. The dentist provided a number of opinions written by endodontists (specialists) to support this views and she refused to sign an agreement with the College or undergo a chart review. An Inquiry Committee Panel was appointed when the dentist refused to sign an agreement. The Panel agreed there were concerns, and while the dentist did not initially admit to the concerns, she did attend a full day one-on-one session on endodontic technique with a certified endodontic specialist. She also took a course in occlusion (bite) and entered into a mentorship relationship with an endodontic specialist who offered to re-evaluate her endodontic cases, as an alternative to undergoing a chart review. **Resolution** The Inquiry Committee Panel accepted the dentist's proposal and acknowledged the continuing education courses she had taken addressed the concerns identified in the investigation.
File 48	**Complaint** The daughter of a patient complained that the dentist should have ordered a biopsy on an extracted tooth, the results of which may have extended her mother's life through an earlier diagnosis of oral cancer. **Investigation** The dentist told CDSBC Investigators that the patient had regularly attended hygiene appointments until about a year before the tooth extraction. He said

	that the extraction was uneventful, and that at the time, there was nothing abnormal that would suggest the need to order a biopsy. He said that when the patient returned about 10 days later, he noted what appeared to be a lot of granulation tissue (part of the healing process) and recommended increased use of a saline rinse. The dentist did not make a follow-up appointment for the patient. The patient returned two months later, at which time there was a large polyp attached to the socket. The dentist immediately referred the patient to an oral surgeon who obtained a biopsy, which led to the diagnosis of oral cancer. The patient underwent treatment but passed away within a year. The dentist expressed his condolences over the situation and acknowledged the dental professional's role in the early detection of oral cancer. CDSBC Investigators found that the dentist did not have proper protocols in place for the detection and management of oral mucosal disease. They were also concerned about the adequacy of his recordkeeping after it was noted that no periodontal probing had been recorded in nearly a decade, and there was an overall lack of sufficient detail in the chart for this patient. **Resolution** The dentist signed an agreement to enter into a mentorship with a specialist in oral medicine to conduct a case review specific to this patient's situation and to ensure the dentist has the proper protocols in place for diagnosis and treatment planning and recordkeeping.
File 49	**Complaint** A patient complained about root canal treatment that the dentist provided for two teeth. **Investigation** The patient told CDSBC Investigators that the dentist did not inform her that a file tip separated during treatment, and that both teeth deteriorated shortly thereafter and needed to be extracted. The dentist told CDSBC Investigators that the patient had been under his care for nearly a decade, but often failed to follow treatment recommendations. The dentist said that the patient had poor oral hygiene and a history of cavities in both heavily restored teeth. He said that he recommended extracting the

	teeth, but the patient declined. CDSBC Investigators reviewed the records and confirmed the teeth were non-restorable, raising a question about the rationale for root canal treatment. There was no indication in the chart that the patient was presented with the option of extraction. The dentist said that the root canal treatment for one tooth was completed over the course of two visits. A file tip separated into one of the canals, but the dentist said he told this patient of this at the time. The patient disputed this and said she was told everything was fine. CDSBC Investigators found no note in the chart about the separated file or that it was discussed with the patient. The dentist said this was an oversight on his part. The dentist told CDSBC Investigators that root canal treatment for the second tooth was started but not completed, as the patient did not return. CDSBC Investigators reviewed post-operative X-rays and saw that the canals were not property filled, which raised a concern about the dentist's competency in endodontics, in addition to his recordkeeping protocols. CDSBC Investigators were also concerned with the dentist's delay in responding to the College, which protracted the length of the investigation. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, join a hands-on endodontic study club for a year, acknowledge and agree to respond to the College in a timely way, and undergo a chart review.
File 50	**Complaint** A patient complained that the dentist abandoned his care after placing a temporary filling that came out. He questioned why a permanent restoration could not be placed, which he later had done by another dentist. **Investigation** The patient told CDSBC Investigators that he saw the dentist because he had broken a tooth. The patient said he had no dental insurance and could not afford a crown, so he decided to have a temporary filling placed. The plan was to have the crown placed a couple of months later, when the patient hoped to have some dental insurance. The temporary filling fell out two weeks after being placed, and the patient said that the dentist told him there was nothing that could be done. The dentist told CDSBC Investigators that the tooth had been repaired several times in the past and had a deep filling that was close to the pulp. The dentist

	said that he did not recommend a permanent restoration because he was concerned that it could create problems and lead to root canal treatment being required. He felt the patient would likely complain about this further treatment being required. The dentist said he recommended a temporary filling using a material that would best serve as a base for the crown. CDSBC Investigators were concerned that the dentist did not discuss all of the treatment options with the patient. The dentist should have covered the risk of root canal treatment if a permanent filling was placed. Instead, he allowed the patient to leave with a large hole in his front tooth. This carried the risk of bacterial infection which could further compromise the tooth while waiting for the crown to be placed. CDSBC Investigators noted that several chart entries were misdated, which led to confusion about the timeline of treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to rebook patients with unresolved restorative needs to the next available appointment or referred to a colleague to ensure timely treatment is provided.
File 51	**Complaint** The mother of an adult patient complained that much of the dentist's treatment had to be redone after the patient was seen by another dentist who found a fractured tooth and many cavities under the restorations. **Investigation** The dentist told CDSBC Investigators that the patient suffered from extreme dental anxiety. He said that during the eight years she was a patient, she only attended hygiene and recall examinations once a year. The dentist felt that the patient's poor dental hygiene habits, infrequent visits, and significant medical history (including an eating disorder) contributed to her condition. The dentist told CDSBC Investigators that the patient had extensive cavities but that the recommended treatment was often limited because the patient's mother would not allow any treatment that was not covered by her insurance plan. The dentist said that because the patient cancelled her last appointment, he was not given an opportunity to address her concerns. The dentist said that he attempted to offer an explanation to the patient's mother, but she was so upset that no meaningful discussion could be had.

	CDSBC Investigators found that some of the restorations done by the dentist were not ideal, but the dentist explained that treatment was very difficult due to the patient's extreme anxiety and the mother only allowing it to be managed with Ativan. CDSBC Investigators did not find that the dentist's treatment was sub-standard. The records supported his treatment and suggested that the patient's own failure to take some responsibility for her oral health contributed to the problems she later had. **Resolution** The dentist signed an agreement to take a hands-on operative course.
File 52	**Complaint** A patient complained that a partial crown placed by the dentist had gaps which caused her discomfort, and that when it was redone the next day the bill was much higher than she expected. **Investigation** The patient told CDSBC Investigators that she was formerly a dentist in another country and is currently a CDA in B.C. She said that the dental office would not address her discomfort on the same day that the partial crown was placed and that the receptionist was rude to her. The dentist told CDSBC Investigators that the patient was referred to him from a colleague for whom the patient worked as a CDA. The dentist said that the patient interfered with the treatment, would not allow bite adjustments to be done, and made it difficult for him to complete the treatment as he normally would. The dentist said that he had already left the office for the day when the patient called to report discomfort three hours after treatment. The dentist said that the receptionist told the patient that she could be seen the next day. The patient instead arrived at the dental office, demanding to be seen that day. While there was one other dentist in the office, he was not available, so the receptionist again offered to rebook the patient the following day. Another patient in the waiting room verified for CDSBC Investigators that the patient was very demanding and unreasonable, while the receptionist was calm and professional. CDSBC Investigators reviewed the records and found no concerns with the dentist's billing and quality of care. However, there were concerns with the dentist's recordkeeping and informed consent protocols. There was little detail in the chart, no pre-treatment X-ray was taken, and no estimate given to the patient. The dentist indicated this was not representative of his overall practice

	and agreed to undergo a chart review. The chart review confirmed the dentist's clinical competency, but did show that his recordkeeping and informed consent practices needed improvement. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 53	**Complaint** A former employee of the dentist's clinic complained that she had never seen the dentist practise and questioned whether he met his continuous practice hours requirement as set by the College. She also stated that staff often worked unpaid overtime, and felt that the office's use of audio and video recordings in public areas constituted an invasion of privacy. **Investigation** CDSBC Investigators conducted an on-site inspection of the dental office and interviewed staff. While it appeared that the dentist was very involved in managing and building the practice, he did not appear to be practising dentistry as set out in dentistry regulations and College bylaws. The dentist retained legal counsel and told CDSBC Investigators that he felt his role did constitute the practice of dentistry, which he felt was not clearly defined. After learning that he was not qualified to renew his practising registration, the dentist sold the practice and reverted to volunteer registration status. The dentist told CDSBC Investigators that he paid the complainant's overtime claim to resolve the matter, but that this did not indicate he agreed with it. He also said that the office relied on several clearly visible video cameras to track staff. None of them were located in the patient operatories or the staff room, and staff were aware of the cameras. **Resolution** The Inquiry Committee accepted the dentist's signed undertaking that he would abide by the College's registration requirements should he decide to apply for reinstatement to return to active practice.
File 54	**Complaint** A patient complained about how the dentist responded to his post-operative pain following root canal treatment.

	Investigation The patient told CDSBC Investigators that when his symptoms had not resolved a week after treatment, he called the dental office asking to speak with the dentist. He said that the dentist did not return his call. The patient said he went to see another dentist for emergency care, which resulted in the extraction of a different tooth than had been root canal treated. The patient said he called the dental office again with his concerns, but the dentist again failed to return his call. The dentist acknowledged to CDSBC Investigators that there was a miscommunication between his office and the patient. The dentist said that he saw the patient following the root canal treatment and recommended giving the area another week to settle. The dentist said that when the patient called a week later, his receptionist booked an appointment but did not advise the dentist of the patient's request for a phone call. The dentist said that the patient was a no-show for his appointment. The dentist said that when the patient called again, he was reportedly enraged and used inappropriate language to the receptionist, reducing her to tears. The dentist said he decided not to call the patient back because of this and he felt the patient would be better served seeing someone else. CDSBC Investigators reviewed the records and found that they supported the rationale for the treatment, though some entries lacked detail. For instance, the root canal treatment was recorded but not the type of material used or the type and amount of local anesthetic used. Notes were also missing on some of the office's reported interactions with the patient. **Resolution** The dentist signed an agreement acknowledging the need to confirm a patient dismissal in writing, including an offer of 60 days of emergency care. He also agreed to take CDSBC's *Dental Recordkeeping* course.
File 55	**Complaint** A patient complained that the upper denture the dentist provided was of poor quality. **Investigation** The patient told CDSBC Investigators that she had a new upper denture made by a denturist at additional cost and coverage was declined by her insurer.

	While a subsequent-treating dentist noted significant issues, the nature and type of issues noted are common with immediate dentures (a denture inserted immediately after the removal of the natural teeth) and the type of procedure performed – each of which have the potential for significant discomfort. Deficiencies in the dentist's recordkeeping and informed consent protocols made it difficult to determine whether the immediate denture provided by the dentist met the standard of care. CDSBC Investigators were concerned with the dentist's informed consent and recordkeeping protocols, as the patient stressed that she was not aware that the immediate denture procedure would require multiple adjustments and/or reline appointments. The records were missing a copy of the information sheet reportedly provided to patients, a signed informed consent form, and any notes about the informed consent discussions with the patient. There were no notes to indicate that the adjustment/reline appointments were set up, nor any indication that the office attempted to contact the patient. **Resolution** The dentist signed an agreement to ensure that he and his staff complete the CDSBC's *Dental Recordkeeping* course.
File 56	*This file deals with the matter addressed in File 35 above. This complainant in this file is the patient referenced in the earlier file. The files are otherwise identical, including the investigation and resolution.*
File 57	**Complaint** A patient complained about restorations provided by Dentist A. **Investigation** The patient told CDSBC Investigators that she saw Dentist A to have several fillings placed over the course of three appointments. The patient said she felt like Dentist A did not provide any treatment after noting that no anesthetic was given and there was no drilling. The patient saw Dentist B who took X-rays and found areas of missed decay and minimal evidence that restorations were done by Dentist A. Dentist B also found evidence of cavities under the restorations that were done by Dentist A. Dentist A told CDSBC Investigators that she did a number of composite and preventative resin restorations for the patient. She said she used topical freezing in most cases, and anesthetic was given for the others. Dentist A said

	that the patient declined X-rays, so her diagnosis was made based on only a clinical examination Dentist A later learned that the patient went to Dentist B and allowed X-rays to be taken, which identified areas of concern. Dentist A agreed to reverse the charges for the restorations she provided so that they could be redone by Dentist B at no charge to the patient. CDSBC Investigators reviewed the records and had concerns about Dentist A's restorative competencies as well as her diagnosis and treatment planning. They noted that she proceeded with an extensive number of restorations even without X-rays. **Resolution** Dentist A signed an agreement to take a restorative course and spend ten half day sessions with a mentor to improve her diagnosis and treatment planning protocols. She also agreed to take CDSBC's *Dental Recordkeeping* course and undergo a chart review after completing the courses and mentorship.
File 58	**Complaint** A patient complained that the dentist's office changed their regular billing arrangement and that she was asked to pay more than the estimate to have three crowns replaced. **Investigation** The patient told CDSBC Investigators that her billing arrangement with the dentist had been in place for four years. She said that the office would process the claim and the next day she would pay the amount due. For this treatment, however, she was asked to pay over $700 immediately after the appointment, an amount that was higher than the estimate she had earlier been provided by the dentist. The dentist told CDSBC Investigators that the patient had a "pay patient only" plan and would bring her insurance payment to the dental office when she received it. The dentist said that the crown replacements were a large expense, however, and that the patient was told that the office was unable to extend the previous billing arrangement for this treatment. The dentist told CDSBC Investigators that treatment began and he removed the old crowns, but that he noted a large amount of decay into the pulp on one of the teeth. He said that the need to provide root canal treatment before

	placing the new crown was discussed with the patient. The dentist explained that an additional cost was due to the unexpected root canal treatment that was required, which was not included in the estimate originally provided to the patient. The dentist did write-off a cost that was mistakenly billed; the College concluded that there was no intentional overbilling or inaccurate billing. CDSBC Investigators found that the dentist's records did not include a diagnosis or X-rays to substantiate the need to replace the three crowns. In fact, they could not find any concerns with two of the teeth using X-rays taken a year prior to treatment. The post-treatment X-rays showed that one of the root canals was not sufficiently filled. CDSBC Investigators also noted that discussions with the patient were not documented in the chart and that there was no indication the patient was informed of the risks, limitations, and possible outcome of the root canal treatment. **Resolution** The dentist signed an agreement to take a hands-on endodontic course and CDSBC's *Dental Recordkeeping* course, ensure treatment estimates represent treatment plans accurately, and review cost/payment policies with patients before treatment begins.
File 59	**Complaint** A patient complained about several issues related to a crown placed by the dentist after it fell off less than two years after being placed. **Investigation** The patient told CDSBC Investigators that the crown was placed on a tooth that had been previously root canal treated. The crown fell off a year and a half later and she says she was then told by the dentist that the tooth was non-restorable and would need to be extracted. The patient said that the dentist promised to help cover her treatment costs, but that this was not honoured. She questioned why the dentist placed the crown in the first place, if the tooth was so compromised. The dentist told CDSBC Investigators that the patient's tooth had been root canal treated by another dentist four years earlier and had been prepared for a crown at that time. Despite the patient waiting four years to have the crown placed, the dentist expected the crown to last much longer. The dentist did note that the tooth was already structurally compromised when the crown was placed. He felt that the patient's grinding habit and failure to regularly wear her night guard contributed to the loss of the crown.

	CDSBC Investigators were concerned with the dentist's treatment approach. They felt that it was very likely that the crown would fail, given how seriously compromised the tooth was. The dentist disagreed and felt the rationale for his treatment was justified. The Inquiry Committee appointed a panel to review this file. The panel also questioned the dentist's treatment approach, but later agreed that there are differing views about the approach to treatment, after receiving two opinions from other dentists suggesting that there was sufficient tooth structure to reasonably justify placing a crown. **Resolution** The dentist acknowledged the concern with the lack of detail in his recordkeeping and took CDSBC's *Dental Recordkeeping* course. For the past two years he has also participated in a hands-on implant study club focused on comprehensive treatment planning for compromised teeth. After providing proof of the steps he had taken to improve his recordkeeping, informed consent, and diagnosis and treatment planning protocols since the time of the complaint, the dentist signed an agreement to take further continuing education on providing restorations to compromised teeth and to take CDSBC's *Tough Topics in Dentistry* course.
File 60	**Complaint** A patient complained that the dentist did not provide two fillings as requested, but instead restored two other surfaces. When he did later fill the requested areas, they fell out a month later. **Investigation** The patient told CDSBC Investigators that he wanted to have two fillings done but the dentist did not take the time to understand what his concerns were and instead restored two other surfaces of the teeth in question. The patient said that the dentist later agreed to provide the two fillings requested, but that they fell out a month later. The patient felt the dentist was unprofessional and said that he did not go back to the dentist because he had been told by the dentist not to return. The dentist told CDSBC Investigators that the patient was new to his practice and attended for a specific examination. He said that the patient asked to have two cavities filled on two teeth. The dentist said that he examined the

	patient and found severe receding gums and significant loss of dental tissue on both teeth, but no cavities. The dentist said he proposed restoring those areas of the teeth and that the patient consented. He said it was only afterwards that he realized the patient wanted fillings done on the biting surface of these teeth. The dentist said that there were no cavities and that the patient's area of concern was instead regular tooth wear caused by tooth-to-tooth contact. The dentist said he filled these areas at no charge. The dentist said he was professional at all times and treated the patient with respect. He denied telling the patient not to return. The dentist said that he did not know the fillings later fell out, because the patient did not return. The dentist offered to either re-do the fillings at no charge or issue a refund to the patient. CDSBC Investigators found that the dentist may not have taken enough time to determine what the patient's specific concerns were at the outset. The dentist acknowledged CDSBC Investigators' concerns that his diagnosis and treatment planning were not sufficient detailed in the chart. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 61	**Complaint** An associate dentist complained that a CDA was performing restricted activities not permissible for a CDA to perform and which may only be performed by a dentist. **Investigation** The dentist told CDSBC Investigators that he was a former associate dentist at the dental office. He said that the office manager, the only CDA in the office, was performing restricted activities such as placing crowns. He said that the CDA assessed and dismissed a patient who had dry socket (painful condition when a blood clot does not develop after a tooth is extracted) without first consulting him. The dentist admitted that he did not witness the CDA or other staff re-cement crowns and he did not provide specific patient names or clinical information to the College to support these allegations. The CDA told CDSBC Investigators that she understood and agreed that treatment planning needs to be based on patient needs, referrals must be directed by the dentist, and discussions regarding production should be held

	between the principal dentist and the associate. The CDA denied that she or any of the staff provided a patient with treatment that was outside their duties. She emphasized that only dentists can cement permanent crowns. She admitted that no dentist saw the patient with dry socket, and that she dismissed the patient based on him reporting comfort. **Resolution** The CDA signed an agreement to abide by the *Guide to CDA Services* at all times, acknowledging that dentists must direct treatment and that it is inappropriate for a CDA to assess a patient's clinical situation and make a recommendation based on that assessment.
File 62	**Complaint** A patient complained about treatment provided by the dentist to repair damage caused in a motor vehicle accident. **Investigation** The patient told CDSBC Investigators that the motor vehicle accident loosened his upper left bridge and knocked out a front tooth. He said that he was preapproved by the public auto insurer for $5000 worth of dental treatment related to the accident. The patient said he wanted the dentist to provide treatment for the accident-related concerns, on the basis of an advertisement posted by the dentist claiming that the provincial health insurance plan could cover treatment of up to seven teeth. The patient said that the dentist removed his upper left bridge without his permission. He said that extractions done by the dentist created bone damage in the area, causing two implants to later fail. The dentist told CDSBC Investigators that he noted the effects of trauma to the patient's upper left jaw as well as very unhealthy gum tissue along all of the patient's upper teeth. The dentist said that the patient had a 12-unit implant-supported bridge on the lower jaw that had been provided by another dentist a few years earlier. A panoramic X-ray showed that this bridge was healthy and functioning. The dentist said that the patient wanted a similar treatment for his upper left jaw to replace an existing bridge that was failing due to the effects of the recent accident. The dentist said that he presented treatment options and the patient opted for implant surgery. The dentist said he provided five implants but was later unhappy with the position of two of them and he replaced them. The dentist

	said that he attempted to refer the patient to restorative dentists to complete the bridge-portion of the treatment, but the patient did not follow through. Two implants failed three years later. The dentist said that the relationship broke down and he dismissed the patient. CDSBC Investigators reviewed the records and found they did not meet the expected standards. There appeared to be no written treatment plan. The treatment notes were illegible, making it difficult for the investigation to determine what informed consent discussions were had before treatment. There was also no indication of cost estimates of the prosthetic component of the proposed treatment, nor any evidence the patient was informed of the type or cost of the restorative phase of the treatment. CDSBC Investigators had additional concerns about misleading advertising and appropriate patient dismissal protocols. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course; provide full restorative treatment plans to patients, including costs; review the guidelines for dismissing a patient; and ensure his advertising is not misleading.
File 63	**Complaint** The College opened a complaint file after it learned that the dentist administered dermal fillers, which is outside the scope of practice for general dentists in B.C. **Investigation** The dentist confirmed she administered dermal fillers but told CDSBC Investigators that she did so as part of a separate practice that was overseen by physicians and in accordance with the policies of the College of Physicians & Surgeons, and not in her capacity as a dentist. CDSBC Investigators told the dentist that if she wanted to continue to administer dermal fillers, she would have to resign as a dentist. If she wished to remain a registrant, she would need to undertake to refrain from offering dermal fillers, as long as it remains outside the scope of practice for general dentists. **Resolution** The dentist signed an agreement not to administer dermal fillers.

Files 64 and 65	**Complaint** A patient complained about treatment provided by two dentists (from the same practice) to repair damage caused in a car accident. **Investigation** The elderly patient said she was referred to the first dentist (Dentist A) for a consultation after she complained of facial pain following a car accident. She believed that the costs of treatment would be covered by her settlement with the public auto insurer. When she arrived at the appointment she was seen by another dentist at the practice (Dentist B). The patient said she could no longer use her partial denture because Dentist B removed its precision clips, that the insurer refused to cover the cost of her treatment, and that she could not afford to have her partial denture replaced. She felt that the dentists should cover this cost. Dentist B told CDSBC Investigators that he had previous experience with facial trauma and felt the patient presented with symptoms that were due to her car accident, in addition to several other pre-existing dental needs. He recommended that the patient have eight teeth root canal treated based on a clinical examination and a panoramic X-ray. The dentist said that this treatment would allow her partial dentures to fit comfortably which would address her TMJ issues. Dentist B told CDSBC Investigators that he made the diagnosis, but Dentist A performed the treatment. The dentists said that the insurer determined not to pay for the treatment after reviewing an independent medical/legal report prepared by an oral surgeon which suggested the root canal treatment was not needed as a result of the car accident. They told CDSBC Investigators that the clinic was unable to recover the $5,000 in fees billed for the patient's treatment. Dentist B said that it was a denturist, and not him, who removed the precision clips from the patient's partial denture. CDSBC Investigators reviewed the records and were concerned about the root canal treatment diagnosis. The pre-treatment X-rays were insufficient and inappropriate to confirm the diagnosis and individual X-rays should have been taken. CDSBC Investigators also found that the endodontic testing was insufficient. The records confirmed the treatment plan but did not reference informed consent discussions to confirm the patient understood that not all of the recommended treatment would be covered by the insurer because some of it was unrelated to her accident.

	Resolution Each dentist signed an agreement to take a course in endodontic diagnosis as well as CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 66	**Complaint** A patient complained of several post-operative problems after the dentist extracted a tooth. **Investigation** The patient told CDSBC Investigators that he agreed to have one tooth extracted but that the dentist failed to advise him of possible post-operative complications. He said that he was diagnosed with dry socket following the extraction, but that the dentist did not adequately address his symptoms of pain. The patient said that the dentist referred him to an oral surgeon seven weeks later and he was still in significant pain. The oral surgeon diagnosed infection in the jaw bone and the patient had to have another tooth extracted and undergo an additional six months of treatment to clear up the infection. The dentist told CDSBC Investigators that he believed the patient's pain was from a dry socket because he had never had a patient with symptoms of bone infection before. This caused a delay in referring the patient to an oral surgeon. The dentist recognized his recordkeeping and informed consent protocols required improvement. CDSBC Investigators reviewed the records and found that they supported the rationale for the extraction of the tooth, but that they were lacking detail and included no reference to informed consent discussions with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and spend a half day with a mentor to do a detailed review of this patient's case to improve his diagnosis and treatment planning.
File 67	**Complaint** The patient complained about dentures provided by the dentist.

	Investigation The patient told CDSBC Investigators that she saw the dentist because of sensitivity on her lower front teeth and pain on a lower left premolar. She said the dentist provided her with three treatment options but did not inform her of the associated risks and potential additional costs. The dentist made a removable partial denture for the patient, but it failed when the supporting teeth were lost. It was replaced with a complete lower denture. The patient told CDSBC Investigators that the new denture is ill-fitting and made her lower lip protrude. The patient said she saw a denturist who said that a new lower denture and upper denture are needed. CDSBC Investigators reviewed the records and found they lacked detail. It was difficult to ascertain which options were provided to the patient and if thorough discussions of risks and costs were had. CDSBC Investigators were concerned with the dentist's diagnosis and treatment planning, finding his use of the support teeth (that later fell out) to be questionable. One of these teeth had a poor crown/root ratio and the other was not properly assessed prior to the crown being placed, despite pre-treatment X-rays showing the potential for problems. CDSBC Investigators told the dentist that the X-ray should have been re-taken prior to placing a new crown to ensure that the root of this tooth was completely visible and free of disease. **Resolution** The dentist provided proof of the proactive steps he had already taken to address the concerns raised in the complaint, including joining an implant study club, and completing CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. The dentist signed an agreement acknowledging: informed consent is a process and includes discussions of risks, limitations, and benefits of treatment; consultation notes should provide a summary of these discussions; and a proper pre-treatment X-ray is appropriate in making an accurate diagnosis for treatment.
File 68	**Complaint** A patient complained about the dentist's treatment plan that involved crowning two teeth used to support a partial denture.

Editor's note: While similar in description, this file involves entirely different parties than File 67 above.	**Investigation** The patient told CDSBC Investigators that one of the teeth became noticeably loose after the crown was placed. He said that the dentist did not take any pre-treatment X-rays to assess the tooth before proceeding with the treatment. The patient said he went back to see the dentist four times about his loose tooth but nothing was done. The patient said he was later diagnosed with a severe gum infection, which he believed the dentist failed to take into consideration during treatment planning. The dentist told CDSBC Investigators that he had not seen the patient in four years. He said that when the patient returned, he wanted a bridge. It appeared to CDSBC Investigators that the patient was initially seen by an associate dentist who developed the plan to crown the two teeth; however that associate left the practice and the dentist then took over the treatment plan. CDSBC Investigators identified concerns with the dentist's recordkeeping and informed consent protocols, along with diagnosis and treatment planning that was not supported by the appropriate records. The dentist said that the tooth that was later lost was healthy and free of infection when the crown was placed. The dentist did not take any pre-treatment X-rays, but CDSBC Investigators noted that X-rays taken a month later showed significant bone loss. The dentist said he did periodontal probing, but this was not noted in the chart. The dentist said he discussed the treatment plan with the patient, but conceded that these discussions were not recorded in the chart. The dentist said that the patient's tooth was not loose and that he still felt the treatment plan was viable. CDSBC Investigators noted there was a reference to a prosthodontics certification under the dentist's name on his letterhead. This was potentially misleading to the public, as the dentist is a general dentist and not a specialist. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, review his diagnosis and treatment

	planning to ensure it is supported by appropriate records, and change his letterhead so that it is not confusing to the public.
File 69	**Complaint** The patient complained that the dentist performed root canal treatment without advising her. She complained that not only did this double the bill from what was initially quoted, but also that the treatment failed and she ended up losing the tooth. **Investigation** The dentist told CDSBC Investigators that he had determined the need to replace a crown, and the patient agreed. The dentist then discovered a large amount of decay that extended into the pulp and he completed root canal treatment. CDSBC Investigators reviewed the pre-treatment X-rays and found extensive decay around the entire margin of the old crown, and the root canals appeared to be significantly calcified. These records supported the dentist's treatment plan. They found that the post-treatment X-rays showed an adequate root canal treatment result was achieved. While CDSBC Investigators found no concerns with the root canal treatment provided, the dentist's recordkeeping was deficient and lacked significant detail as to the actual services provided. There were no notes about the severe structural compromise shown in the X-ray, nor about any discussions of periodontal management, treatment options, and costs. It was also noted that the dentist provided antibiotics at the beginning or at the end of appointments. The American Heart Association does not recommend antibiotics for patients with a history of total joint replacement (the patient had knee replacement surgery). **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, and to review the American Heart Association recommendations and protocols for antibiotic prophylaxis.
File 70	**Complaint** The College opened a complaint file after concerns were found during a separate investigation about treatment provided by the dentist to several patients.

	Investigation CDSBC Investigators were concerned by the dentist's operative care after chart review results showed cavities remaining after fillings were done, restorations that did not maintain their form, and a grossly incompetent composite restoration. The dentist was provided with a copy of the records reviewed by CDSBC Investigators and he acknowledged their concerns and indicated his willingness to take remedial courses to address them. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and a clinical operative/restorative course with a component on cavity diagnosis and treatment planning, followed by chart reviews.
File 71	**Complaint** A dentist was criminally charged with multiple counts of trafficking in bear gall bladders and bear paws, and unlawful possession of dead wildlife. **Investigation** The dentist explained to CDSBC Investigators that a patient of his was a hunter and showed him pictures of animals that he had killed over the years, including bears. The dentist said he asked how the gall bladders were disposed of. When the patient told him that they were disposed of in the bush, the dentist said he offered to pay for them. The dentist admitted that he did not make the necessary inquiries to ensure the purchase of gall bladders was legal. He confirmed that he was convicted of the charges and required to pay a fine. The dentist expressed remorse for his conduct, and said that it resulted in embarrassment for him and his family. **Resolution** The Inquiry Committee received a summary of the investigation and agreed the dentist's conduct was adequately addressed through the criminal justice system. The dentist signed an agreement to never repeat the conduct.
File 72	**Complaint** A patient complained that the dentist's implant and crown treatment resulted in one of his teeth fracturing and left him with a very uncomfortable bite.

	Investigation The patient told CDSBC Investigators that he underwent a treatment plan that included having four implants placed, a bite adjustment, and several crowns placed. After one tooth fractured and his bite was still very uncomfortable, he questioned why the dentist did not refer him to a specialist. The dentist told CDSBC Investigators that the patient was non-compliant and difficult to manage, which affected the treatment. The dentist felt that good results were achieved with the implant and crown placement, but acknowledged the patient's bite was less than ideal and that he was unable to address those concerns through several adjustments. CDSBC Investigators found it likely that this did contribute to the fracture of the tooth and led to temporomandibular joint (TMJ) discomfort, and other problems with the patient's bite and jaw. **Resolution** The dentist signed an agreement to pay for and undergo a mentorship session with a prosthodontic specialist to review this case to help improve his prosthodontics diagnosis and treatment planning protocols.
File 73	**Complaint** A patient complained about the dentist's surgical skill and lack of concern for his comfort after implant surgery lasted nearly three hours and was ultimately aborted. **Investigation** The patient told CDSBC Investigators that on the day of his scheduled implant surgery, the dentist told him that he would first need to remove root tips from a previously extracted tooth and he felt pressured to agree. The patient said that the dentist did not have an assistant throughout the two hour and forty minute procedure. He said that his lips became dry and cracked and that the dentist did not offer lubrication or any breaks to rest his jaw muscles. The patient said that the dentist aborted the procedure after being unable to properly position the implant. The dentist told CDSBC Investigators that he identified the retained roots at the consultation, but that the patient did not seem to understand this until he explained it again at the surgical appointment. He said that he did not have his assistant with him for the first half hour, but that she was present for the

	remainder of the lengthy appointment. The assistant provided a signed statement to this effect. The dentist said that the surgery was more complex than anticipated with some difficulty in accessing the implant site. The dentist said that the root tip did not look normal and was made up of particulate material that was very difficult to remove. He also told CDSBC Investigators that he did attempt, unsuccessfully, to place an implant but chose to abort the procedure because he was unable to place it in the best position. He said that he did not charge the patient for the procedure because he felt badly about the long appointment and the failed implant placement. The dentist said that appropriate follow-up was done and that he fully intended to proceed with implant placement once the area healed. The dentist said that the patient did not mention any of his concerns during the follow-up appointments. The dentist said that he was unaware of the patient's reported discomfort during the procedure, and said he did give him breaks to rest his jaw. The dentist said that he questioned whether a swelling on one side of the patient's lip could be due to a blocked salivary gland, but says this was not a firm diagnosis. CDSBC Investigators found no concerns with the dentist's diagnosis and treatment planning, but were concerned about the dentist's informed consent protocols after it was noted the informed consent document signed by the patient was different than the copy retained by the practice. The dentist explained that his receptionist had added additional notes after the patient had received his copy. The extraction of the root tips was not included on the consent form, which simply referenced the implant. Investigators were further concerned that the dentist did not recognize the unusual presentation of the root tips in the X-rays, and recommended that anomalies in X-rays be addressed before surgery. **Resolution** The dentist signed a letter of agreement agreeing to take more care in X-ray assessment, to be more mindful of a patient's comfort throughout treatment, and to take CDSBC's *Dental Recordkeeping* course.
File 74	**Complaint** The patient complained that the dentist punctured his tooth while preparing it for a bridge and that the dentist should have provided an implant instead.

Investigation
The patient told CDSBC Investigators that he initially consulted the dentist when one of his teeth broke off at the root. He said that he wanted an implant, but due to cost restraints opted for a six-unit bridge instead. The patient said that the dentist perforated a tooth while preparing his mouth for the bridge and, several years later, informed him the tooth next to the one that had broken off had undergone root resorption (a rare natural process where the body dissolves the tooth structure). The patient said he consulted an oral and maxillofacial surgeon who believed the tooth had decay and not root resorption. The patient believed that the dentist had punctured this tooth during the placement of the bridge, causing this decay. After a biopsy, the patient said that the oral surgeon told him that root amputation was not possible and he instead recommended an implant or a new bridge. The patient was upset that an implant would have been the best option for him initially, and that it would have cost less than the dentist originally quoted.

The dentist explained to CDSBC Investigators that due to the patient's cost concerns and insurance coverage, he decided a six-unit bridge was most suitable. She noted a slight shadow in X-rays taken before preparing the bridge, but said it was difficult to determine whether this was an indication of infection or an image distortion; however, X-rays taken a year and a half later confirmed there was a problem and she referred the patient to an oral surgeon. The dentist said that the patient refused the referral to the oral surgeon, and she was unable to follow through with care.

CDSBC Investigators concluded that the tooth in question appeared to develop external resorption as reported by the dentist. The investigation did not raise concerns with the standard of care provided. The records supported the dentist's recommendation to extract the tooth and to replace it with an implant. However, CDSBC Investigators were concerned about the dentist's recordkeeping, informed consent, and billing protocols. The dentist acknowledged she had billed inappropriately by charging the patient before treatment was completed, and it was unclear to CDSBC Investigators whether cost estimates were provided before treatment.

Resolution
The dentist signed an agreement to ensure that her billings are accurate and reflect the procedures provided, and ensure that the patient is provided with a pre-treatment cost estimate of all treatment options provided and that this information is recorded in the chart.

File 75	*This complaint was addressed as a health file.*
File 76	**Complaint** A patient complained that a bridge placed by the dentist failed after only two years. **Investigation** The patient told CDSBC Investigators that the dentist provided a cantilever bridge. After it fractured, the patient said that the dentist offered to provide him with implants at no cost as part of her study club, but later withdrew the offer. The patient said that the dentist did not give him any other treatment options and he questioned whether the cantilever bridge was the best option for him given issues with his bite. The patient said that he had also began legal action against the dentist for compensation to cover his future dental care costs. The dentist told CDSBC Investigators that she did provide the patient with several treatment options, however, the records provided were minimal and did not reference any informed consent discussions, including the risks and benefits of each treatment. CDSBC Investigators found that there was no indication that the dentist had fully taken into consideration the patient's bite before proceeding with treatment. Pre-treatment X-rays included a set that was several years old, and a recent set that was not of diagnostic quality. The dentist did not use mounted models, and CDSBC Investigators felt that there would likely be a problem with one of the supporting teeth. The dentist told CDSBC Investigators that she did not offer to provide the patient with free implants. She said that she did not have the expertise at the time to do implants and was offering a discount only through a course she was taking on implant placement, which offered patients a $500 discount if implants were received in the context of the course. The dentist acknowledged the College's concerns with her informed consent and recordkeeping protocols. She voluntarily took CDSBC's *Dental Recordkeeping* course and created informed consent documents for patients to sign to improve her informed consent practices. CDSBC Investigators felt that concerns remained with the dentist's prosthodontics diagnosis and treatment planning protocols.

	Resolution The dentist signed an agreement to spend two half day mentoring sessions with a prosthodontics specialist to do a case review and develop a treatment plan for another complex prosthodontic case.
File 77	**Complaint** The patient complained that the dentist was inexperienced and unprofessional. **Investigation** The patient told CDSBC Investigators that during an appointment, the dental impression tray became stuck and caused her pain and discomfort. Due to a language barrier, the patient was unable to communicate with the dentist. The patient was concerned that she was never directly contacted by the dentist, which caused some delay in following-up with her. The dentist admitted to CDSBC Investigators that the impression tray became stuck and he indicated that he has learned from this case and now assesses patients more thoroughly. CDSBC Investigators were concerned with the dentist's recordkeeping. The patient's daughter was regularly contacted for the patient's dental consultations (due to the language barrier); however, the daughter's contact information was not in the patient chart. The dentist was unable to contact the daughter which caused significant delay in addressing and following-up with the patient. CDSBC Investigators found other recordkeeping concerns, including the lack of clear documentation of findings from the dentist's exams and X-rays, and the rationale in developing a comprehensive treatment for the patient. There was no documentation of any discussions with the patient or her daughter in the chart. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course. The dentist was also advised to find ways to communicate directly with patients.
File 78	**Complaint** A patient complained that the dentist did not provide emergency care after a newly cemented crown placed by him fell out. The patient also complained that the upper removable partial denture never fit properly.

Investigation
The patient told CDSBC Investigators that the crown fell out on a Saturday, three days after the dentist placed it. He said that when he contacted the dentist at his home, the dentist said that it was not an emergency and that he would see him at his office on Monday. The patient felt that it was unacceptable that he would have to go through a whole weekend without a front tooth. The patient said he saw another dentist that day who re-cemented the crown. The patient said he wanted the dentist to cover this cost. The patient also said that the denture provided by the dentist was a poor fit and that the dentist never followed-up after saying that he would discuss solutions with him. The patient said he wanted the cost of the denture refunded as well.

The dentist told CDSBC Investigators that that the patient was demanding and aggressive which was a factor in his choice to not see the patient on the weekend. Regarding the denture, the dentist said that the patient was adamant about the treatment he wanted to receive and did not follow the dentist's recommendations. The dentist said that the patient insisted that he address his bite not having sufficient force. He said he told the patient that increasing the force would result in more movement of the denture, but that the patient wanted to resolve things his own way. The dentist said that the patient had multiple adjustments for the denture without a successful outcome.

CDSBC Investigators found that the dentist's handling of the loose crown could have been managed more professionally. It appeared that the dentist did not fully consider the patient's perspective when assessing if it was a true emergency. The dentist was advised that if he was unable or unwilling to personally deal with the issue, he should have made arrangements for another practitioner to attend to it on his behalf.

CDSBC Investigators found that the records included a letter from the dentist to the patient offering to work with him to resolve his concerns. However, the letter is dated one month after the patient's complaint to the College, it is not on letterhead, and the patient said that he never received it. CDSBC Investigators could not determine whether a follow-up was attempted, nor whether the denture fit satisfactorily or not.

Resolution
The dentist signed an agreement to improve his patient relations protocols and to ensure that he follows through on his professional obligations to his

	patients, especially in situations outside of regular business hours. The dentist also acknowledged that the issues contained in the complaint could have been addressed by him, preventing the complaint from being lodged in the first place.
File 79	**Complaint** The mother of a patient complained about the orthodontic treatment the dentist provided to her son. **Investigation** The patient's mother told CDSBC Investigators that the dentist misrepresented herself as a specialist and later left the practice without making follow-up arrangements for her son's continued care. Subsequent dentists treated the patient and found that there were gaps between the two upper front teeth and other teeth were twisting. The patient's mother said that they advised that further orthodontic treatment was required. The patient's mother wanted to be refunded the money she paid for the original treatment. CDSBC Investigators reviewed the information and were concerned with the dentist's orthodontic diagnosis and treatment planning. When the dentist chose to proceed with treatment, the patient still had a number of his primary ("baby") teeth and it was going to take some time until the permanent teeth erupted. CDSBC Investigators told the dentist that placing fixed appliances, such as braces, prior to all of the adult teeth coming in was not recommended as it would prolong treatment. The chart notes revealed that the braces on most of the lower premolars could not be placed for almost a year after the orthodontic treatment was started. CDSBC Investigators also found that the patient had serious compliance issues. The patient had poor hygiene and repeatedly broke the appliance. CDSBC Investigators told the mother that the patient's lack of cooperation contributed to a compromised treatment outcome. The dentist acknowledged the orthodontic concerns but opted to limit her practice rather than undertake an educational program to address them. **Resolution** The dentist signed an agreement to cease providing orthodontic treatment and that if she wished to provide orthodontic treatment in the future, she would enter into an agreement with the College regarding the remedial steps she must take before the practice limitation will be removed.

File 80	**Complaint** A patient complained that the dentist repeatedly treated her tooth without using anesthetic, despite her being in pain. She also complained that the dentist punctured a different tooth which required treatment by another dentist to fix, but was not covered by her insurance. **Investigation** The patient told CDSBC Investigators that she saw the dentist seven times in one year about one tooth, and that anesthetic was only used once. She said that the tooth broke and she saw another dentist, who told her it needed root canal re-treatment and a neighbouring tooth was severely compromised due to a hole. She said that she was referred to a specialist who was able to seal the puncture and re-treat the tooth, but at a cost that was not covered by her insurance. The dentist told CDSBC Investigators that the patient was only seen on an emergency basis. He said that he provided a temporary restoration for the tooth at each appointment, but that his office was unable to book an appointment for her to return. The dentist acknowledged that anesthetic was not used, but explained he did not feel it was necessary because the tooth had been previously root canal treated. The dentist said that he recommended the patient see a specialist about both teeth, but that the patient resisted due to the cost. As a result, the dentist said he performed root canal treatment on the neighbouring tooth, but denied it was perforated under his care. However, both the subsequent treating dentist and the specialist noted the hole. The specialist sealed and re-treated the tooth and noted the unusual structure of the tooth with five very calcified canals and fused roots. CDSBC Investigators were concerned about the dentist determining to treat this tooth himself when the patient declined a referral. They recommended that he use the Canadian Academy of Endodontics case classification chart to assist him in his root canal treatment planning. They also recommended the dentist send a letter to a patient who does not accept the recommended treatment. CDSBC Investigators found that the records did not capture the informed consent discussions he says he had with the patient and it appeared that the patient did not have a clear understanding of what was being done. **Resolution** The dentist signed an agreement to: take the CDSBC's *Dental Recordkeeping* course; ensure anaesthetic is given to patients in pain; send letters confirming

	treatment recommendations if the patient does not accept the recommendation; consult UBC's endodontic assessment chart for treatment planning purposes.
File 81	**Complaint** A patient complained about the dentist's poor handling of her post-operative concerns after he removed a wisdom tooth. **Investigation** The patient told CDSBC Investigators that she suffered from paresthesia (extended numbness and prickling/burning sensation) as a result of having the wisdom tooth removed, but that the dentist did not inform her ahead of time that this was a potential risk. She said that her bleeding did not stop and that the dentist had not given her post-operative instructions about what to do, and that it took him 15 hours to respond to her emergency call. The patient said she felt the dentist was minimalizing her post-operative concerns and that he had a poor chairside manner. After being his patient for 20 years, the patient said she found a new dentist as a result of this experience. The dentist told CDSBC Investigators that he extracted the patient's wisdom tooth uneventfully and gave her verbal post-operative instructions, which included using pressure on a tea bag to address any bleeding. He said that when the patient was discharged, she was not bleeding. He said that he called the patient back the next day after receiving her emergency call, by which time the bleeding had stopped on its own. The dentist said that it is his usual practice to go over the risks with all of his surgical patients, but he was unable to locate the signed consent form given to patients, and agreed he may not have done so in this case. The dentist said that he usually responds to emergency calls within an hour but cannot explain they delay in this instance. The dentist said he had no idea the patient felt he had a poor chairside manner or that his attempts to assess the paresthesia were being interpreted as minimalizing her symptoms. The dentist said he was shocked when he received the complaint. CDSBC Investigators found that the records lacked detail and did not reference any informed consent discussions with the patient. **Resolution** The dentist signed a letter of agreement to take the *Dental Recordkeeping* course, implement detailed and comprehensive recordkeeping for every

	patient, consistently provide both written and verbal post-operative instructions for all surgical patients, and have a discussion about the risks and benefits of the surgery. The dentist also agreed to respond in a timely fashion (1-3 hours) to emergency calls.
File 82	**Complaint** A patient complained that he felt pressured to have hygiene treatment and X-rays taken despite only requesting teeth whitening. He also complained that scraping done by the hygienist caused gum infection. **Investigation** The patient told CDSBC Investigators that he had limited dental coverage provided by government social services. He said he saw the dentist for the first time in seven years to have his teeth whitened and wanted no other treatment. He said that after treatment his teeth were "barely a shade brighter than before." The dentist told CDSBC Investigators that while the patient's main concern was to have his teeth whitened, he declined to proceed because the procedure was not covered by his dental insurance plan and he could not pay for the procedure himself. The dentist said that he offered to try using composite to freshen up the patient's old fillings and cover a decalcified area to create a whitened tooth. He said that the patient agreed and returned to have the treatment done, and later asked for his bottom teeth to be treated as well. The dentist said that the hygienist advised the patient of the severely compromised status of his gums and recommended more frequent hygiene and better home care. CDSBC Investigators were concerned that the dentist did not also follow-up on this with the patient and recommend he be seen by a specialist or outline other treatment options. The dentist said he did not follow-up because he thought it was very unlikely that the patient would see a specialist or opt for any treatment options, given his financial limitations. CDSBC Investigators told the dentist that he had a professional responsibility to ensure the patient was aware of the diagnosis and treatment options, including a referral, regardless of the patient's likelihood to pursue them. CDSBC Investigators reviewed the chart and were concerned that it did not contain sufficient detail of the dentist's interactions with the patient.

	Resolution The dentist signed an agreement to take a course in periodontal diagnosis and treatment planning and CDSBC's *Dental Recordkeeping* course.
File 83	**Complaint** The Inquiry Committee Panel directed that a complaint file be opened after a patient reported (without submitting a written complaint) that she had paid cash to a dentist and a dental technician for the latter to replace a number of crowns at the dentist's office after hours. **Investigation** The dentist told CDSBC Investigators that he provided restorative treatment for the patient over a two-year period and that the dental technician prepared the restorations he used. The dentist denied being aware that the dental technician was cementing crowns or otherwise practising dentistry illegally until four years later when the patient informed his office. The dentist said that he contacted the dental technician when he became aware of the concerns, but CDSBC Investigators found that this was not recorded in the chart. The dentist said that he never charged the patient for her treatment, but did accept cash along with a thank you card. CDSBC Investigators found that the records did not show any evidence that the dentist had initiated any follow-up with the patient after he placed two crowns with temporary cement. The dentist said he only cemented the crowns temporarily because he was concerned about an inflamed lesion on the tooth. CDSBC Investigators noted that no referral was made to an endodontist and that the crowns were splinted. The dentist met with a Panel of the Inquiry Committee to discuss these matters. The dentist said he was unaware of any unauthorized practice and acknowledged the risk to the public posed by illegal practitioners and why it is imperative he not support such activity. He agreed such matters should be referred to the College without delay so steps can be taken to address such concerns. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and consult with an endodontist as necessary. He also agreed that it is generally not a good idea to splint crowns and that he would implement a patient follow-up system when crowns are temporarily cemented.

	The College of Dental Technicians investigated the allegation of unauthorized practice about their registrant.
File 84	**Complaint** A patient complained that root canal treatment provided by the endodontist (specialist) left her with periodic discomfort until it was successfully re-treated by another specialist. The patient also complained that she had difficulty obtaining her records as well as the discount offered by the specialist, and that she was not informed of a hole in the tooth that was caused during treatment. **Investigation** The patient told CDSBC Investigators that she saw the specialist because of a tooth ache. She said that the dentist began root canal treatment after diagnosing a dead pulp and inflammation. The patient said that she was told that she had a challenging root canal, which necessitated additional appointments to complete the treatment. The patient said that she was pain-free after treatment, but that she continued to experience periodic discomfort around the tooth until it was successfully re-treated by another endodontist more than two years later. The specialist told CDSBC Investigators that he had difficulty with a canal during the root canal treatment. He said that he explained the options to the patient and informed her of the challenges of trying to reach part of the canal. He said that he informed her of the hole in the tooth as a result of treatment and that he offered to re-treat the tooth at no charge. The patient denied that she was informed of the options, the hole in the tooth, or the offer for free re-treatment. CDSBC Investigators found that the records lacked information, particularly regarding the patient's informed consent. **Resolution** The specialist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 85	**Complaint** A husband and wife complained that the dentist did not advise them of or otherwise address long-standing dental problems that they learned of after seeing a new dentist.

	Investigation The couple told CDSBC Investigators that they saw the dentist for many years but eventually sought care elsewhere after the dentist was unable to address continuing symptoms. The patients said that their new dentist identified long-standing dental problems which appeared not to have been addressed or had been inappropriately addressed by the dentist. The patients were also surprised to learn about two separated file tips (metal fragments) left in a root-canaled tooth, which could have caused serious health complications as a result of a heart condition. CDSBC Investigators reviewed all the information and had significant concerns with the dentist's diagnosis and treatment planning of endodontics and periodontics, pharmacology, informed consent and recordkeeping. CDSBC Investigators raised these concerns with the dentist who advised that he would be retiring by the end of the year, and that he would be spending three of the four intervening months recovering from a health issue and travelling. The very few days that he planned to practise before his retirement would be used to finish orthodontic cases and wrap things up with long time patients. **Resolution** The dentist signed an agreement in August to cease practising dentistry (retire) by the end of the year (December 31). The agreement states that if he wishes to continue practising or return to practice at a later date, he will take educational courses followed by a six-month monitoring period and a chart review. The educational courses include: CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses; X-ray technique and interpretation; and hands-on endodontics.
File 86 *Also see related: File 33*	**Complaint** The College opened a complaint file after a chart review was conducted in the context of a separate complaint investigation (File 33) which raised concerns about the dentist's endodontic and restorative treatment as well as his recordkeeping and informed consent protocols, X-ray interpretation and ethical conduct. **Investigation** The dentist voluntarily agreed to a chart review in the context of a separate complaint investigation.

	CDSBC Investigators found many of the same concerns raised in the earlier investigation. **Resolution** The dentist signed an agreement to: • voluntarily withdraw from practice and cease providing any dentistry while undergoing a remediation program; • take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, an X-ray interpretation course, and an ethics course; • participate in two mentorships focused on recordkeeping, informed consent, materials science, diagnosis and treatment planning, and preclinical operative and restorative treatment; and • a 30 month monitoring period during which he will undergo five chart reviews following his successful completion of the courses and return to practice.
File 87	**Complaint** A patient complained that the dentist provided injectable sedation without his consent and delivered a faulty partial denture, causing him to return several times for repairs. **Investigation** The dentist said, and CDSBC Investigators confirmed, that he has never used intravenous sedation in his practice. The dentist said he delivered an upper denture but that it required multiple repairs and it was eventually replaced following trauma. The patient was missing many upper and lower teeth. The lack of lower teeth caused there to be no support at the back of the mouth. As a result, the front teeth were taking an excessive load and this likely caused the fractures to the upper denture. CDSBC Investigators told the dentist that a lower denture should have been considered to provide support and to protect the patient's bite. The dentist told CDSBC Investigators that the patient declined having a lower denture, but the records did not document any discussions about a lower denture or the likely effects of not having one.

	Resolution The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to document informed consent discussions with each patient.
File 88	**Complaint** A complaint file was opened after a CDA failed to respond to the College about the need to renew her Criminal Record Check. **Investigation** The CDA failed to respond to communications from the College's registration department and the registrar's office. Her criminal record check expired and she was no longer permitted to work on children or vulnerable adults. As a result of the CDA's failure to respond, it was impossible to determine if she was still practicing, and whether she posed any risk to the public. The matter was referred to a Panel of the Inquiry Committee that considered whether an extraordinary action to protect public (s.35 of the *Health Professions Act*) was necessary. The CDA was invited to retain counsel and make submissions, but failed to reply and her telephone number was no longer in service. The CDA failed to renew her certification, causing it to lapse. The Panel was satisfied she was not likely practising and determined to close the file with a letter to the CDA reminding her of her obligations should she choose to apply for reinstatement. **Resolution** The closing letter to the CDA confirmed her lapsed status and noted that if she applies for reinstatement, she will be required to meet the College's quality assurance requirements and any other limits or conditions that may be imposed by the Registration Committee. The Inquiry Committee Panel also asked for her letter of undertaking to reply promptly to College communications in the future.

File 89	**Complaint** A patient complained about the quality of root canal treatment provided by the dentist and about the dentist not acknowledging any errors and instead having security remove her. **Investigation** The patient told CDSBC Investigators that she went to see the dentist because she was in pain. She said that the dentist provided root canal treatment to one tooth and prepared another for root canal treatment to be provided once the infection had cleared. The patient said she was given antibiotics and painkillers, but her symptoms worsened and she went to the ER. The patient said that when she later confronted the dentist, she denied any wrongdoing and refused to issue a refund. The patient said that security was called to escort her from the premises. The patient went to another dentist who referred her to a specialist for re-treatment. The specialist informed her that what she thought was a large infection was actually excess dental material extruding beyond the end of the root. The dentist told CDSBC Investigators that she tested both teeth and diagnosed the need for root canal treatment to address the patient's pain. She said that the root canal treatment and preparation for the other tooth was provided uneventfully. The dentist said that she did not complete the treatment due to complications that the patient experienced. She said that the patient later became very aggressive with her and her staff. The dentist confirmed she had security escort the patient from the premises. CDSBC Investigators reviewed the records provided by the dentist and were concerned about the dentist's recordkeeping, informed consent protocols along, and endodontic diagnosis and treatment planning. There were no entries for some of the appointments, no indication of any testing being done to support the diagnosis and no indication other treatment options were discussed with the patient. CDSBC Investigators were concerned about the dentist's failure to recognize the potential risks and complications of having excess dental material extrude past the end of the root. CDSBC Investigators found that prescriptions were not recorded, including the type and amount of medications prescribed. The dentist acknowledged these recordkeeping deficiencies but insisted all testing had been done appropriately to support the diagnosis, and she later provided copies of the prescriptions given to the patient.

	Resolution The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and spend a half day with a mentor to do a case review with a focus on endodontic diagnosis and treatment planning.
File 90	**Complaint** A patient complained that the dentist did not provide the treatment she had paid for and consented to. **Investigation** The patient told CDSBC Investigators that she thought the dentist had provided two crowns during two appointments about a year apart. Three years after the last appointment she went to a different dental office where she was told that she did not have crowns on these teeth, but rather two large fillings. The patient contacted her insurer and learned that the dentist had billed for two gold crowns. The patient said she was not properly informed of the dental treatment and wanted to be reimbursed. CDSBC Investigators reviewed the records and confirmed that partial coverage restorations had been placed. These do not meet the definition of a cast gold crown and it was inappropriate to have billed them as such. The records from the subsequent dentist showed gaps between the restorations and the remaining tooth structure. The dentist explained to CDSBC Investigators that he was trying to preserve as much tooth structure as possible. The dentist said that he explained to the patient that this type of restoration would support and strengthen the remaining tooth structure, but he did not tell the patient that they would not cover the entire chewing surface of the teeth. The dentist acknowledged the deficiencies raised by the investigation, but told CDSBC Investigators that he is no longer practicing dentistry. **Resolution** The dentist signed an agreement to improve his recordkeeping and informed consent protocols and to enrol in a hands-on study club or complete a clinical course in prosthodontics, should he want to return to practice.
File 91	**Complaint** The patient complained that the dentist's office manager, who is the dentist's husband, wanted him to pay in cash for a lower partial denture that did not fit.

	Investigation The patient told CDSBC Investigators that he saw the dentist at an appointment to have his denture fitted. He said that it did not fit and that the dentist said she would have to send it back to the lab to be adjusted. The patient said that the office manager pressured him in front of other patients, and later followed him into the parking lot, to demand payment for the dentures in cash. The patient told CDSBC Investigators that the office manager made him feel humiliated, but he did not want to pay for dentures that he had not yet accepted. The patient also told CDSBC Investigators that cost estimates kept going up at each visit and he questioned why he was being asked to pay in cash. The patient said he never returned to pick up his denture because he no longer felt welcome at the office and was suspicious of its billing protocols. The office manager told CDSBC Investigators that he did ask the patient to pay by cash or cheque, but said that was because the dental practice had been sold and they thought that using the debit machine would affect the accounting for the new dentist. The office manager said that he could not explain to patients why they required cash or cheque payments because he was instructed not to tell patients about the sale. The office manager denied that he was rude to the patient. He said that he was never asking for payment of the denture, but rather for amounts owed for already completed crown and bridge work. CDSBC Investigators reviewed the chart and found several root canal treatments had been done prior to the crown and bridge work. These treatments were not included on the estimate given to the patient. The dentist explained this was because it was fully covered by the patient's dental plan. The chart did not reference any discussions with the patient about the diagnosis requiring root canal treatment, and there was no testing done to support the treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and a course on endodontic diagnosis and treatment planning.
File 92	**Complaint** A patient complained that two of the three bridges placed by the dentist failed.

	Investigation The patient told CDSBC Investigators that the dentist did not discuss any treatment planning options for one of the bridges that was replaced. The patient said that he eventually sought a second opinion and had the bridges replaced by another dentist following lengthy negotiations with the original dentist to cover the costs. The dentist told CDSBC Investigators that the patient had multiple failing bridges five years before treatment began to replace them. The dentist said that they had multiple treatment planning discussions, but conceded that these were not confirmed in the patient chart. The dentist told CDSBC Investigators that the patient returned numerous times complaining of problems with the bridges, which she addressed until it was clear the patient wanted to see another dentist. The dentist told CDSBC Investigators that she covered the cost to have a bridge replaced by the patient's new dentist. CDSBC Investigators found that while cost estimates were present for all three bridges, there was no indication that they had been given to the patient or reviewed with him. CDSBC Investigators were also concerned that the dentist had not done a more comprehensive assessment before beginning treatment on this very complex case. The dentist recognized this with the benefit of hindsight. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and to conduct a comprehensive review of the patient's chart to evaluate his case with a mentor. She also agreed to undergo a chart review.
File 93	**Complaint** A patient complained that the dentist diagnosed nine of her teeth as needing fillings after she obtained a second opinion that said no treatment was required. She also complained there was a delay in transferring her dental records. **Investigation** The dentist told CDSBC Investigators that he based his diagnosis on his clinical examination and review of the X-rays. He confirmed that he recommended composite fillings for nine teeth and to monitor two other teeth. The dentist said that the patient's X-rays were transferred to her new dentist

	through a secure email referral but that the dental office did not access them until his office sent them a reminder. When the patient later asked for her complete file, the dentist said it was provided in a timely fashion. CDSBC Investigators reviewed the records and found them to be adequate, but they were concerned that his X-ray interpretation was flawed which led to a misdiagnosis. This was confirmed when the X-rays were reviewed by the patient's new dentist, College Investigators, and a radiologist. **Resolution** The dentist signed an agreement to recalibrate his X-ray equipment and take a course in X-ray interpretation.
File 94	**Complaint** A family member of a dentist complained she was providing dental treatment to family members when she not authorized to practise dentistry. **Investigation** The family member told CDSBC Investigators that the dentist held non-practising status and was treating family members at the office of another dentist. The dentist told CDSBC Investigators that she changed to non-practising status several years ago after she was diagnosed with a brain tumour and had to undergo surgery to have it removed. The dentist admitted that she did provide hygiene for her mother three times over the last three years. She also admitted that she did some polishing and placed a restoration on herself. She said that she did so because she was contemplating a return to practice, but she has since realized she does not have the fine motor skills to do so. The dentist denied treating anyone else or receiving any payment. The dentist said that there were underlying family matters which had likely contributed to the complaint being made. The dentist whose office she used told CDSBC Investigators that it was his understanding she provided free hygiene to family members, while he handled their restorative needs. He said that he was unaware of her non-practising status at the time. The dentist acknowledged that she was not entitled to practice and confirmed she had no plans to return. Her registration has since lapsed.

	Resolution The dentist signed an agreement acknowledging that she was not permitted to perform any dentistry, even hygiene, as a non-practising registrant, and that she would not do so again.
File 95	**Complaint** A patient complained that she received composite replacement fillings when she did not want them. She also complained about the receptionist's behaviour. **Investigation** The patient told CDSBC Investigators that the receptionist pushed her to make appointments for unnecessary treatments and an associate dentist told her to not allow the receptionist to book another appointment, as she did not have any cavities. The patient said that she observed the receptionist give orders to associate dentists, other staff, and patients. The patient said that her relationship with the office deteriorated and when she requested the transfer of her records, there was some resistance from the office. CDSBC Investigators reviewed the files and found that the treatments provided were justified. The associate dentist treated three teeth that had deteriorating amalgam fillings and evidence of decay. CDSBC Investigators also found that the patient's records were provided to her in a reasonable timeframe of five days. CDSBC Investigators were concerned with the role of the receptionist in dictating direction of clinical treatments. The associate dentist told CDSBC Investigators that the receptionist exerted undue influence with associate dentists, staff, and patients. The associate said that he did not allow the receptionist to dictate to him and that he now no longer works in the practice. **Resolution** The dentist signed an agreement acknowledging responsibility to establish clear roles and responsibility and to properly supervise all non-dentist staff.
File 96	**Complaint** A patient complained about the quality of a bridge she received from the dentist after it failed 18 months later.

	Investigation The patient told CDSBC Investigators that at the appointment to insert the bridge, the dentist expressed anger and frustration with the difficulty of placing it. She said she was in the dental chair for three hours and that the dentist's demeanour towards her and his staff was aggressive and intimidating. The patient said she left the practice as a result of this experience. She said her new dentist noted that the tooth supporting the bridge had serious decay and could not be saved. The bridge was removed and the tooth extracted. The patient said that the original faulty bridge supplied by the dentist caused her to require an expensive treatment plan involving an implant supported bridge. The dentist told CDSBC Investigators that the bridge was expected to last for many years and he suggested that there was a defect in the dental materials used by the lab. The dentist said that he was unable to address the patient's concerns because she did not return to his practice. He said that he had no recollection of being rude or having any type of altercation with a staff member in front of the patient. The dentist said that he had previously provided root canal treatment to the supporting tooth that was later removed by the patient's new dentist. The root canal treatment, and the removal of a different tooth, were not noted in the patient's chart until five years after treatment. The dentist could not explain these late chart entries. CDSBC Investigators reviewed the records and were concerned with the dentist's recordkeeping, endodontics, prosthodontic diagnosis and treatment planning, and prosthetic evaluation. The dentist was agreeable to taking remedial program to address the concerns raised in the complaint, but before an agreement could be signed, he commenced a leave of absence due to an unrelated health matter. **Resolution** The dentist was informed that should he return to practice he will be required to undertake remedial training, including: taking CDSBC's *Dental Recordkeeping* course, a multi-day hands-on endodontic course, and to be mentored by a prosthodontic specialist to conduct a case review and to focus on prosthodontics diagnosis and treatment planning.
File 97	**Complaint** A patient complained that the dentist failed to diagnose the need for root canal treatment.

Investigation
The patient told CDSBC Investigators that he had two fillings replaced followed by crowns. He said that the dentist seated the crown on one tooth, even though he told him that it did not feel right. The patient returned to the dental office nine times over a three month period with worsening, unresolved symptoms. He said that the dentist prescribing three rounds of antibiotics, but failed to diagnose the need for root canal treatment until after it was diagnosed by another dentist several months after the crowns were placed. The patient said that the dentist offered to do the root canal treatment and would guarantee it for two years, but later changed his mind because the patient had not had dental hygiene in the past five years, which is likely what led to the infection.

The dentist told CDSBC Investigators that he replaced the fillings and delivered crowns for the patient after fracture lines and failing restorations were found in two teeth. The dentist said that the patient went on to experience discomfort in one of the teeth but that there was no evidence that root canal treatment was needed at that time. He said that he made several adjustments which seemed to initially resolve the patient's discomfort, though the patient kept coming back when the symptoms returned.

The dentist told CDSBC Investigators that he prescribed antibiotics, even though there was no evidence of an infection. He explained that he would sometimes do this to appease the patient or if there was a possibility of an infection in the sinus, gums, or roots. The dentist said he did endodontic testing at each of the patient's appointments, but that the tooth did not seem to be sensitive to temperature.

CDSBC Investigators reviewed the files and were concerned with the dentist's recordkeeping and endodontic diagnosis and treatment planning protocols. The records did not record any testing being done, and there was no notes on the dosage or amount of antibiotics prescribed. CDSBC Investigators were also concerned that he was prescribing antibiotics when no infection was present. They found that many chart entries were not initialed making it difficult to determine who the author was.

While the College expects dentists to stand by their work and address any post-operative problems that may arise, offering a guarantee is discouraged because it creates unrealistic patient expectations which may be impossible

	for the dentist to manage if unforeseen circumstances create post-operative issues. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and a course in endodontic diagnosis and treatment planning. The dentist also agreed not to prescribe antibiotics in the absence of an infection and to refrain from offering guarantees.
File 98	*This complaint was addressed as a health file.*
File 99	**Complaint** A patient complained that the dentist was not compassionate during her painful recovery from having all four wisdom teeth removed. **Investigation** The patient told CDSBC Investigators that for weeks after the dentist removed her wisdom teeth she suffered extreme pain with severe bruising, swelling, and she could no longer open her mouth properly. She said that she believed the dentist tore her TMJ muscles during treatment trying to access her teeth. The dentist told CDSBC Investigators that when he first saw the patient, she had clicking and popping of the jaw joint, difficulty opening and easily bruised. CDSBC Investigators found that the records were clear, thorough, and documented an in-depth consultation with appropriate diagnosis and treatment plan for the extraction of third molars. The dentist said that he had suggested extracting teeth on one side of the mouth at a time to minimize trauma, but given the patient's anxiety, she opted to have all four wisdom teeth removed at one time. CDSBC Investigators found that the dentist managed the patient's ongoing pain conservatively. CDSBC Investigators were concerned with the dentist's patient relations protocols. While the initial consultation notes recorded a discussion and review of the risks and benefits to the proposed treatment, the treatment was not completed until 17 months later. CDSBC Investigators also noted that the dentist had called in a prescription of an antibiotic without examining the patient when she called complaining of continued pain. The records did not include the patient's pre-surgical condition, such as the findings of the TMJ examination.

	Resolution The dentist signed an agreement to ensure proper communication with patients; document pre-surgical conditions such as TMJ exam findings; arrange for additional consultation and/or referral; ensure an updated examination and informed consent discussion with the patient is done before surgery if significant time has passed since the initial consultation; and assess patients before prescribing antibiotics to determine that antibiotics are indeed required.
File 100	**Complaint** A patient complained about problems with implant integration and fractures in implant-supported restorations placed by associate dentists at the dentist's practice that required re-treatment. **Investigation** The patient told CDSBC Investigators that he had been a longstanding patient of the dentist, and that while the dentist did not provide the actual treatment, he felt he was ultimately responsible for the post-operative problems and additional treatment that was required. The dentist told CDSBC Investigators that she had not been directly involved in the patient's care for several years and that a few associate dentists at her practice had overseen the treatment plan. The dentist told CDSBC Investigators that she issued a full refund to the patient as a gesture of goodwill. CDSBC Investigators found that the extensive patient records were complete and supported the treatment provided. They noted that the patient had a long history of dental treatment and a grinding habit. It appeared that the patient was not complying in wearing a nightguard to protect the restorations, which contributed to the post-operative difficulties he experienced. CDSBC Investigators were concerned with the number of associate dentists involved in the patient's care, the lack of oversight of the treatment plan, and how this affected continuity of care. **Resolution** The dentist signed an agreement to create a clinical environment that encouraged collaboration amongst the associate dentists involved in more complex treatment plans and a level of overall office oversight to ensure the practice was being managed properly.

File 101	**Complaint** A former CDA complained of inappropriate behavior by the dentist during the ten years she worked with him. **Investigation** The former CDA told CDSBC Investigators that throughout her employment, the dentist would often touch her inappropriately by biting her shoulder, slapping her behind, kissing her neck, massaging her shoulders, and rubbing her arm. She told CDSBC Investigators about an incident which occurred after she gave her notice, where the dentist grabbed her hair and directed her head to his crotch area as she was trying to remove dental material from his pants. The dentist denied all of the allegations. He told CDSBC Investigators that he always felt he had a good working relationship with the CDA and was shocked to receive the complaint two years after she left his employ. He felt they parted on good terms and gave her a very positive letter of reference, as she was highly skilled. The dentist said that he does sometimes make off-colour remarks, but only to close friends or long-standing colleagues. He admitted that he may have massaged her shoulders briefly after lengthy treatment. The dentist said that he does tend to touch people's shoulders, but this is his "signature greeting" and nothing more. The dentist questioned why, if the CDA felt his conduct was so inappropriate, she continued to work with him for ten years. The dentist did remember dental material spilling onto his pants, though he had a different recollection of the events. He told CDSBC Investigators that he felt embarrassed and uncomfortable to have the CDA near this area, so he grabbed the CDA's hair to direct her away. One staff member was in the lunchroom at the time, but her back was to the CDA and dentist, and she declined to participate in a teleconference with the College. The CDA disagreed with the dentist's version of events, but agreed that there is no independent evidence. Three other former CDAs who did some temp work for the dentist told CDSBC Investigators that they did witness the dentist massaging the CDA's shoulders or touching her arms. They said that each instance occurred in an open, public area of the office. They agreed that the CDA appeared uncomfortable with this conduct. They also confirmed that the dentist often made off-colour remarks.

	The dentist and his legal counsel met with the College to discuss the concerns. He said that the CDA often spoke of her personal life and also made suggestive comments. He agreed this is not an appropriate work environment and that it had become sexualized during the last two years of the CDA's employment. **Resolution** The dentist signed an agreement to take a two day communication and leadership course with a focus on setting healthy and professional boundaries as well as personal responsibility and the difference between familiarity and professionalism.
File 102	**Complaint** Dentist A complained that Dentist B had not yet changed his trade name signage and advertising, despite a court order to do so and his previous commitment to the College to do so. **Investigation** Dentist A told CDSBC Investigators that the longstanding dispute created confusion for patients due to the very similar office name being used. Dentist B retained counsel and was appealing the court decision. He initially agreed that he should have changed his signage and advertising while the matter was pending. He agreed to make the changes, but did not in fact do so. He then stopped responding to the College after he was no longer represented by legal counsel. The matter was referred to the Inquiry Committee for direction. The dentist was asked to sign an agreement to make the necessary changes and pay a fine. The dentist did not sign the agreement and failed to complete the signage changes he had agreed to within the time stipulated by the Committee. The dentist later rehired his lawyer and provided confirmation that he had made all of the necessary changes to his office signage, company car, a bus stop bench and related online advertising. **Resolution** The dentist signed an agreement to pay a fine of $4,000.

File 103	**Complaint** A patient complained of ongoing pain and discomfort for two years after the dentist removed one tooth and provided root canal treatment to another. He also complained that the dentist failed to make an accurate diagnosis when he said that the root canal treated tooth later needed to be extracted. **Investigation** The patient told CDSBC Investigators that the dentist had not advised him of the potential side effects of tooth extraction. Given his ongoing pain, he wanted to save the second tooth and sought a second opinion from a specialist. The specialist recommended that the roots of the tooth be amputated, rather than removing the tooth entirely. The patient believed that both teeth could have been saved. The dentist confirmed for CDSBC Investigators that his initial treatment plan included extracting one tooth and root canal treating and placing a crown on another. CDSBC Investigators found that the removal of the first tooth was appropriate as it had severely compromised bone support and inflammation. The second tooth was later found to have an abscess at the root, caused either from a fracture that was noted by the specialist, and/or a remaining canal that was not treated by the dentist when three other canals were filled. CDSBC Investigators reviewed the records and were concerned about the dentist's root canal treatment diagnosis and treatment planning and his recordkeeping and informed consent protocols. The records did not include diagnostic tests, diagnosis with follow-up treatment plans, nor any documentation of comprehensive consultation regarding options or the risks and benefits of recommended treatments or treatments provided to the patient. **Resolution** The dentist signed an agreement to: take an endodontic diagnosis and treatment planning course; develop a comprehensive treatment plan listing all options with associated risks and benefits and costs; document consultations in the record; and ensure he and his staff take CDSBC's *Dental Recordkeeping* course (which covers informed consent).

File 104	**Complaint** A patient complained about the standard of care she received from the dentist after four veneers and two crowns chipped and fractured two years after treatment. **Investigation** The patient told CDSBC Investigators that her new dentist recommended that all of the veneers be replaced. The dentist told CDSBC Investigators that the patient was a good candidate for veneers and that the treatment was completed uneventfully. The patient had a follow-up visit with the dentist, at which time the restorations were all intact and the patient expressed her satisfaction. The dentist said that he did not hear from the patient until two years later when she contacted him asking for a refund. The dentist said that he asked her to come in to be assessed, but that she refused. The dentist received X-rays taken by her new dentist, but he could not see the fracture lines reported. He said that the other dentist mentioned some micro-fracturing but that he felt this was normal wear and tear and would not warrant replacing the veneers. As a result, the dentist said he declined to issue a refund. The second dentist provided a report to CDSBC Investigators clarifying that he did not initially recommend any of the veneers be replaced. He agreed they were well done by the first dentist, but when a few months later the patient presented with chipping on a tooth, he did recommend that it be replaced and suggested the patient may want to have all of the veneers redone only for esthetic reasons, so that they would match. CDSBC Investigators found that no standard of care issues were raised about the first dentist's treatment and it was not unreasonable for him to ask to see the patient to make his own assessment. They did note that the wrong billing code was used for crown lengthening procedure done on one of the teeth and brought to the dentist's attention. **Resolution** The dentist signed a letter of agreement agreeing to ensure he bills accurately and in accordance with the descriptor in the relevant fee guide and that he provide confirmation the insurer was reimbursed.

File 105	**Complaint** A patient complained that the dentist failed to vigilantly monitor swelling in her lower right jaw, which resulted in her requiring the surgical re-section of her jaw and the loss of three teeth. **Investigation** The patient told CDSBC Investigators that the dentist thought that the swelling was a swollen lymph gland and that it was nearly three years before she was referred to a specialist. As a result of the surgery required, she suffered nerve damage and needed further complex dental treatment. The dentist told CDSBC Investigators that the patient had been a longstanding patient and had attended for regular hygiene visits over the years. He said that the patient attended for a specific examination of swelling in the lower right area of her mouth. The dentist said that he believed it to be an infected lymph node that would resolve on its own over time. He said that the patient's symptoms improved but that the swelling remained, so he would monitor the area. The dentist told CDSBC Investigators that the hygienist conducted head and neck examinations at every visit, but that because the patient declined X-rays, a more definitive diagnosis could not be made. The dentist acknowledged the patient had a history of breast cancer, which is why she was reluctant to have any X-rays. Nearly three years later, the patient suffered minor trauma to the area. As the pain was disproportionate to the incident, she returned to the dentist who referred her to an oral medicine specialist. The specialist diagnosed and surgically removed a benign inflammatory cyst. The dentist said he was unable to diagnose the problem earlier due to the patient's refusal to have X-rays evaluated. He also said that the patient did not express any concern about the area at her recall visits, which the patient denied. CDSBC Investigators reviewed the records and found that the dentist was not proactive enough in monitoring the lesion. It would have been advisable to refer the patient to a specialist when she first declined to have X-rays taken, as it would be impossible for any clinician to determine the cause of the lesion without imaging and a referral to a specialist for a biopsy. CDSBC Investigators were also concerned that the dentist delegated head and neck examinations to the hygienist. They told the dentist he should be conducting these examinations, as it is the responsibility of the treating dentist to make a

	diagnosis. CDSBC Investigators were also concerned by sets of X-rays from a decade earlier that suggested the dentist was not providing effective comparative analysis of X-rays. **Resolution** The dentist signed an agreement acknowledging the concerns with his diagnosis and treatment planning and staff delegation and agreed to participate in a case review with an oral medicine specialist.
File 106	**Complaint** An elderly patient complained about post-operative problems after the dentist extracted his tooth. **Investigation** The patient told CDSBC Investigators that his mouth was traumatized and that he experienced significant pain and swelling. He said he lost 20 pounds because he could not eat, and his quality of life deteriorated. His daughter arranged for him to be seen by another dentist, who noted significant trauma around the extraction site, including visible shards of jagged bone. The second dentist repaired the area but had to extract an adjacent tooth that had loosened as a result of the trauma. The dentist, who is now retired, told CDSBC Investigators that he saw the patient only once. He said that the patient attended in severe pain and asked to have the tooth extracted. The dentist said there was some difficulty because of a piece of bone attached to the tooth after extraction, but he said he was not concerned about it at the time. He prescribed antibiotics and pain medications and did not hear from the patient until nine months later when the patient's daughter called to report the problems her father had experienced and to request compensation (which the dentist declined to provide). CDSBC Investigators were concerned with the dentist's recordkeeping protocols and about the manner in which this patient was treated. They found that the records contained minimal notes related to diagnosis and treatment planning and there was no indication that any follow-up had been done to ensure the patient was healing as expected. No pre-operative X-ray was taken.

	Resolution The dentist signed a letter of agreement to take CDSBC's *Dental Recordkeeping* course and participate in a case review with a mentor, should he opt to return to practice in the future.
File 107	**Complaint** A patient complained that an associate dentist placed a crown on a tooth that had a fractured root and needed to be extracted shortly thereafter. **Investigation** The patient told CDSBC Investigators that she was referred to the associate dentist by her regular dentist to replace a fractured crown on a tooth. The dentist replaced the crown but while making a bite adjustment, removed some of the porcelain and exposed the metal of the crown. The patient said the dentist replaced the porcelain and inserted the crown, making adjustments as necessary. The patient said she continued to be in pain and returned to the dentist six months later. She was told that the tooth had a fractured root and an abscess and would need to be extracted. The dentist confirmed for CDSBC Investigators that the patient was referred to him by the principal dentist who had treatment planned the replacement of the crown. The dentist said he did not do any periodontal probing, review the existing X-ray, or consider taking a new one before replacing the crown. The dentist acknowledged, with the benefit of hindsight, that there was a missed diagnosis as a result. The dentist acknowledged that this could have saved the patient the time and expense of replacing a crown on a tooth with a poor long term prognosis. The dentist said that he and the patient had resolved the financial concerns related to her complaint. The dentist acknowledged that there were concerns with his diagnosis and treatment planning protocols and said that this was a valuable learning experience for him as a new graduate at the time. **Resolution** The dentist signed an agreement to spend half a day with a certified specialist in prosthodontics to conduct a case review with a focus on improving his diagnosis and treatment planning protocols.
File 108	**Complaint** A principal of a former associate dentist reported a billing concern after it appeared the associate had charged a patient for a recall examination that

	was not done, and also reported two other instances that raised concerns about the associate's root canal therapy diagnosis and treatment planning. **Investigation** The associate dentist confirmed for CDSBC Investigators that the recall examination was in fact done, which resulted in the complainant withdrawing the billing complaint. The dentist provided a response to the remaining concerns which, along with the patient charts, caused CDSBC Investigators to be concerned about the dentist's diagnosis and treatment planning protocols in the areas of endodontic and prosthodontic care. They also noted a recordkeeping issue. The dentist voluntarily agreed to undergo a chart review so that CDSBC Investigators could determine if these were isolated concerns or part of a pattern of practice. Ten charts were randomly selected and the review confirmed the concerns earlier identified. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, take a hands-on endodontic course, join an endodontic study club, and spend time with a mentor to review her prosthodontic diagnosis and treatment planning protocols.
File 109	**Complaint** A patient complained that an orthodontic office failed to determine she was at the wrong office and proceeded to take a set of full-mouth X-rays without her consent. **Investigation** The patient told CDSBC Investigators that she was scheduled to see a periodontist who had an office on the same floor as the dentist's orthodontic office. The patient said she was unsure if the offices were set up together but presumed she would be told if she was in the wrong place. She gave the receptionist her name and was asked if she had been there before. When she said "no," she was asked to complete new patient forms. Staff then took full-mouth X-rays and seated her in an operatory for an examination. The patient said that only then did they determine she was in the wrong office and redirect her to the periodontist.

	The dentist told CDSBC Investigators that he was not present on the day in question, but had been told about the mix-up by staff. The dentist agreed that staff should be asking the patient to confirm why they were there and which dentist they were expecting to see. He agreed that had that been done, the patient would have been redirected down the hall without delay. The dentist told CDSBC Investigators that his office routinely has staff take X-rays before a clinical examination by the dentist, contrary to the College's *Dental Radiography Standards & Guidelines.* **Resolution** The dentist signed an agreement to ensure his staff ask all patients the purpose of their visit and the name of the dentist they are expecting to see, and ensure X-rays are only taken as prescribed by the treating dentist following a clinical examination as set out in the *Dental Radiography Standards & Guidelines*.
File 110	**Complaint** A patient complained about treatment he received within a two-year period related to the replacement of four crowns. **Investigation** The patient told CDSBC Investigators that despite wearing a nightguard, the crowns began to chip immediately. They were re-cemented several times and eventually had to be replaced. The patient said that one of the associate dentists punctured the root of one of the teeth, requiring it to be extracted. Another crown later failed and two implants and implant-supported restorations were needed. The patient felt that the principal dentist should be responsible for the costs of the implants. The dentist told CDSBC Investigators that she had not been directly involved in the patient's care, but that he was seen by several associate dentists at her practice. The patient was the brother-in-law of a CDA who worked there at the time and received a discounted rate for all of the dental treatment he received. For this reason, she declined to offer him a refund. The dentist provided the patient's extensive records and met with CDSBC Investigators to review the treatment plan. The records were complete and supported the treatment provided. It was noted that the patient had reported two traumatic injuries to his face shortly after the crowns were initially delivered. These injuries may have further damaged the crowns. It was also

	apparent from the records that the first associate dentist involved in the patient's care had advised him the replacement crowns would likely fail without orthodontic treatment being initiated first to correct his bite. The patient, however, declined orthodontic treatment until after the crowns had already failed. It appears the patient was at all times provided with appropriate treatment options and consented to all of the treatment he received. CDSBC Investigators found no evidence suggesting sub-standard care from any of the five associates involved in the patient's care. The only concern was the number of associate dentists involved in the patient's care, the lack of oversight of the treatment plan, and how this affected continuity of care. It also appeared the associates felt obliged to remain involved in the patient's complex care needs due to his affiliation with their CDA. A more objective assessment may have resulted in an earlier referral to a specialist. **Resolution** The principal dentist signed an agreement acknowledging the continuity of care concerns, agreeing to create a clinical environment that encouraged collaboration amongst the associate dentists involved in more complex treatment plans, and a level of overall office oversight to ensure the practice was being managed properly with proper patient boundaries in place.
File 111	**Complaint** A patient complained about the quality of fillings he received from the dentist after they fell out within six months. **Investigation** The patient told CDSBC Investigators that he is a single father and a disabled person who is a food bank recipient, and that he questioned the dentist's proposal to pay for his share of the treatment costs by providing a food bank donation. The patient also told CDSBC Investigators about other appointments where there were problems. At one, the dental instruments slipped and injured his tongue and gum, and at another, the dentist extracted a wisdom tooth but left behind the root tip. The patient said that when he reported these concerns, the dentist told him to leave and called the police. The dentist told CDSBC Investigators that food bank donations are a part of his practice and a way for patients to give back to the community while also credits for dental treatment. The dentist questioned why the patient would return to his practice if had been injured during treatment. The dentist said

	that the patient would have been referred to an oral surgeon to address the root tip remaining after the wisdom tooth extraction. CDSBC Investigators found that the records confirmed the treatment provided but were erratic, non-sequential, and there appeared to be entries that were made later. They found that the restorative care was not ideal, with the restorations failing within six months. The chart did reference an oral surgeon regarding the wisdom tooth, but it is unclear if the referral was actually made. The dentist began a leave of absence due to an unrelated health matter before an agreement to address his restorative care and recordkeeping could be signed. **Resolution** The dentist was informed that, should he wish to return to practice, he will need to complete CDSBC's *Dental Recordkeeping* course and a restorative course.
File 112	**Complaint** A patient complained that the dentist said the only treatment option for her cracked tooth was to have it extracted and replaced by an expensive implant. The patient said that she sought a second opinion from another dentist who was able to save the tooth and resolve her symptoms with root canal treatment. **Investigation** The dentist told CDSBC Investigators that she based her treatment recommendation on a diagnosis made by a dentist that the patient had seen several years earlier. That dentist noted in the chart a crack and the possibility of future extraction if the tooth continued to cause the patient problems. The dentist told CDSBC Investigators that she did not recommend root canal treatment assessment as it was her view, based on many years of experience, that the tooth would eventually need to be extracted. CDSBC Investigators found that the records confirmed the recommendation made but did not contain any evidence of the dentist's own independent diagnosis of a crack, nor were all treatment options provided including referral to a specialist. They were also concerned about an antibiotic that had been prescribed to the patient. She had a severe reaction to the medication, but the dentist said she was unaware of these side effects because the patient did not

	return. She explained that it was her view that this medication was preferable to the alternatives that the patient was not allergic to. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and a hands-on endodontic course that focuses on diagnosis and treatment planning and pharmacology.
File 113	**Complaint** A patient complained that she was provided with a bill after treatment which was more than double the estimated amount. **Investigation** The patient told CDSBC Investigators that she was advised by the dentist that additional work was done, but she was not informed of the change in treatment, nor advised of the additional costs she would incur. The dentist told CDSBC Investigators that the patient had decay that required immediate attention. The dentist recognized that the change in treatment, treatment options, and associated additional costs should have been discussed with the patient. The dentist subsequently wrote off the patient's outstanding balance and the patient was satisfied. The dentist was reminded that treatment changes and cost estimates are part of informed consent. **Resolution** The dentist signed an agreement to review CDSBC's *Dental Recordkeeping* course and to inform patients of all treatment options, the treatment to be performed, changes in the treatment plan, the associated risks and benefits and all costs before initiating treatment.