



Complaint Summaries

2016/17



Complaints: The Year 2016/17 in Review

The College of Dental Surgeons of BC (referred to below as CDSBC or “the College”) closed 208 complaints for the fiscal year ending February 28, 2017:

- 63% were closed without any formal action required against the registrant (dentist, certified dental assistant, or dental therapist).
- 31% were closed on the basis of the registrant’s agreement to take steps to address concerns identified during the investigation.
- 6% 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.
- **More 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 patient complained that the orthodontic treatment paid for in full was not completed by the dentist.

Investigation

The patient told CDSBC Investigators that the appliance provided by the dentist was painful, unwearable, and affected his normal daily activities. The patient said he had to pay for replacement retainers that were no better than the original. The patient said that the dentist told him that his bottom teeth would straighten up naturally, but they did not. He said that the dentist should have referred him to a specialist.

CDSBC Investigators reviewed the limited post-treatment records and found that the dentist did correct a significant portion of the misalignment, but he was unsuccessful in achieving complete correction of the crooked and crowded teeth. They found that the dentist did not explore other treatment options either in the pre-treatment planning phase or during the treatment when difficulty with correction became evident.

The dentist told CDSBC Investigators that a successful correction was prevented because the patient did not comply in wearing the removable appliance. CDSBC Investigators noted that the desired correction was not likely achievable with the appliance the dentist chose to use, and furthermore, had it been worn sufficiently to move the upper teeth, problems would have been created with other teeth.

CDSBC Investigators found that the records were incomplete and lacked documentation of various discussions the dentist said he had with the patient regarding relapse and the need for further orthodontic treatment, including a later referral. There was also no documentation of treatment alternatives, nor sufficient post-treatment records.

Resolution

The dentist signed an agreement to: take CDSBC's *Dental Recordkeeping* course, paying particular attention to both the recordkeeping and informed consent components; acknowledge that patients with severe/complex malocclusions such as in this case would benefit from referral to a specialist; acknowledge that treatment in this case could have been undertaken in a more optimal manner; and confirm that he is no longer taking on any new orthodontic patients.

**File 2****Complaint**

A patient complained about the dentist's orthodontic competency after receiving a second opinion from a certified specialist that questioned the dentist's treatment approach and recommended redoing the treatment.

Investigation

The patient told CDSBC Investigators that after spending \$6,000 and undergoing 29 months of orthodontic treatment, she was told by the dentist that treatment was not yet complete, that an implant and a bridge were needed, and that significant additional costs would be incurred. The patient also told CDSBC Investigators that she believed the dentist was a specialist rather than a general dentist who also provides orthodontics.

The dentist told CDSBC Investigators that she provided routine hygiene and restorative work for the patient for two years before the orthodontic treatment was undertaken. She said that she never misrepresented herself as an orthodontic specialist, which was confirmed by the records. The dentist agreed that the treatment did go longer than estimated, but that this was due to the patient's non-compliance with wearing elastics and the appliance. The dentist said that she outlined a number of treatment options (including the option noted by the specialist that the patient later saw), but the patient rejected this option and declined a referral to a specialist because of the cost.

The dentist told CDSBC Investigators that she felt she had sufficient education and experience to undertake the case; however, the orthodontic specialist's second opinion report raised concerns about the dentist's approach to treatment. The dentist's approach was over-complicated and she did not appear to recognize that it was too much for her to handle. The specialist questioned the dentist's "counter-productive" treatment of extracting five teeth and then recommending implants.

CDSBC Investigators were concerned with the dentist's informed consent and recordkeeping protocols, in addition to her orthodontic diagnosis and treatment planning. The dentist said that she planned to retire and was not accepting new patients, so the College monitored her two current orthodontic cases. The dentist later advised the College that she no longer planned to retire and did not want a limitation on her practice against providing orthodontic care.



	<p>The dentist signed an agreement to participate in a mentorship arrangement with a certified specialist in orthodontics to review and evaluate the areas of concern. The dentist would have to cease providing all orthodontic treatment, except for the one case she had, which would be monitored by the mentor.</p> <p>The dentist then told the College that she had sold her practice and would be retiring right away.</p> <p>Resolution</p> <p>The dentist signed an agreement to fulfil the terms of the earlier agreement if she decided to return to practice in the future.</p>
File 3	<p>Complaint</p> <p>A patient complained about the result of her orthodontic treatment by the general dentist.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she was left with an aesthetically displeasing result and that despite complying with wearing her retainer, she experienced relapse, which the dentist said would require another two years of treatment to fix.</p> <p>The dentist told CDSBC Investigators that he had been providing orthodontic treatment for the past 30 years and felt that a good result had been achieved for the patient. He said that the patient had severe crowding of her lower teeth. The dentist said that at the time of debanding, the patient's teeth were aligned and straight. He said that the subsequent relapse was due entirely to the patient's lack of compliance in wearing her retainer.</p> <p>CDSBC Investigators found that the dentist's clinical notes were minimal. There were few chart notations, no written treatment plan, and no indication that any other treatment options were discussed with the patient. A review of the X-rays and photographs revealed severe lower crowding and a significant "overbite." There was no indication that the dentist fully recognized the complexity of the patient's case or suggested a referral to a specialist.</p> <p>CDSBC Investigators met with the dentist to further discuss with him the basis for his treatment plan and the shortcomings, which had set the</p>



	<p>patient up for relapse. They determined the dentist's orthodontic diagnosis and treatment planning protocols required improvement and that he had limited insight into these issues.</p> <p>Resolution</p> <p>The dentist signed an agreement to participate in a specialist-mentored hands-on orthodontic study club for two years, with chart reviews conducted at one and two years. The dentist also agreed to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses.</p>
File 4	<p>Complaint</p> <p>A patient complained that one tooth became non-vital and required root canal treatment because the orthodontist over-tightened wires during treatment. She also complained that after she was debanded, she experienced problems with another tooth and that TMJ issues developed that prevented her from continuing with treatment.</p> <p>Investigation</p> <p>The orthodontist told CDSBC Investigators that the patient had been seen by several other orthodontists before she came under his care. He said that she had brackets already attached but no arch wires. The orthodontist said that treatment was uneventful, but that the patient reported some discomfort after a routine adjustment. The orthodontist said no TMJ issues were ever mentioned.</p> <p>The dentist said that when his office was closed for two weeks while he was on holiday, problems developed with one of the teeth. His answering machine invited patients to consult their general dentists or leave an emergency message. The patient said that she left messages, which were eventually returned by the dental office next door. That office arranged to see her and removed the orthodontic wire that she felt was causing the pain.</p> <p>It appeared to CDSBC Investigators that this was the beginning of the deterioration of the patient/dentist relationship. The orthodontist said he offered to pay for the tooth to be root canal treated, once he learned of it. However, he said that the patient demanded additional compensation and asked to be debanded and to stop the orthodontic treatment. The orthodontist said that he provided her with Invisalign appliances at her request. He said that talks broke down, however, when the patient continued to press for additional compensation.</p>



	<p>CDSBC Investigators found that there was no information supporting the allegations that the problems the patient experienced with two teeth were linked to the orthodontic treatment she received under the care of the orthodontist or that it was because the wires were over-tightened as she believed. CDSBC Investigators were, however, concerned about the orthodontist's recordkeeping protocols; records were sparse and the chart entries were over-written and illegible.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> course and undergo a chart review within six months.</p>
File 5	<p>Complaint</p> <p>The College opened a complaint file against a dentist after it received an email from a patient indicating significant concerns about treatment she said she received regarding three teeth that were extracted after the dentist provided white fillings to replace amalgam fillings.</p> <p>Investigation</p> <p>The patient reported experiencing pain after receiving the fillings and X-rays could not determine the cause of the pain. One tooth was extracted and a cyst was found attached to it. The patient continued to experience pain from the other two restored teeth. A biopsy of the cyst indicated the patient had a rare adverse reaction to the white fillings, which caused her body to reject the material. The dentist reportedly felt it was acceptable to extract these teeth. This report concerned CDSBC Investigators about the dentist's diagnostic competency and treatment rationale.</p> <p>CDSBC Investigators reviewed the dentist's records and were concerned with his recordkeeping, billing protocols, periodontal and endodontic diagnosis and treatment planning, X-ray interpretation, understanding of minimally invasive dentistry, cavities management protocols, root canal treatment, ethics, and informed consent.</p> <p>The dentist voluntarily underwent a review of 11 patient charts. The review confirmed the same concerns above, and also found concerns with:</p> <ul style="list-style-type: none">• Fixed prosthodontics• Treatment plans (difficult to understand) and rationale• Root canal treatment (six of the nine patients who received RCT showed a variety of problems from insufficient fill to creating holes



	<p>on the tooth to not informing patients when procedures were compromised)</p> <ul style="list-style-type: none">• Lack of information about periodontal probing depths, endodontic working and completion films, the rationale for endodontic treatment (such as pulp vitality testing)• Informed consent discussions (often not documented)• Treatment options (not all were provided)• Fixed prosthodontics (post choice and excessive removal of tooth structure that often made the teeth unrestorable)• Billing (the dentist made multiple submissions to insurance providers before completion of treatment, multiple submissions using codes for which the treatment rationale did not appear justifiable, and inaccurately billed for the higher fee of cyst removal instead of a tooth extraction) <p>Resolution</p> <p>The dentist signed an agreement to review and comply with the <i>Dental Recordkeeping Guidelines</i> and to take CDSBC's <i>Dental Recordkeeping</i> course. He agreed to ensure his billings are accurate. He agreed to take: an ethics course; an endodontic diagnosis and planning course; a hands-on endodontic course on cleaning and filling of root canal systems; an X-ray interpretation course; and a cavities management course. He agreed to cease providing root canal treatment (except for emergency procedures to alleviate pain) until he successfully completed the endodontic courses. He also agreed to participate in a full-day mentorship session and case review with a prosthodontics specialist, and to a 12-month monitoring period and a chart review.</p>
File 6	<p>Complaint</p> <p>A patient complained that the dentist did not inform her of the risks and potential complications of implant placement.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the dentist perforated her sinus during the procedure and then recommended a bridge. The patient said that the dentist was ready to place another implant at a different site, but the patient said she was overwhelmed by the perforation and wanted to wait. She said that the dental office then charged her a \$250 late cancellation fee and subsequently described her as a difficult patient. The patient said she felt pressured into the treatment by the front desk staff, who told her that if she waited, there would be bone loss and the</p>



procedure could not be done. The patient questioned his authority to give dental advice and began to lose confidence in the office.

The dentist told CDSBC Investigators that she did outline the risks and complications associated with the treatment during the consultation and notes the patient signed an informed consent document to this effect. The patient confirmed that she signed the document, but told CDSBC Investigators that no one went over it with her and she was not given a copy to take home. CDSBC Investigators were concerned about the dentist's recordkeeping and informed consent protocols because while the chart references a discussion about the risks and benefits and treatment options, no specifics were provided.

The dentist confirmed that the sinus was perforated and said she was surprised by this, as she was not expecting it based on her earlier review of the X-rays provided by the patient's general dentist. The X-rays were not of diagnostic quality, however, and the dentist did not take her own nor suggest that a dental cone beam scan be done prior to implant placement.

The dentist denied that her front desk staff gave false information to the patient and said that the receptionist told the patient what the dentist had advised him to say. She denied that the comments made were intended to pressure the patient into treatment or for the financial gain of the dentist. The dentist said that the patient asked for a refund and that she declined, providing her rationale directly to the patient.

CDSBC Investigators were concerned about the dentist's supervision of staff when the dentist confirmed that a CDA who was present on the day of treatment sent the patient a letter indicating that if she had not been such a difficult patient, perhaps the late cancellation fee could have been waived.

Resolution

The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and participate in a mentorship to focus on diagnosis and treatment planning, implant placement, post-operative treatment, supervision of staff and X-ray interpretation as well as an evaluation of the execution of the patient's case.



File 7	<p>Complaint A patient complained that several fillings placed by the dentist seven years earlier appeared to be slowly deteriorating.</p> <p>Investigation The patient told CDSBC Investigators that she was not informed that composite (white) fillings would not last as long as amalgam fillings and questioned whether the dentist used them because they were more expensive. The patient also said that there was an unreasonable delay in the office transferring her records to her new dentist.</p> <p>The dentist told CDSBC Investigators, and the records confirmed, that the fillings were replaced because of cavities under the old, leaking amalgam fillings. The dentist said that he did not have a discussion with the patient about material alternatives and the risks and benefits of each. The dentist noted that she does not use amalgam in her office and that the patient wanted the amalgam fillings replaced with a more esthetic material. This was not included in the chart and CDSBC Investigators found other recordkeeping concerns such as no medical history, no periodontal assessment, and no reference to any informed consent discussions with the patient. They also noted billing discrepancies in the procedure codes used to cover the costs of replacing the fillings. CDSBC Investigators told the patient that the wear on the fillings was normal given the passage of time and the potential of parafunctional habits (grinding, clenching, fingernail biting, etc.).</p> <p>Resolution The Inquiry Committee noted that the recordkeeping, informed consent and billing discrepancies were already being addressed through the dentist's participation in an educational program arising out of another complaint and directed the file be closed without further action.</p>
File 8	<p>Complaint A patient complained there was a lack of communication from the dental office in addressing her post-operative concerns and answering her questions about the treatment performed.</p> <p>Investigation The dentist told CDSBC Investigators that the patient is very nervous and, given her history of startling in the dental chair, requires treatment to be performed under sedation. The dentist said he extracted one of the</p>



	<p>patient's teeth to prepare for a bridge. He said that the patient reported lingering paresthesia (extended numbness and prickling/burning sensation) in her face and neck afterwards. He said he did not feel this was related to the treatment provided, but CDSBC Investigators noted that it appeared there was no immediate follow-up done with the patient to monitor her symptoms.</p> <p>At a later appointment, the patient returned with an ache in a different tooth. The dentist recommended, and the patient consented, to root canal treatment under sedation. Treatment was started, but could not be completed because only one canal could be located. An associate dentist assisted in the procedure, but it was agreed that the patient should be referred to a specialist or consider having the tooth extracted instead.</p> <p>Afterwards, the patient questioned why the tooth still ached. She called the office asking about what happened because she could not remember anything. After some delay, the office scheduled a consultation with its treatment coordinator, a CDA. The CDA told the patient about the failed root canal treatment and informed her that this information had been provided to the companion who picked up the patient following the procedure.</p> <p>It did not appear to CDSBC Investigators that any follow-up had been initiated by the office to ensure the patient was aware of the status of her treatment. The patient said that she only learned through this consultation that the associate dentist had also been involved in her treatment. She noted that she did not give her permission for this dentist to be involved in her care.</p> <p>CDSBC Investigators reviewed the records and found they supported the rationale for the treatment provided but revealed concerns in patient management, informed consent and recordkeeping.</p> <p>Resolution</p> <p>The dentist signed an agreement to arrange for him and his staff to take CDSBC's <i>Dental Recordkeeping</i> course, for the dentist to take CDSBC's <i>More Tough Topics in Dentistry</i> course.</p>
File 9	<p>Complaint</p> <p>An adult patient complained about a general dentist's orthodontic treatment plan that involved the use of appliances to expand her jaw after</p>



	<p>she received a second opinion from an orthodontist who said they were not effective for adults and typically are only used for children.</p> <p>Investigation</p> <p>The general dentist told CDSBC Investigators that he never held himself out as an orthodontist but did offer the service in his practice after taking several CE courses. He said that he had recommended the expansion appliances based on literature suggesting it was a viable treatment option for adults. The dentist told CDSBC Investigators that he issued a full refund after the patient questioned the treatment.</p> <p>CDSBC Investigators reviewed the records and were concerned with the dentist's orthodontic diagnosis and treatment planning, informed consent and orthodontic treatment. They found that the dentist did not have sufficient experience to treat the patient's fairly complex needs.</p> <p>Resolution</p> <p>The dentist signed an agreement to enroll in a hands-on orthodontic study club and limit his orthodontic cases to only those the study club mentor deemed suitable. The dentist also agreed to take CDSBC's <i>More Tough Topics in Dentistry</i> course and undergo a chart review after one year.</p>
File 10	<p>Complaint</p> <p>A patient complained that the dentist left residual roots when extracting teeth from his lower jaw and that the complete lower denture that he received following the extractions caused him discomfort.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that after the teeth were extracted he received an immediate complete lower denture, which always caused him discomfort and pain. He said that he only learned about the residual roots after a consultation with another dentist.</p> <p>The dentist told CDSBC Investigators that the patient only came to see him when he had specific issues, and never complained or requested any treatment related to his lower jaw or the denture. The dentist said that there had been significant bone loss in the lower jaw in the 15 years since the teeth were extracted, which may have significantly changed the fit and contributed to the discomfort of the denture.</p>



	<p>CDSBC Investigators found that a complete lower denture was a reasonable treatment choice, but that it was unlikely that the patient understood the limitations and associated risks of the treatment ahead of time. The treatment record indicates that the patient was advised of the possibility of retained root fragments on the day of the extractions, although the patient disputes this. It appeared that the dentist attempted to attend to the needs of the patient, but did not manage the case well and did not establish whether or not tooth matter was left behind or consider a referral to an oral surgeon.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and to acknowledge the importance of post-operative radiographs in a surgical case such as this one.</p>
File 11	<p>Complaint</p> <p>The mother of two young boys complained that the dentist diagnosed the need for seven restorations for each of her two children after obtaining a second opinion from another dentist who recommended none at all.</p> <p>Investigation</p> <p>The dentist told CDSBC Investigators that her diagnosis was based on her clinical examination and that she noted small lesions that are often not visible on X-rays. The dentist said that both boys had a history of cavities and poor hygiene which was another factor in her diagnosis. The dentist also said that she was an associate dentist in the practice which had a verbal policy of treatment planning on a worst case scenario basis. She said that if the mother had expressed concern about the treatment plans to her directly, she would have explained this and offered to monitor the areas of concern instead.</p> <p>It did not appear to CDSBC Investigators that the option of monitoring the teeth was offered to the mother and patients at the time. They found that a more conservative treatment plan was a better choice in both cases. In addition to her diagnosis, treatment planning, and informed consent protocols, CDSBC Investigators were also concerned about the dentist's ethical conduct. They found that the dentist appeared to have been influenced by the office policy and did not recognize her responsibility as the treating dentist to make her own diagnosis in the best interest of her patients.</p>



	<p>Resolution</p> <p>The dentist signed an agreement not to treatment plan in the absence of verifiable clinical or radiographic pathology, and to take CDSBC's <i>More Tough Topics in Dentistry</i> course as well as a series of five dental ethics courses offered by the American College of Dentists.</p>
File 12	<p>Complaint</p> <p>A patient complained that the dentist did not tell her that a file had separated in one of her canals during root canal treatment, and that the crown later placed on the tooth did not extend to the gum line as it should.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she experienced an infection after the treatment which ultimately led to the extraction of the tooth.</p> <p>The dentist said that a file did separate in the canal during treatment and that this is referenced in the chart, but CDSBC Investigators found that there is no indication that the patient was advised. A post-operative X-ray showed the crown had a gap. The dentist acknowledged this but said it was an isolated incident that was not representative of his general practice.</p> <p>The dentist voluntarily underwent a chart review which revealed concerns with his recordkeeping and informed consent protocols. He acknowledged the concerns but noted that he has since taken several prosthodontic courses. The dentist asked the Inquiry Committee to consider having him undergo a further chart review within three months so that his crown and bridgework could be further evaluated.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, participate in a chart review within three months to evaluate crown and bridgework and, if concerns were identified, require the dentist to participate in a clinical hands-on prosthodontics study club.</p>
File 13	<p>Complaint</p> <p>A patient complained that the orthodontic treatment provided by the general dentist was taking an excessive length of time.</p>



	<p>Investigation</p> <p>The patient told CDSBC Investigators that because her orthodontic treatment had already taken five years, she eventually sought second opinions from a several certified orthodontic specialists. They agreed that the duration of the treatment was inordinately long and should have been completed within two years, but that another two years of treatment was still required. The patient said that the dentist failed to explain why treatment was taking so long.</p> <p>The dentist told CDSBC Investigators that he had been providing orthodontic treatment for the past 30 years. He admitted this case did not complete as anticipated, and that he should have done a reassessment after one year. CDSBC Investigators found that while the dentist recognized that matters had not progressed as planned, his insight into why was limited.</p> <p>CDSBC Investigators found that the dentist's records were minimal. There were few chart notations, no written treatment plan, and no indication any other treatment options were discussed with the patient. CDSBC Investigators were concerned with the dentist's orthodontic diagnosis and treatment planning as well as with his recordkeeping and informed consent protocols.</p> <p>Resolution</p> <p>The dentist signed an agreement to participate in a specialist-mentored hands-on orthodontic study club for two years, with a chart review being conducted at one and two years. He also agreed to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses.</p>
File 14	<p><i>This file required public notification.</i></p> <ul style="list-style-type: none">• Read the publication notice: Anonymous Dentist >>
File 15	<p>Complaint</p> <p>A patient complained that three crowns failed shortly after they were placed by the dentist.</p>

**Investigation**

The patient told CDSBC Investigators that an infection developed under one crown, which required the tooth to be extracted, while the other two crowns were loose.

Initially, the dentist disputed that the crowns failed due to the treatment she provided, indicating that the patient's medical issues and the medications she was taking compromised the patient's immune system and made the patient more prone to infections. The dentist told CDSBC Investigators that she believed the patient's lack of proper dental hygiene was another contributing factor. CDSBC Investigators reviewed the records and were concerned with the dentist's prosthodontic, periodontic, and endodontic treatment.

CDSBC Investigators found that one of the crowns appeared to have a gap while the other two had poorly placed posts that did not provide sufficient support. The patient had hygiene appointments every three months, but the dentist had not done any root scaling in almost ten years because the patient found it painful. The dentist also admitted that she did not record periodontal probing as she should. There was no indication that the patient's periodontal issues were ever explained to her.

The patient's medical history indicated she was allergic to penicillin but the chart confirmed the dentist had prescribed amoxicillin to address the infection and had previously prescribed this medication numerous other times because the patient had advised she was not allergic. There was no indication the dentist had verified this with the patient's physician or otherwise recommended further allergy testing so the patient's medical history could be updated accordingly.

CDSBC Investigators also noted that several root canals were not filled sufficiently as part of root canal treatment, and in one instance, a separated file was left in the canal but with no indication the patient had been advised of this.

The recordkeeping was minimal and did not reference informed consent discussions with the patient nor findings to support diagnosis. The dentist acknowledged the concerns but indicated they were isolated to this case and not representative of her overall practice.



	<p>The dentist voluntarily agreed to a chart review. Several patient charts were randomly selected and the concerns with the dentist's periodontic, prosthodontic, endodontic, recordkeeping and informed consent protocols continued to be noted, suggesting a pattern of practice.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, a hands-on endodontic course and a series of sessions with a mentor to include a case review evaluating the execution of the patient's case, followed by a 24 month period of monitoring during which four more chart reviews would be conducted.</p>
File 16	<p>Complaint</p> <p>A patient complained of post-operative discomfort that continued several months after two restorations were done by Dentist A. She also questioned Dentist A's diagnosis that her daughter needed to have eight teeth filled when she had no cavities just nine months earlier.</p> <p>Investigation</p> <p>The patient sought a second opinion from Dentist B, who was employed at the same clinic. Dentist B told her the two restorations had gaps and should be replaced, and that her daughter did not need to have any teeth filled.</p> <p>Dentist A told CDSBC Investigators that the differing opinions were due, at least in part, to a difference in treatment philosophies. Dentist A denied that there was evidence of gaps on the restorations, and CDSBC Investigators found that the X-rays supported his position. However, they were concerned because the pre-treatment X-rays did not show decay that would require the two restorations to be placed. Dentist A explained that he took a preventative approach to the daughter's treatment. The X-rays, however, were not of diagnostic quality and suggested that only three teeth had any decay. The records also did not contain any notes for the basis of the diagnoses made, nor of treatment options or informed consent discussions.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> course and a course in X-ray interpretation, followed by a chart review.</p>

**File 17****Complaint**

A patient complained about her experience in having a wisdom tooth extracted by the dentist.

Investigation

The patient told CDSBC Investigators that the dentist was rude and condescending to both her and the dental assistant throughout the procedure, which caused her anxiety to increase. She said she felt the dentist was lacking in compassion and empathy. She said that she was later told by the dentist that a small portion of her tooth remained, but it would be dealt with later if it caused a problem. The patient said she did not return to the dentist following this very difficult appointment. She later saw a new dentist who diagnosed a dry socket and referred her to have the remaining portion of the tooth extracted by an oral surgeon.

The dentist told CDSBC Investigators that she was aware of the patient's anxiety because she had previously extracted a different wisdom tooth, which was very difficult due to its curved roots. The dentist said that the patient was uncooperative throughout the procedure and would frequently raise her hand to stop the procedure which broke the flow of the treatment. The dentist said she advised the patient after treatment that a small portion of the tooth remained and could be dealt with later if a concern arose.

CDSBC Investigators reviewed post-operative X-rays that showed a significant portion of the tooth remained. It did not appear that this was explained to the patient or that any plan was started to have the tooth fragment removed by an oral surgeon. It also did not appear that the dentist had provided the patient with the option of having the extraction done under the care of an oral surgeon (with associated sedation) at the outset.

CDSBC Investigators found that the dentist was unprepared for the patient's increasing anxiety and did not address it in a meaningful way. Through the investigation, they were concerned about the dentist's odontogenic surgery, diagnosis and treatment planning, patient relations and ethics.

CDSBC Investigators were unable to reach the dentist to discuss these concerns. She did not respond to phone messages, mail, or email. She has since allowed her registration to lapse and is no longer practising.



	<p>Resolution</p> <p>The Inquiry Committee directed that if the dentist applies to return to practice at some point in the future, she will be required to sign an agreement to undertake a remedial program to address the concerns identified in the complaint.</p>
File 18	<p>Complaint</p> <p>A patient complained about root canal treatment provided by the dentist which became swollen and infected shortly after.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that her dental insurer would not cover the cost of re-treating the tooth and she did not have the financial means to pay for it, so she complained to the College in the hopes of obtaining some assistance.</p> <p>The dentist told CDSBC Investigators that she had provided root canal treatment for the patient over the course of two appointments a few years ago. She said that she saw the patient for a routine recall examination, and that the patient did not report any concerns. The dentist said that she did not see the patient again after that visit.</p> <p>CDSBC Investigators reviewed the records and found they supported the rationale for the root canal treatment, but the chart did not include a health history and did not confirm that treatment options, including a referral to a specialist, had been discussed with the patient. The X-rays showed that the root canal treatment was poorly done, with insufficient fills on three of the canals and no fill in the fourth canal. In addition, the restoration had a gap near the gums. There was no indication that the patient was advised of these issues.</p> <p>The dentist, who was no longer practising, acknowledged the concerns and indicated she would be agreeable to addressing them upon her return to active practice. The patient was referred to the BCDA's mediation program to assist in resolving the matter with the dentist.</p> <p>Resolution</p> <p>The dentist signed an agreement acknowledging that should she return to active practice, she will be required to take a hands-on endodontic course</p>



	and CDSBC's <i>Dental Recordkeeping and More Tough Topics in Dentistry</i> courses.
File 19	<p>Complaint A parent complained the dentist billed for treatment that was not provided to his two children.</p> <p>Investigation The parent told CDSBC Investigators that he learned from their new dentist that the five restorations billed for each of his two children had not been done.</p> <p>The dentist told CDSBC Investigators that the chart confirmed the restorative work was planned, but she could not remember if the children had returned to have the treatment done or if the notations in the chart were for the purposes of pre-authorizations. The dentist said that she was unaware that the planned treatment had been billed to the insurer. She said that when the patients switched dentists, their files were deactivated so she did not become aware of the billing issues until the complaint was made. The dentist confirms the funds were then refunded to the insurer in full.</p> <p>CDSBC Investigators conducted a random chart review to determine if the billing discrepancies were isolated to these two cases or part of a broader pattern of practice. The chart review revealed concerns with how hygiene was being billed, in addition to diagnosis and treatment planning, X-ray interpretation, and recordkeeping.</p> <p>Resolution The dentist signed an agreement to: take CDSBC's <i>Dental Recordkeeping</i> course, a course in X-ray interpretation, and an ethics course; and engage in a mentorship with a College-approved dentist to review recordkeeping and billing protocols, diagnosis and treatment planning, and restorative technique, followed by a 12-month monitoring period with two additional chart reviews.</p>
File 20	<p>Complaint The patient complained she received substandard dental care from the dentist which led to bone loss, failed implants, poorly done root canal treatment, gum disease, and a five-unit bridge that is likely to fail.</p>



	<p>Investigation</p> <p>The investigation raised concerns with the dentist's diagnosis and treatment planning of periodontal cases involving implants and concerns with his recordkeeping and informed consent protocols.</p> <p>CDSBC Investigators found minimal evidence to support the dentist's assessment that the patient's gums were stable prior to implant placement. Periodontal records were minimal, and only two hygiene visits occurred over two years where two units of scaling were provided at each visit. The X-rays and photographs confirmed evidence of gum recession and significant bone loss in several areas of the mouth. There was also evidence of failing treatment or compromised teeth which were not recognized or recorded in the chart.</p> <p>It was also unclear if the dentist assessed the patient's bite during the evaluation of pain after insertion of the bridge. It also appeared that the dentist did not inform the patient at the initial exam of the failing or less than ideal treatments she had already received.</p> <p>CDSBC Investigators found that there was minimal detail in the treatment notes, no summary of treatment and option discussions, no notes on complete exam findings, and minimal periodontal records.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, participate in a case review with a periodontist who does implants, followed by a chart review to evaluate his recordkeeping, diagnosis and treatment planning and informed consent protocols.</p>
File 21	<p>Complaint</p> <p>A patient complained that the dentist failed to completely remove his tooth when extracting it.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the dentist assured him that the tooth was completely removed, but he began experiencing pain several months later. He said that he consulted another dentist who told him that the tooth was not completely extracted and that another surgery was</p>



	<p>required. The patient wanted the dentist to reimburse him for the cost of the second surgery.</p> <p>CDSBC Investigators confirmed that a significant portion of the root was left behind. They were concerned with the dentist's recordkeeping, informed consent, and post-extraction protocols.</p> <p>CDSBC Investigators found that the dentist's records did not include details of the extraction of the tooth. There were no notes that a flap was laid, that sutures were placed, nor that anesthetic was provided. The records were unclear as to how the dentist was going to address the patient's request for reimbursement, though there was a copy of a cheque made out in the patient's name that remained at the dental office. The medical and dental histories were also not completed.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, to take post-extraction X-rays, and only bill for fully completed extractions.</p>
File 22	<p>Complaint</p> <p>The patient complained about four implants placed by the dentist.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that three years after the dentist placed the implants she consulted a periodontist who said that she needed new implants and a large bone graft. She said that the specialist explained that the implants had worn down and caused pressure and bone loss.</p> <p>CDSBC Investigators found that the dentist appeared to appropriately diagnose the need for implants to help support an ill-fitting lower denture. The implants he placed appeared to be functioning well and the patient did not have any concerns with them until she was evaluated by the periodontist more than three years later. CDSBC Investigators acknowledged that the patient's case was challenging, given her history of heavy smoking, oral cancer, and lack of regular dental care since the implants were placed.</p> <p>The investigation raised concerns with the dentist's treatment of this implant case as well as his recordkeeping and informed consent protocols. There was minimal detail in the records about the extensive discussions</p>



	<p>the dentist reportedly had with the patient regarding the risk factors which may decrease the success of the implants. In addition, the patient said she was not advised to return for regular exams to maintain the implants. It was not possible for CDSBC Investigators to determine whether the bone loss was caused by unevenly placed implants, as the specialist suggested, or the lack of regular maintenance.</p> <p>Resolution</p> <p>The dentist signed an agreement to participate in a case review and to take CDSBC's <i>Dental Recordkeeping and More Tough Topics in Dentistry</i> courses.</p>
File 23	<p>Complaint</p> <p>A patient complained about post-operative pain and other problems after the dentist placed eight crowns.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she had sensitive teeth and that they were starting to show signs of wear on the biting surfaces due to a grinding habit. She said that the dentist made a nightguard for her upper front teeth and recommended crowns for eight teeth to protect them from further damage. The patient said that she agreed but that she did not understand what was involved in preparing her teeth for the crowns. She said that she experienced severe post-operative pain which she had difficulty managing with pain medications. The patient said that the nightguard was uncomfortable and made her feel worse. She later saw two other dentists who said she needed a full mouth guard, an analysis of her bite, root canal treatment on several teeth, and replacement of several of the crowns.</p> <p>The dentist told CDSBC Investigators that the patient had tooth sensitivity before she became her patient. The dentist said she was aware the nightguard was of limited use and that she would have switched to a guard for the full mouth had the patient said she was experiencing any discomfort. The dentist explained that the rationale for the crowns was to protect the patient's teeth; however, she said she did not do any testing to determine whether root canal treatment was needed to relieve the patient's pain. The dentist said she used zirconia for the crowns, but CDSBC Investigators found that another material would have been preferable, given the patient's grinding habit.</p>



	<p>CDSBC Investigators reviewed the records and found that they lacked detail about diagnosis and treatment planning and informed consent. While the patient did sign a consent form, she did not understand the risks and benefits associated with the treatment, and was unprepared to have her teeth filed down in preparation for crowns.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses and to undergo a chart review with a mentor to evaluate this case.</p>
File 24	<p>Complaint</p> <p>The father of a patient complained that the dentist took seven X-rays of his daughter during her cleaning appointment, despite his specific request not to take any.</p> <p>Investigation</p> <p>The father told CDSBC Investigators that he raised his concern with the dentist and she told him it was standard to take X-rays of all patients. The father said he was concerned about over-exposure to radiation as his daughter's orthodontist had recently taken a series of X-rays. He questioned why it was necessary for the dentist to take more.</p> <p>The dentist told CDSBC Investigators that she took the X-rays because she had not seen the patient in several years and, because the patient had a history of cavities, she wanted to check for decay and assess bone levels. The dentist said that she felt she had the informed consent of the father, because he had signed a general informed consent document several years earlier when his daughter first became a patient. CDSBC Investigators explained to the dentist that it is not appropriate to rely on such a document to constitute informed consent in the absence of explaining to the patient why X-rays were needed and what the proposed treatment options were.</p> <p>CDSBC Investigators were concerned about the dentist's rationale for taking the X-rays, given that they were of questionable diagnostic quality and did not capture the entirety of the tooth. The patient was in the midst of orthodontic treatment and had an orthodontic wire in place and large spaces between the teeth that would have allowed for the dentist to take a clinical view, rather than X-rays. The dentist acknowledged it is important to know when to take X-rays.</p>



	<p>CDSBC Investigators also found that the dentist's recordkeeping protocols were lacking in detail. While the patient's appointments were noted, there was no reference to informed consent discussions, the amount and type of anaesthetic used during the restorative treatment was not recorded, and the patient's dental and medical histories were incomplete. The dentist confirmed she recognized this on her own and had successfully completed the CDSBC's <i>Dental Recordkeeping</i> course.</p> <p>Resolution</p> <p>The dentist signed an agreement to implement the recommendations of CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses. She also agreed to take a course focused on X-ray technique and interpretation.</p>
File 25	<p>Complaint</p> <p>A patient complained that the dentist did not fully inform her about the treatment plan using Invisalign.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she believed the Invisalign treatment would be a two year process. She said that the dentist never told her that she would need to wear retainers for the rest of her life, nor the associated costs. She said no instructions were given to her about retainer wear and that the dentist failed to respond to her messages when the retainers became loose and appeared to have black dots on them.</p> <p>The dentist told CDSBC Investigators that she had a very detailed discussion with the patient about the Invisalign aligners and follow-up retention, but acknowledged that none of these discussions were referenced in the chart. The dentist said she did not receive the first messages the patient left for her due to a staffing issue that was not within her control. The dentist said that when the patient was later contacted by the office, she became aware of her concerns and tried to arrange for the patient to come in so she could be assessed and have new retainers ordered. She said that the patient declined, however, and that she tried again but that the dentist/patient relationship had broken down.</p> <p>CDSBC Investigators reviewed the records and found that they needed more detail and notes on informed consent discussions. They were also</p>



	<p>concerned that the rationale for the orthodontic treatment – avoiding recession and tooth loss – was overstated and not appropriate.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses and to ensure patients are provided accurate and adequate information about treatment options, the proposed treatment and a cost estimate (preferably in writing).</p>
File 26	<p>Complaint</p> <p>The director of a remote community dental clinic complained that the associate dentist did not meet current standards during her six-month term at the clinic.</p> <p>Investigation</p> <p>The director, who was the primary dentist at the clinic, was concerned with the associate dentist's diagnosis and treatment planning, X-ray interpretation, and operative and endodontic competency. She supplied records of 13 cases to support these concerns. CDSBC Investigators reviewed the patient charts and were concerned with the dentist's: X-ray interpretation and diagnosis; cavities management protocol and minimally invasive dentistry; operative protocols in composite restoration placements; root canal treatment competency; and recordkeeping.</p> <p>The associate dentist met with CDSBC Investigators to review the results of the chart review. She explained that she had realized that practising at a community clinic was not the right work environment for her. She had already given her notice to the clinic. The dentist said that she had reassessed each patient she saw and she only provided treatment which she agreed with; however, she admitted often the scheduling was determined by the administrative staff and she felt pressured to complete the work scheduled for that day. The dentist acknowledged the concerns raised from the chart review, but reported that she was now following all guidelines.</p> <p>CDSBC Investigators conducted another chart review in her current practice. The records were legible, well organized and generally met the guidelines, with a few exceptions. Nine of the ten endodontic procedures reviewed were done to the expected standard. The results of this chart review were discussed with the dentist and she addressed concerns that were found to be outside of the guidelines, including that she is now using</p>



	<p>acceptable methods for composite restorations, is no longer administering fillers, and documents diagnosis for all endodontic procedures and takes diagnostic post-treatment X-rays.</p> <p>The concerns originally identified regarding X-ray interpretation, cavities management and recordkeeping appeared to CDSBC Investigators to have been limited to the dentist's six-months of employment at the community clinic and are not a concern in her current practice.</p> <p>Resolution</p> <p>The dentist signed an agreement to enroll in a hands-on composite placement course and take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses.</p>
File 27	<p>Complaint</p> <p>A patient complained that a tooth that the dentist had hemisected (see explanation below) and crowned later needed to be extracted.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the dentist could not complete root canal treatment and so he hemisected the tooth. (This procedure is for teeth with two roots, such as lower molars. The dentist cuts the tooth in half to remove damaged bone and root, and tries to save the tooth by leaving a healthy root and replacing the portion of the tooth that was removed with a crown.) The patient said she saw a new dentist who told her that there was a gap that created a food trap, which caused decay and the ultimate failure of the crown. The patient's new dentist extracted the tooth and provided her with options of having a bridge or an implant, both at significant cost.</p> <p>The original dentist told CDSBC Investigators that a canal of the tooth was calcified and he recommended that the patient be referred to an endodontic specialist. He said that she declined due to the cost and instead agreed that he could section and extract half the tooth and restore the remaining half with a crown. The dentist said that he advised the patient that the long-term outlook for the tooth was not good and he recommended that the tooth be monitored over the following year. He told CDSBC Investigators that he believed the crown failed because of the patient did not wear her nightguard to protect against her grinding habit.</p>



	<p>The dentist told CDSBC Investigators that he sold his practice shortly after the treatment for the tooth and he did not see the patient again.</p> <p>CDSBC Investigators reviewed the records and found that they lacked detail and did not contain any information about the clinical observations to justify the diagnosis and treatment planning. There was no reference to any informed consent discussions with the patient and no indication the patient was offered a referral to a specialist. CDSBC Investigators were concerned about the treatment approach taken and noted that no post-operative X-rays were taken by the dentist following delivery of the crown.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> course and participate in a case review with a prosthodontic specialist to evaluate the execution of the patient's case.</p>
File 28	<p>Complaint</p> <p>A patient complained that the dentist did not proactively address his pain after he provided a filling.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that after the post-operative pain from the filling did not resolve, the dentist diagnosed the need for root canal treatment followed by a crown. The patient also raised other concerns, saying that the dentist's assistant performed duties she was not qualified to do, that his outstanding bill for the crown was sent to a collections agency, and that he heard from a friend that the dentist's sterilization protocols were lacking.</p> <p>The dentist explained to CDSBC Investigators the sequence of events leading to the need to root canal treat the tooth. They found that his diagnosis and treatment planning was fully supported by the records, but that the chart lacked detail and appeared to be missing important components such as: clinical observations, informed consent discussions with the patient, periodontal probing, and scaling. This indicated that the dentist's informed consent and recordkeeping protocols were in need of improvement.</p> <p>The dentist told CDSBC Investigators that the patient's account was sent to collections without his knowledge by a temporary receptionist. The dentist said he had the account retracted as a gesture of good will. Both</p>



	<p>the dentist and his chairside assistant denied that she was doing duties she was not qualified for (administering anaesthetic, seating crowns, scaling or adjusting teeth). She explained that she looks very similar to the hygienist and is often mistaken for her by patients both in and out of the office. The dentist and his assistant told CDSBC Investigators that the office adheres to the CDSBC's <i>Infection Prevention and Control Guidelines</i>, that all staff wear gloves, and that rubber dams are often used. There was no evidence to suggest sterilization was lacking within the office.</p> <p>Resolution The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping and More Tough Topics in Dentistry</i> courses.</p>
File 29	<p>Complaint A patient complained about the restorative treatment provided by the dentist.</p> <p>Investigation The patient told CDSBC Investigators that she saw the dentist after a filling fell out and wedged between two teeth. She said that the dentist restored the tooth but the filling was defective and was causing food to be impacted which led to painful gum inflammation. The patient said she went to another dentist who told her that the decay had not been removed prior to the filling being replaced, and that there was a gap on a crown that the dentist had placed on another tooth.</p> <p>The dentist told CDSBC Investigators that, as a new associate to the practice, he became involved in the patient's care for emergency issues and that he did not have an opportunity to perform a comprehensive examination. The dentist said that he takes a conservative approach and that he planned to monitor the areas of concern. The dentist said he felt that he was not given an opportunity to address the patient's concerns, as she went to a new dentist.</p> <p>CDSBC Investigators reviewed the records and confirmed the concerns identified by the second dentist. The dentist said that he had not taken a post-operative X-ray and was not aware of the defective crown margins. The dentist acknowledged cavities in the tooth, but suggested the restorations failed because of the patient's grinding habit and failure to consistently wear her mouth guard. The dentist acknowledged that three</p>



	<p>restorations had failed within the five-months that he saw the patient (at four appointments). The dentist also acknowledged that his recordkeeping and informed consent protocols needed improvement.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses. He also agreed to either a case review with a mentor or to join a clinical hands-on prosthodontics study club for one year, followed by a chart review within six months.</p>
File 30	<p>Complaint</p> <p>The patient complained that the dentist provided bridge work when he only wanted a tooth that was causing him pain to be extracted.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that he was upset when the dentist presented a \$14,000 estimate for proposed permanent dental treatment. He said that he was given an estimate totaling \$4,000 for work already performed. When his bridge broke, the patient said he saw another dentist and learned that the bridge was temporary. The patient said he was confused about what treatment he received, as he thought he had received a permanent bridge by the original dentist.</p> <p>The dentist told CDSBC Investigators that he diagnosed a failing lower 12-unit bridge and reviewed a complex treatment plan, which included a new 12-unit bridge, with the patient. He said that the bridge needed to be provided within a very short period of time because the patient was going out of the country, but that the patient declined the proposed treatment after seeing the estimate. The dentist said that instead of the proposed treatment, he extracted the tooth and placed a temporary bridge, and attended to other dental needs such as addressing decay and providing root canal treatment. He said that he advised the patient to seek permanent treatment as the treatment he received was temporary and would not last. The bridge lasted six months before breaking. The subsequent-treating dentist repaired the broken bridge and advised the patient to return to his original dentist regarding permanent treatment.</p> <p>CDSBC Investigators were concerned with the dentist's recordkeeping, diagnosis and treatment planning, and billing. They questioned the feasibility of placing a bridge because there was evidence of substantial bone loss around these remaining six teeth, making them unsuitable as</p>



	<p>abutments to support a 12-unit bridge. CDSBC Investigators were concerned by the lack of detail in the treatment notes, which lacked information to indicate that options and prognosis had been reviewed with the patient. The billing records were often not reflected in the chart. It was also noted that the endodontic fill of a tooth was not thick enough and did not fill the canal sufficiently.</p> <p>Resolution</p> <p>The Inquiry Committee took into consideration that as a result of the complaint, the dentist had already completed CDSBC's <i>Dental Recordkeeping</i> course, enrolled in a prosthodontic study club, and completed a two-day hands-on endodontic course.</p> <p>The dentist signed an agreement to take CDSBC's <i>More Tough Topics in Dentistry</i> course, an ethics course, and participate in a review of this case with a mentor.</p>
File 31	<p>Complaint</p> <p>A patient complained that she experienced drooping eyes, bruising to the left side of her eye socket and cheek, and a frozen upper lip, after the dentist administered 148 units of Botox injections.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she had received Botox injections elsewhere in the past, but not in the amount she received from the dentist. She also said that the advertising outside the clinic promoted Botox to treat forehead lines, crow's feet, frown lines, grinding and clenching.</p> <p>CDSBC Investigators found that the patient was not an existing patient of record at the time of consultation with the dentist about receiving Botox injections. The patient had not had a dental examination and the injections were not part of a dental treatment plan. CDSBC Investigators raised this concern with the dentist and they advised her to consider a conservative dosage initially for new patients, as per manufacturer's direction, and to document the dosage in the patient chart. They also warned the dentist that health product advertising should not emphasize product benefits without also including safety information.</p> <p>As a result of the concerns raised, the dentist met with a Panel of the Inquiry Committee. The dentist showed evidence of voluntarily making</p>



	<p>meaningful changes to her practice to address each concern, and the Panel was satisfied that the dentist had learned from the experience.</p> <p>Resolution</p> <p>The dentist signed an agreement to ensure she is practising within the scope of practice, ensure that her advertising is in compliance with the College's <i>Bylaw 12: Advertising & Promotional Activities</i> and the provisions of the <i>Food and Drugs Act</i> and <i>Food and Drug Regulations</i>, and acknowledged that she has an enhanced awareness of the safety and use of Botox and will only offer it to patients of record as part of a comprehensive dental plan.</p>
File 32	<p>Complaint</p> <p>The mother of a teenaged patient complained about the significant post-operative complications her daughter experienced after undergoing a frenectomy (a surgical procedure that removes or loosens a band of muscle tissue that is connected to the lip, cheek or floor of the mouth).</p> <p>Investigation</p> <p>The dentist told CDSBC Investigators that the frenectomy was quick and uneventful and that post-operative instructions were provided to the patient. He said that he did not become aware of the post-operative problems until seven months later. By that time, the patient was under the care of a periodontist who diagnosed infection and inflammation of the bone marrow. The specialist performed surgery to remove dead bone matter and graft fresh tissue. The specialist told CDSBC Investigators that the patient was very slow to heal, which was attributed to her smoking habit, failure to comply with antiseptic rinses, and poor hygiene. The specialist indicated that this appeared to have been a very rare post-operative occurrence and he could not conclude that the dentist had done anything wrong in the procedure.</p> <p>The dentist told CDSBC Investigators that he discussed the procedure with the patient, who consented, but there are no notes in the chart reflecting this, nor notes relating to diagnosis and treatment planning. The dentist said he recommended the procedure to prevent orthodontic relapse and a gap in the teeth from occurring, but said that he did not consult with the patient's orthodontist first.</p>



	<p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping and More Tough Topics in Dentistry</i> courses.</p>
File 33	<p>This file required public notification.</p> <ul style="list-style-type: none"> • Read the publication notice: Dr. Mansour Foomani >>
File 34	<p>Complaint</p> <p>A patient complained that after the dentist replaced a crown on his tooth, it developed problems after only a month, and had to be extracted within a year because of a fractured root.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the tooth had been previously root canal treated by a different dentist.</p> <p>The dentist told CDSBC Investigators he was surprised when he received the complaint. He said that the crown clearly needed to be replaced and that the patient agreed. The dentist said that the tooth had no symptoms and that there was no evidence it was loose. The dentist said that when the patient later returned, no mobility or inflammation was noted.</p> <p>CDSBC Investigators reviewed the records and found that they supported the rationale for replacing the crown. However, there was no indication that the dentist noted the short fill on the previous root canal treatment, that he offered a referral to a specialist, or that he advised the patient of this and how it might compromise the tooth. There was no indication that any consideration was given to a potential root fracture; the dentist did not assess periodontal findings or develop a management plan.</p> <p>CDSBC Investigators found that the records lacked detail and did not include periodontal probing or sufficient information of what was discussed with the patient to ensure the patient was able to provide informed consent. They noted that there were issues with the dentist's recordkeeping protocols despite him having already successfully completed CDSBC's <i>Dental Recordkeeping</i> course.</p> <p>Resolution</p> <p>The dentist signed an agreement to review the <i>Dental Recordkeeping Guidelines</i> and take CDSBC's <i>More Tough Topics in Dentistry</i> course.</p>

**File 35****Complaint**

A Registered Dental Hygienist contacted CDSBC pursuant to her duty to report under the *Health Professions Act*. She was concerned that the dentist had altered her chart entries without her knowledge or consent, and had deleted entries made by another staff member.

Investigation

The dentist told CDSBC Investigators that her longstanding partnership with the other dentist at the practice was ending and that she was preparing to transition into her own dental practice. The dentist said that a patient told her she wanted to be seen at the dentist's new office, but that she noticed this was not reflected in the entries made by the Registered Dental Hygienist in the patient's electronic chart.

The dentist admitted that she altered the Registered Dental Hygienist's notes and deleted the front desk staff's notes and did not use her own login identification when doing so. She said her only objective was to ensure that the chart notes were accurate. The dentist said she felt it was okay to make the alterations to the chart because it was not treatment related and because the system's audit trail allowed such edits to be made within 24 hours and would show from which work station the changes were made, even if she did not use her own login identification.

The complaint raised serious concerns about the dentist's ethics and recordkeeping protocols.

Resolution

The dentist signed an agreement acknowledging the ethical concerns, undertaking never to repeat the behaviour, to pay a \$1,000 fine, to set a lock on her current electronic recordkeeping software system to ensure it cannot be modified by other users, and to take six online dental ethics courses offered by the American College of Dentists.

File 36**Complaint**

A Registered Dental Hygienist contacted CDSBC pursuant to her duty to report under the *Health Professions Act*. She reported concerns about the dentist's periodontal recordkeeping protocols.



	<p>Investigation</p> <p>The Registered Dental Hygienist was concerned because the dentist told her that the office only recorded periodontal probing over 3mm. She found no detail about probing depths, mobility, furcation (area of bone loss where the roots of a tooth branch out), or bleeding was noted in the chart for a patient.</p> <p>The dentist told CDSBC Investigators that he routinely records probing depths of 3mm or more, mobility at 1mm or more, furcations, and bleeding in the chart. CDSBC Investigators reviewed the records and found that more information was needed.</p> <p>CDSBC Investigators were also concerned about the rationale for the treatment plan offered for the patient, which included splinting two crowns together. They felt this treatment plan had a poor long term prognosis and would likely result in the failure of both teeth. It did not appear that any consideration had been given to other treatment options, such as crown lengthening, extraction or adding to the patient's existing partial upper denture.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and undergo a case review with a certified specialist in prosthodontics.</p>
File 37	<p>Complaint</p> <p>A patient complained about the upper and lower dentures provided by the dentist.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the dentures were not made as promised, would not stay in place, and did not allow him to eat properly. He said that his concerns were not resolved by the dentist during multiple visits and repeated adjustments, so he saw a new dentist who was able to provide him with functional dentures.</p> <p>The dentist told CDSBC Investigators that the patient's teeth were quite worn and needed some restorative work, but that he had good bone levels, long tooth roots and had stable gums. The dentist said that ideally, the treatment plan would have involved crown and bridgework, but the</p>



	<p>patient declined this option due to the cost. He said that the patient instead opted to have all his teeth extracted and partial removable upper and lower dentures placed. The dentist said she was reluctant to proceed, as she realized there could be chewing and retention issues. She said she believed that implants would help support the dentures if this became a problem, but suspected that this was not likely an affordable option for the patient. As a result, the dentist said she offered another option: overlay dentures (dentures that rest on top of natural teeth) and retain some teeth after performing root canal treatment to provide vertical support. The dentist said she felt the patient understood the rationale for the treatment. The dentist agreed that there were problems with the dentures that she was unable to resolve following multiple adjustments and after remaking them twice. She said the patient declined a referral to a specialist.</p> <p>With the benefit of hindsight, the dentist acknowledged that the patient's case was more complex than she realized at the outset, and that the treatment plan was limited by cost considerations. The dentist agreed the patient would have benefitted from a referral to a prosthodontist at the outset. CDSBC Investigators found that the records provided by the dentist were very detailed and thorough.</p> <p>Resolution</p> <p>The dentist signed an agreement to participate in a case review with a certified specialist.</p>
File 38	<p>Complaint</p> <p>A patient complained about the dentist's replacement of a fractured bridge.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the bridge had originally been placed while in China and that this was the second time the bridge had failed. He said that he saw the dentist as a new patient and wanted her to replace the bridge a third time. He said that the dentist used too much force and that he heard a loud crack as the dentist was attempting to remove a crown. The patient said that the dentist agreed to pay for the cost of an implant if she could not replace the bridge. The patient said that the dentist replaced the bridge, but that it broke just three days later. He said that the dentist tried to get out of the agreement to pay for an implant.</p> <p>The dentist told CDSBC Investigators that indeed there was a loud crack as she attempted to loosen the crown. She said that she immediately told</p>



	<p>the patient that the root of the tooth might be broken and that extraction might be necessary, but that she was not yet in a position to confirm the restorability of the tooth. She said that when the patient accused her of using too much force and threatened legal action, she agreed to cover the cost of an implant if she could not restore the tooth. The dentist said she later confirmed the root of the tooth was intact. She said that she remade the bridge but that it failed shortly afterwards.</p> <p>The dentist acknowledged that she did not have an informed consent discussion with the patient about the risk of damaging the supporting teeth during the removal of the fractured bridge, nor did she explore why the bridge had failed twice earlier. The dentist admitted that she jumped to the conclusion that the tooth was likely unrestorable and offered to cover the costs of an implant to deter the patient's threat of legal action. The dentist told CDSBC Investigators that the patient was not charged for the build-up of the crowned tooth or the replacement of the bridge.</p> <p>Resolution</p> <p>The dentist signed an agreement that she and her staff will take CDSBC's <i>More Tough Topics in Dentistry</i> course, and that she will participate in a case review with a prosthodontist.</p>
File 39	<p>Complaint</p> <p>A patient complained that the dentist did not wear gloves during treatment.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that he declined to return to the office as a result and was told by staff that it was standard practice for this dentist not to wear gloves.</p> <p>The dentist told CDSBC Investigators that he does not wear gloves as he does not believe it is necessary and it tends to aggravate his eczema. The dentist said that if a patient objects and does not accept his rationale, he will then wear gloves. CDSBC Investigators told the dentist that under the <i>Infection Prevention and Control Guidelines</i> it is a requirement to wear gloves. The dentist maintained his position and said that he had never heard of a reported case of a dentist transmitting a disease to a patient because gloves were not worn.</p>



	<p>Resolution</p> <p>The dentist signed an agreement to review the <i>Infection Prevention and Control Guidelines</i>, wear gloves when providing treatment, and to have a site inspection conducted by CDSBC Investigators to monitor practice standards.</p>
File 40	<p>Complaint</p> <p>A patient complained about several issues related to treatment she received from the dentist to address overlapping and loose front teeth.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she was an anxious patient and went to see the dentist because he offered oral sedation. She said that she proceeded with the only treatment option offered: to extract her teeth and replace them with a fixed bridge. The patient said that the bridge was loose and uncomfortable, and created problems eating and speaking. The patient said that she was billed for nitrous oxide, but that she only received a pill mixed with baby Tylenol given to her by the receptionist. The patient said that she later sought a second opinion about the bridge and was told that she had severe gum disease which is why the bridge was ill-fitting. She was told she was at risk of losing all of her teeth. She questioned why the original dentist did not assess her gum condition prior to treatment and wonders if her teeth could have been saved.</p> <p>The dentist told CDSBC Investigators that he did outline various treatment options, including implants, but that the patient declined due to cost. The patient denied this, noting that after her gum disease was treated, she received four implants.</p> <p>CDSBC Investigators found that the dentist's chart lacked detail and did not confirm what was discussed at the initial consultation. The diagnosis and treatment planning notes were minimal. The dentist said he did note concerns with the gums and would have addressed them, likely by referring the patient to a specialist, had she remained a patient. The chart confirmed the gum concern, but no probing was noted and it was not addressed through more frequent hygiene.</p> <p>The dentist told CDSBC Investigators that he dispensed the sedation medication and allowed his receptionist to give it to the patient. The dentist acknowledged that this is not permitted. CDSBC Investigators noted that the types and amounts of sedation medications were not noted in the</p>



	<p>chart. The dentist said that they were logged separately. He said that the patient received two different benzodiazepines and that he used a billing code for “nitrous oxide and/or conscious sedation.” CDSBC Investigators told the dentist that this was not the correct code and that he should have used “oral sedation” that does not include nitrous oxide. The dentist was also advised that since he is only authorized to provide minimal sedation (he had previously been authorized to provide moderate sedation) he cannot administer two medications.</p> <p>CDSBC Investigators found issues with diagnosis and treatment planning for the fixed bridge and its abutments. They were concerned that the dentist did not appear to diagnose the patient’s gum disease, which should have been addressed prior to starting a treatment plan.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC’s <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, only provide minimal sedation in accordance with the guidelines, bill only for treatment provided, and participate in a case review with a mentor to evaluate the execution of the patient’s case from a periodontic viewpoint.</p>
File 41	<p>Complaint</p> <p>The patient complained that the dentist did not properly seat a crown, and changed the treatment plan to replace a bridge with a more costly option and began to prepare the abutment teeth without his consent.</p> <p>Investigation</p> <p>The patient said he later saw a new dentist who told him that the crown placed by the first dentist was not seated properly and was causing food to get trapped. The patient wanted a refund for the crown. The patient also believed that it would have been sufficient to replace his bridge with a new one of the same type at less cost to him. Instead, he said that the dentist changed the plan mid-treatment and provided him with a more costly ceramic bridge.</p> <p>CDSBC Investigators were concerned with the dentist’s diagnosis and treatment of fixed prosthodontic cases, recordkeeping and informed consent protocols.</p> <p>The dentist told CDSBC Investigators that there were no gaps at the margin of the crown when it was inserted, but X-rays from the subsequent</p>



	<p>treating dentist noted an open contact and a gap between the crown margin and the crown. Given the discrepancy, CDSBC Investigators obtained an independent opinion, which confirmed the open contact and gap on the crown.</p> <p>CDSBC Investigators found that the records confirmed the patient was advised at the new patient exam that the bridge was failing and would require replacement. Notes from 10 months later document the patient was again advised a PFM bridge (porcelain supported by a metal substructure) would be the treatment of choice. However, there is no record of the patient's agreement, and the signed cost estimate and the consent for the treatment provided is dated over a year later. The patient received a three-unit PFM bridge and reported to CDSBC Investigators that he is happy with the function of the bridge.</p> <p>CDSBC Investigators found that the records required improvements to document consultation and informed consent. They did not include all aspects of discussions with the patient, including medical history review, treatment planning, informed consent and post-operative complications.</p> <p>Resolution</p> <p>The dentist signed an agreement to participate in a case review with a prosthodontist, improve his recordkeeping about consultation and informed consent, take CDSBC's <i>Avoiding Complaints</i>, <i>More Tough Topics in Dentistry</i>, and <i>Dental Recordkeeping</i> courses.</p>
<p>Files 42 & 43</p> <p><i>Editor's Note:</i> A separate complaint file was opened for each of the two dentists complained about.</p>	<p>Complaint</p> <p>Eight registrants complained about a column in a local newspaper authored by two dentists.</p> <p>Investigation</p> <p>The registrants told CDSBC Investigators that the column implied that dentists who charge less are less qualified and provide lower quality dental care than those charging higher rates. They complained that the articles are unprofessional, misleading, disrespectful, and contravene the College's advertising guidelines.</p> <p>CDSBC Investigators found that the articles were promotional pieces, as each column ended with an offer of a free implant consultation. They told the dentists that the articles raised concerns, including the prohibition against inducements as set out in CDSBC's Bylaw 12.</p>



	<p>Both dentists acknowledged their responsibility and indicated they were receptive to make the necessary changes going forward. CDSBC Investigators reviewed subsequent articles and found their tone and content were much improved.</p> <p>Resolution</p> <p>The dentists signed an agreement to maintain positive professional relationships with other members of the local dental community; to be aware of the sensitivity that other practising dentists have to published claims and comments; and to ensure that all future advertising and promotional activities comply with the College's <i>Bylaw 12: Advertising & Promotional Activities</i>.</p>
File 44	<p>This file required public notification.</p> <ul style="list-style-type: none">• Read the publication notice: Dr. Mansour Foomani >>
File 45	<p>Complaint</p> <p>The parent of a child complained that the dentist extracted the wrong tooth because he did not have the referral letter from the patient's orthodontist.</p> <p>Investigation</p> <p>The dentist told CDSBC Investigators that he took full responsibility and admitted that he extracted the wrong tooth. The dentist said that the office did not have the referral letter in hand at the time, and that he relied on the verbal communication between the receptionists at his and the orthodontic office, which had been recorded in the office's computer system.</p> <p>The dentist said that when he learned of the mistake, he immediately accepted responsibility, apologized to both the parent and the orthodontist, and offered to issue a refund to the parent. The dentist said that while the extraction of the baby tooth did not adversely affect the outcome of the patient's orthodontic treatment plan, he appreciated the seriousness of the matter and had implemented steps to ensure it could not happen again. He said that his practice no longer books referrals for tooth extraction until a written referral letter has been received.</p> <p>The dentist agreed that it would have been advisable to have rescheduled the appointment until he could either speak with the orthodontist directly or until the referral letter had been received. It appeared to CDSBC</p>



	<p>Investigators that it was a learning experience for the dentist who did appear to be genuinely remorseful, but it was nevertheless a concern the dentist proceeded with the extraction without complete information and without reviewing any X-rays.</p> <p>Resolution</p> <p>The dentist signed an agreement that he will not appoint referral extraction patients without a written referral, and that he will ensure he reviews any related X-rays prior to undertaking treatment.</p>
File 46	<p>Complaint</p> <p>The mother of a teenager complained that the dentist did 10 fillings for her son despite the fact that she had specifically told the dental office only to do two fillings that had been recommended by their regular dentist.</p> <p>Investigation</p> <p>The mother told CDSBC Investigators that she felt her son had been taken advantage of, noting that he was not aware that the cost of the treatment was \$1,800 and almost entirely exhausted their dental plan.</p> <p>The dentist told CDSBC Investigators that he was aware the patient wanted to have his dentistry done prior to leaving for University. The dentist said he had two bitewing X-rays from the patient's regular dentist, but took his own panorex (captures the entire mouth in a single image) to make an independent diagnosis. He said that he concluded that several more restorations were necessary. The dentist said that the patient consented and that he did not contact the mother about the cost, which was covered under her dental plan, because she was out of town and unavailable. The dentist said he was unaware that the mother only wanted the two cavities diagnosed by the patient's regular dentist to be filled.</p> <p>CDSBC Investigators felt that it would have been prudent for the dentist to have held off on some of the treatment until the mother returned and financial consent could be obtained.</p> <p>CDSBC Investigators found no evidence suggesting that the dentist had tried to take advantage of the patient. In speaking to the patient, it seemed that he had consented to the treatment. The dentist treated him as a new patient and based his treatment recommendation on his own examination. They were, however, concerned with the dentist's recordkeeping and informed consent protocols. They also noted problems with some of the</p>



	<p>fillings, including: empty spaces, overhangs, and the possibility of decay. The dentist acknowledged the concerns with his recordkeeping and informed consent protocols. He also agreed to replace those fillings where problems were identified.</p> <p>Resolution The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and an operative course to be followed by a chart review.</p>
File 47	<p>Complaint CDSBC opened a complaint file after a chart review of randomly selected patient charts as part of another complaint investigation revealed significant concerns relating to the dentist's diagnosis and treatment planning, billing, recordkeeping, periodontic and endodontic care.</p> <p>Investigation A Panel of the Inquiry Committee oversaw the investigation. CDSBC Investigators completed the chart review by reviewing additional charts, which supported the serious concerns initially identified. The dentist provided a report and acknowledged the concerns. The dentist agreed to retire from practice and not to apply for reinstatement.</p> <p>Resolution The dentist signed an agreement to voluntarily withdraw from practice and not to apply for reinstatement. If she wants to return to practice she must meet the requirements of a remedial agreement as set out by the Panel.</p>
File 48	<p>Complaint A patient complained that the dentist made her feel unworthy of his treatment at a new patient examination.</p> <p>Investigation The patient told CDSBC Investigators that during the appointment the CDA obtained X-rays and photos, and presented the treatment plan. The patient said that the dentist conducted only a cursory exam and said that his treatment is very expensive and would depend on what she was willing to pay. She said that the dentist used an analogy of a visit to a car dealership, where one could leave with a very expensive car or a cheap car, depending on what they were willing to pay. The patient said she "felt</p>



	<p>like a loser.” She said she was very upset and offended and chose to seek treatment elsewhere.</p> <p>The dentist told CDSBC Investigators that his consultation with the patient was “not his finest hour” and that he deeply regretted the emotional impact it had on the patient. The dentist acknowledged that the analogy used was in bad taste and confirmed he had called to apologize to the patient and offered to see her again to resolve her concerns and to apologize to her in person. The dentist said his intent was to be completely up front about costs, noting he charges more than the BCDA <i>Fee Guide</i>.</p> <p>The dentist confirmed that his CDA obtained X-rays and photos before he had examined the patient and prescribed the X-rays. He also confirmed that he did not discuss the findings or his examination with the patient, but left it to his CDA to present the treatment plan. The dentist said that this visit did not follow his usual protocol because the patient was scheduled as the last visit of what turned out to be a very busy day. The dentist said that this was not representative of his usual practice.</p> <p>The investigation raised concerns with the dentist’s patient relations, recordkeeping, informed consent, and CDA delegation protocols.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC’s <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and to only delegate duties to his CDA that a CDA is authorized to perform. The Inquiry Committee was satisfied that the dentist had demonstrated sufficient insight into the patient relations matter and will take a different approach in future.</p>
File 49	<p>Complaint</p> <p>A patient complained that Dentist A placed a new crown that fell off within hours and that she would not issue a refund to have the treatment provided by another dentist.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the tooth had first been root canal treated and crowned by Dentist B. Dentist A re-cemented this crown several times and eventually made a new one for the patient, but it too fell out, within a few hours. The patient said that Dentist A suggested an implant and offered to deduct the cost of the crown from the treatment</p>



	<p>cost. The patient said she wanted a full refund instead, so that she could receive treatment from another dentist, but Dentist A refused.</p> <p>The patient told CDSBC Investigators that she then saw Dentist C, who told her that the tooth required further root canal treatment and crown lengthening before a crown could be placed. The patient said that Dentist C told her that the tooth had a guarded/poor long-term prognosis.</p> <p>Dentist A told CDSBC Investigators that the tooth had a history of persistent decay and was quite compromised with minimal tooth structure remaining. She said that she replaced the crown at no charge to the patient.</p> <p>It appeared to CDSBC Investigators that Dentist A correctly diagnosed the need for crown lengthening on the tooth before re-doing the crown, but the records do not indicate that this was done. CDSBC Investigators found that Dentist A's description of the crown lengthening procedure did not accurately capture what the procedure should entail.</p> <p>CDSBC Investigators also had minor concerns about Dentist A's recordkeeping and informed consent protocols. Discussions lacked detail, specifically about the options for replacing the crown, the patient's concerns about the root canal treatment before placing the second crown, and certain treatment that was provided. CDSBC Investigators also noted that the crown was billed out on the day of preparation, not when it was inserted.</p> <p>Resolution</p> <p>The dentist signed an agreement to participate in a case review with a certified specialist in prosthodontics and to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses. She also agreed to ensure crowns are billed out on insertion not at preparation.</p>
File 50	<p>Complaint</p> <p>The College opened its own complaint file after the dentist failed to respond to numerous communications about the need to obtain a permit to operate under his corporation name.</p> <p>Investigation</p> <p>The dentist delayed in providing a substantive response to CDSBC Investigators, although he confirmed he had been practising dentistry</p>



	<p>under his corporation name since 2013 without the required permit, contrary to the <i>Health Professions Act</i> and the College's bylaws.</p> <p>The dentist explained that he had since received approval for a new corporation name that he intended to practice under. He said that he had not yet paid for a permit to do so because he was awaiting an insurance payout from a flood. The dentist explained he did not intend to ignore the communications from the College, but did not closely read the letters and was confused about what his obligations were and what was required to obtain approval for his new corporation. CDSBC Investigators explained to the dentist his obligations and he paid for a permit to operate under his new corporation. The dentist apologized for his delayed response.</p> <p>Resolution</p> <p>The dentist signed an agreement to never repeat the conduct, consented to a reprimand, and acknowledged his responsibility to be aware of and comply with his obligations under the <i>HPA</i> and College bylaws, which includes not operating a dental corporation without a valid permit, and acknowledged his duty to respond to all communications from the College in a timely and substantive matter.</p>
File 51	<p>Complaint</p> <p>A patient complained about root canal treatment and a crown provided by the dentist, which caused him to experience prolonged pain and problems with three other teeth.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that he questioned the necessity of the root canal treatment in the first place, because he did not think there was anything wrong with the tooth. He said after the treatment he was in pain and the post and crown that were placed caused him to chew on only the other side of his mouth which led to problems.</p> <p>The dentist told CDSBC Investigators that the root canal treatment was needed due to infection and significant decay at the roots. CDSBC Investigators reviewed the records and found that the root canal treatment and post and crown placement were all well done. However, they found the records did not reflect the treatment plan in sufficient detail, the guarded prognosis of the tooth when the crown was initially placed, or the discussions the dentist says he had with the patient about treatment options.</p>



	<p>The dentist acknowledged the concern with his recordkeeping and informed consent protocols, but stated that he would have verbally informed the patient of the guarded prognosis of the tooth and the various treatment options.</p> <p>A year after the treatment, the patient returned with the crown in hand and a fractured post. The dentist said he re-cemented the crown, but it was unclear to CDSBC Investigators why he did so, given that there was evidence of decay under the crown. A week after it was re-cemented, the crown fell off again.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses.</p>
File 52	<p>Complaint</p> <p>A patient complained that the dentist began drilling a tooth without explaining what he was doing. She said this caused her tooth to break and led to months of pain.</p> <p>Investigation</p> <p>The patient said that when she returned to the dentist, he denied breaking the tooth and referred her to an endodontist. The specialist advised the patient that she had an infection and would require root canal treatment and a crown to be placed. The patient believed the dentist caused her subsequent dental issues when he broke her tooth.</p> <p>CDSBC Investigators did not find any concerns with the diagnosis and treatment that the dentist provided. The records confirmed that the tooth had a significant history of cavities and had multiple fillings close to the pulp chamber. It appeared to CDSBC Investigators that the dentist had appropriately recognized this and closed the open contact on the tooth. Two year later, the dentist appropriately diagnosed dead tooth pulp and calcified canals in the tooth and made a referral to an endodontic specialist. The endodontist confirmed to CDSBC Investigators that root canal therapy and a crown were required.</p> <p>While the dentist reportedly discussed treatment options of extraction or root canal therapy with the patient, CDSBC Investigators found that the records lacked detail regarding these informed consent and treatment</p>



	<p>options discussions. It appeared the patient did not understand the treatment she received, as she insisted the dentist caused her tooth to break.</p> <p>Resolution The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> course.</p>
File 53	<p>Complaint A patient complained that the dentist failed to properly assess a tooth used to support a temporary three-unit bridge he provided. The patient also complained that the dentist performed additional treatment that she had not agreed to.</p> <p>Investigation The patient told CDSBC Investigators that she wanted the bridge completed before her insurance expired. She said that this was not possible, but that the dentist billed her insurer for the bridge prior to its completion, and then attempted to endorse the cheque to her to be cashed after she was dismissed as a patient. The patient said she saw other dentists about the tooth that was supporting the bridge, and was told that the first dentist had left decay and restorative material in the tooth. The patient also said that a crown placed by the dentist on a different tooth had to be continually re-cemented and replaced.</p> <p>The dentist provided CDSBC Investigators with a report and records that confirmed the patient had been a patient of the dental office for 23 years without issue, until she decided to move forward with the bridge. The dentist said that they had treatment planning discussions for the bridge several years earlier, but that the patient held off until shortly before her insurance was set to expire (a precise date for which was never provided to him). The dentist said he obtained a pre-authorization from the insurer to proceed with the bridge and provided the patient with a treatment estimate. The dentist said he told the patient there was a 25% chance that the abutment tooth might later need root canal treatment, but felt that the tooth was fine at the time to be used to support the bridge.</p> <p>Several months after treatment, the patient saw a dentist in Poland who performed root canal treatment on the supporting tooth and told her that the original dentist had left decay and restorative material in the tooth. The original dentist denied this and X-rays provided to CDSBC Investigators by</p>



	<p>a subsequent treating dentist supported him, as they showed no evidence of decay or restorative material.</p> <p>The dentist acknowledged there were problems with crown retention on a tooth and that a referral to a prosthodontist should have been considered.</p> <p>The dentist also acknowledged that he claimed the bridge to the patient's insurer prior to it being completed, but he said he did so at the patient's insistence that all treatment be covered by her insurance before it expired. The dentist said that he hoped to have the bridge completed by the time the claim was processed, but that this was not possible because difficulties in anesthetizing the patient had delayed treatment. The dentist says the dentist/patient relationship deteriorated around this time and she was dismissed as a patient. He endorsed the cheque from the insurer to her in the belief this would assist her in funding the completion of the bridge. The dentist acknowledged to CDSBC Investigators that this was inappropriate.</p> <p>CDSBC Investigators found the records to be extensive, but lacking key details. The type and amount of anaesthetic were not always recorded, and there were no notes of the informed consent discussions. The estimate provided to the patient did not include additional treatment that was done and billed to her insurer. The dentist says it is not uncommon for additional treatment to be required once the treatment is underway. The patient maintained that she was unaware of this and did not consent.</p> <p>Resolution</p> <p>The dentist signed an agreement to take a dental ethics course with a focus on billing as well as CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and to participate in a case review with a prosthodontist to evaluate the execution of the patient's case.</p>
File 54	<p>Complaint</p> <p>The College opened a complaint file after concerns arose with the dentist's diagnosis and treatment planning, X-ray interpretation, and informed consent protocols during the course of a separate investigation.</p> <p>Investigation</p> <p>CDSBC Investigators were concerned that the dentist had not identified problems with the positioning of a crown and signs of loss in the tooth structure following X-rays she had taken. They also found that the chart</p>



	<p>notes did not document X-ray observations, diagnosis, and treatment recommendations, nor whether the patient was informed.</p> <p>The dentist saw the patient twice, six months apart. The patient had been previously seen by another dentist from whom the dentist had purchased the practice. The dentist assumed that the patient was aware of the complications, options, and prognosis for the tooth in question, based on the treatment and discussions with by the previous dentist. The dentist said she spoke with the previous dentist about a gap on the crown of the tooth. She told CDSBC Investigators that she assumed the previous dentist was going to deal with it. The dentist monitored the tooth and noted that the patient was not having any problems with it. She said that the patient wished to save the tooth as long as possible. However, the dentist's chart notes did not include any of her observations, diagnosis, and treatment recommendations, or discussions she had with the patient and the previous dentist.</p> <p>The dentist recognized the recordkeeping concerns and took CDSBC's <i>Dental Recordkeeping</i> course within weeks of receiving the complaint as a remedial action. This was confirmed by CDSBC Investigators.</p> <p>Resolution</p> <p>The dentist signed an agreement to ensure patients are informed of any defective findings and to take CDSBC's <i>More Tough Topics in Dentistry</i> course.</p>
File 55	<p>Complaint</p> <p>A CDA that had worked with the dentist for five years complained that he was a bully with an uncontrollable temper.</p> <p>Investigation</p> <p>The CDA told CDSBC Investigators about multiple incidents where the dentist had lost his temper very quickly and unexpectedly, and directed his anger towards staff and patients.</p> <p>The dentist initially denied that he had acted inappropriately; however, he was provided with letters from numerous previous staff members who corroborated the CDA's experiences. CDSBC Investigators conducted structured interviews with the dentist's current staff. There was general consensus that the dentist does not manage stress or anger effectively,</p>



	<p>and can be extremely intimidating. It was noted, however, that at times the dentist could also be gentle, funny, considerate, and good company.</p> <p>CDSBC Investigators met with the dentist and his legal counsel. The dentist confirmed he has proactively sought treatment with a workplace psychologist. The psychologist explained the treatment program and provided her undertaking to notify the College if, for any reason, the anticipated number of sessions are not completed. She reported that given the dentist's current dedication and commitment to the treatment process, she anticipates a positive outcome.</p> <p>Resolution</p> <p>The dentist signed an agreement to complete the behavior modification program with the registered psychologist.</p>
File 56	<p>Complaint</p> <p>A patient complained that she experienced pain that the dentist could not relieve after she provided restorations to a tooth.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that the dentist attempted root canal treatment but could not complete it. She said that the dentist referred her to a specialist, but she was unable to book an appointment and opted to get treatment in China instead.</p> <p>The investigation raised concerns with the dentist's root canal treatment, post-operative pain management, recordkeeping, and X-ray processing.</p> <p>CDSBC Investigators found that the X-rays did not meet appropriate diagnostic standards and it was difficult to determine if the treatment provided was appropriate for the initial restorations. The open and drain treatment protocol and material used were not appropriate and did not provide adequate sterilization. It was not clear from the records if the patient was advised of options that could temporarily decrease her pain before the dentist started the permanent restorations and assessed the need for root canal treatment.</p> <p>The treatment the dentist provided did not alleviate the patient's pain and while the dentist advised the patient to see a specialist, there was no indication that the dentist reviewed appropriate alternatives with the patient. CDSBC Investigators found that the records had minimal detail in</p>



	<p>the notes about treatment, testing, and patient discussions. The patient told CDSBC Investigators that she told the dentist she wanted permanent fillings placed due to her anxiety and not wanting more needles than necessary; however, this was not clear in the records.</p> <p>Resolution</p> <p>The dentist signed an agreement to: either participate in a case review specific to this case with an endodontist, or take an endodontics course; take CDSBC's <i>Dental Recordkeeping</i> course; and ensure her X-ray equipment is appropriately calibrated, and that X-rays are developed correctly and are of diagnostic quality.</p>
File 57	<p>Complaint</p> <p>A patient complained that the dentist replaced a fractured amalgam filling with a composite filling without informing her of the difference in costs and without offering alternatives.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that she was not provided with the correct refund when the dentist later replaced the composite with amalgam and refunded the difference. The patient said she felt cheated and she believed the dentist used a more expensive, but inferior composite material, based on her own internet research.</p> <p>The dentist told CDSBC Investigators that she saw the patient for a specific examination due to the chipped filling. The dentist said that the tooth had been heavily restored and she identified the trauma that had caused the eventual fracture of the tooth. The dentist said that the patient did not want an extended examination and was only interested in restoring the tooth that same day. The dentist said she believed composite was the better material choice, but admitted she did not discuss an amalgam alternative, or provide an estimate for the molar amalgam restoration.</p> <p>CDSBC Investigators found that the records showed this patient had been challenging throughout her history with the dentist, and while the patient management appeared generally appropriate, the patient had not been given the opportunity to discuss the advantages and disadvantages of composite versus amalgam for molar restorations, nor was she provided with a cost estimate for the amalgam alternative.</p>



	<p>Resolution The dentist signed an agreement to take CDSBC's <i>More Tough Topics in Dentistry</i> course.</p>
File 58	<p>Complaint A patient complained that the dentist's root canal treatment was poorly done and as a result, she lost the tooth.</p> <p>Investigation The investigation raised concerns with the dentist's endodontic treatments and his recordkeeping, informed consent, and billing protocols.</p> <p>CDSBC Investigators found that the dentist was unsuccessful in trying to locate the third root canal on that tooth and closed the attempt with filling material. Subsequent-treating dentists noted perforations at the roots and surrounding area. CDSBC Investigators found that the records did not document that the tooth had a guarded prognosis and that it would require a crown in the future.</p> <p>There was no documentation that the patient was informed that only two of the three canals were filled, that there were possible perforations during the attempts to locate the third canal, or if a referral was offered to a specialist when the treatment could not be completed. The patient told CDSBC Investigators that she did not recall being informed of any of these items; however, she was sedated at the appointment.</p> <p>CDSBC Investigators found that the billing did not accurately reflect the treatment provided, and the records did not include treatment estimates to confirm the patient was advised of the cost for the restorations or the root canal treatment.</p> <p>Resolution The dentist signed an agreement to take a hands-on endodontic course and CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and undergo a chart review after six months.</p>
File 59	<p>Complaint A patient complained about how the dentist and his staff managed her significant post-operative infection following the extraction of her wisdom teeth.</p>

**Investigation**

The patient told CDSBC Investigators that she experienced ongoing swelling, was in constant pain, and had limited opening of her mouth. She said that antibiotics were prescribed several times but did not resolve her symptoms. The patient said that the office told her a specialist would contact her, but the office did not otherwise follow-up with her. Three weeks later she had yet to be contacted by the specialist, so she contacted the dental office only to learn that they were on holidays and the office was closed. The patient said that her mother left a message and a staff member called the next day to give her the name of a specialist, but it was up to the patient to make her own appointment.

The specialist performed debridement surgery (removing unhealthy tissue) and initially suspected bone infection but later diagnosed chronic inflamed connective tissue. The patient underwent IV antibiotics, had an MRI done and was referred to an oral medicine specialist. Over a year after the extractions, her symptoms improved but still remained.

The dentist told CDSBC Investigators that he extracted the patient's wisdom teeth uneventfully. The dentist said that he saw the patient three days later and prescribed antibiotics. He said that the patient was next seen by another dentist in the practice, and further antibiotics were prescribed. He said that he saw the patient again and she reported her symptoms had initially improved but the swelling had recurred two days earlier. The dentist said that he prescribed more antibiotics and agreed to refer the patient to an oral surgeon.

The dentist acknowledged the miscommunication about making the specialist appointment and apologized for the lack of appropriate management of the patient's post-extraction infection. He agreed the referral should have been made earlier.

The dentist also agreed that he could have better explained what to expect while having extractions done under conscious sedation, as the patient expressed concern about waking up twice during the procedure. The dentist's sedation protocols were otherwise appropriate; although it was noted his monitoring equipment was not calibrated to the correct time.

Resolution

The dentist signed an agreement to review this case with a mentor and to



	<p>properly calibrate the time on his monitoring equipment.</p> <p>The College also sent a letter to the principal of the dental office cautioning him to ensure his staff do not misrepresent the general dentist as a specialist when booking the consultation, and that in cases where the patient is experiencing significant post-operative difficulties, the office consider making the referral appointment to a specialist.</p>
File 60	<p>Complaint</p> <p>A patient complained that the dentist extracted the wrong tooth and when she contacted the office to complain and request a refund, both the office manager and the dentist did not communicate professionally.</p> <p>Investigation</p> <p>The dentist told CDSBC Investigators that he examined the patient and noted infection and that the tooth was loose and needed to be extracted. CDSBC Investigators found, however, that the clinical treatment notes of the extraction date lacked information about the patient's complaint of pain, the testing performed, examination findings or a diagnosis to support the extraction of the tooth. The notes recorded that the dentist told the patient over the phone that the tooth had no bone around it, an infection, and was loose – all of which led to the tooth having a “hopeless” prognosis.</p> <p>CDSBC Investigators noted that the dentist did not take new X-rays of the tooth he extracted. The dentist explained that he relied on previous imaging of the area. CDSBC Investigators reviewed previous X-rays that showed adequate bone present around the tooth.</p> <p>The patient had another dentist extract a different tooth the following day, which alleviated her pain. Pre-operative X-rays of this tooth showed decay, bone loss, and a suspected root fracture.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses, and to take diagnostic pre-operative X-rays.</p>
File 61	<p>Complaint</p> <p>Dentist B complained about the quality of care that Dentist A, a pediatric dentist (specialist), provided to an autistic child under general anesthetic.</p>



	<p>Investigation</p> <p>Dentist B is also a pediatric dentist, and saw the patient at a hospital emergency department six weeks after the treatment from Dentist A. The patient had a bacterial skin infection and a fever caused by his oral condition. Dentist B expressed concern about the state of the child's teeth, noting that four additional teeth had to be extracted. Dentist B also noted that the patient had six steel crowns, all of which were perforated. An audit conducted confirmed that these problems all existed at the time that Dentist A treated the patient.</p> <p>Dentist A explained to CDSBC Investigators that he takes a conservative approach to treatment. He said that he was focused on desensitizing the patient to make him comfortable in the dental chair so that general anaesthetic would not be necessary for future treatment. Dentist A said he planned to monitor the patient's condition monthly. He said that he did notice the perforated stainless steel crowns, but opted to monitor them as they were not causing the patient any problems.</p> <p>With the benefit of hindsight, Dentist A agreed that a more aggressive approach should have been taken. He said that he did not expect the patient's condition to deteriorate so quickly. The dentist also acknowledged that his recordkeeping and informed consent protocols were deficient.</p> <p>Resolution</p> <p>Dentist A signed an agreement to: take CDSBC's <i>Dental Recordkeeping</i> and <i>More Tough Topics in Dentistry</i> courses; complete a comprehensive review course offered by the American Academy of Pediatric Dentistry; complete a two-week mentorship session focused on current pediatric practices, diagnosis and treatment planning, X-ray interpretation, recordkeeping, and informed consent; and to undergo a chart review within six months of concluding the mentorship.</p>
File 62	<p>Complaint</p> <p>A patient complained that the replacement fillings placed by the dentist fell out and caused her to experience ongoing sensitivity.</p> <p>Investigation</p> <p>The patient told CDSBC Investigators that since the treatment she has had toothaches, temperature sensitivity, cuts to her tongue and cheek where</p>



	<p>the fillings came out, and cheek biting while eating. She said that she did not have any problems with the old fillings and expressed regret for consenting to let the dentist replace them.</p> <p>The investigation did not raise any standard of care concerns with the treatment the dentist provided. It appeared to CDSBC Investigators that the patient lost confidence in him and did not wish to return for remedial treatment.</p> <p>CDSBC Investigators reviewed the records from the patient's current dentist and found she had a history of poor oral hygiene, significant wear of the teeth, chemical erosion, a grinding habit, and that she had not worn her night guard for a significant amount of time. All of this appeared to be a result of factors other than the dentist's treatment, and the restorations he provided appeared to be functional.</p> <p>CDSBC Investigators found that the dentist's records lacked detail documenting oral hygiene, bite, gum diagnosis, TMJ assessment, or references to discussions had with the patient. There was also no formal treatment plan included in the records.</p> <p>Resolution</p> <p>The dentist signed an agreement to take CDSBC's <i>Dental Recordkeeping</i> course.</p>
File 63	<p>Complaint</p> <p>The College opened a complaint file after CDSBC Investigators became concerned during the course of investigating a separate complaint about the dentist's diagnosis and treatment planning protocols.</p> <p>The dentist had advised one patient that treatment recommended by a previous dentist was not required, and told another that treatment provided by the same previous dentist had failed. CDSBC Investigators reviewed the records and found that the dentist had missed cavities visible on the X-rays for one patient and incorrectly diagnosed gaps on two fillings for the other patient because the X-rays were not interpreted correctly.</p> <p>Investigation</p> <p>The dentist freely acknowledged the concerns in both cases and agreed errors in X-ray interpretation had derailed the diagnosis and treatment planning for both patients. The dentist explained to CDSBC Investigators</p>



	<p>that she was a new grad at the time, and took a conservative treatment approach. The dentist said she had gained more knowledge and clinical experience in the two years that had passed since those incidents. She outlined a risk assessment strategy for cavities that she has used, which appeared to be appropriate. The dentist said that as a result of the complaint, she had voluntarily taken relevant online continuing education courses to address the concerns.</p> <p>Resolution The dentist signed an agreement to take a one-on-one course in X-ray interpretation with an oral radiologist.</p>
File 64	<p>Complaint A father complained that he was denied emergency care for his daughter because of his outstanding balance owing to the previous owner of the practice.</p> <p>Investigation The father told CDSBC Investigators that two staff members refused to schedule his child. He believed that the delay in getting treatment caused his daughter's dental status to worsen, resulting in multiple extractions and restorations.</p> <p>CDSBC Investigators did not find any standard of care concerns, however, it appeared there was miscommunication and tension between the father and the reception staff. The staff were long-term employees of the previous owner of the practice, and both believed that appointments should be denied when accounts have an outstanding balance.</p> <p>One of the staff members is a Certified Dental Assistant and should have known the protocols for appointing emergency patients. The CDA confirmed the dentist spoke with her advising her of their obligation to provide emergency care and instructing her to schedule patients right away when they report pain.</p> <p>Resolution The CDA signed an agreement to take CDSBC's <i>Avoiding Complaints</i> course.</p>