IN THE MATTER OF THE COLLEGE OF
DENTAL SURGEONS OF BRITISH COLUMBIA
AND DR. DEREK DUVALL

DECISION
(Redacted to protect 3rd party confidentiality and Dr. Duvall's personal medical information)

Dr. A. Steinbart (Chair)
Ms. Leona Ashcroft
Dr. J. Gercsak

Hearing Dates:	April 16-18, 2012, Fort St. John, B.C. May 7-10, 2012, Vancouver, B.C.
Counsel for the CDSBC:	Ms. Jean Whittow, Q.C.
Counsel for the Discipline Panel:	Ms. Catharine Herb-Kelly, Q.C.

Introduction

A Panel of the Discipline Committee of the College of Dental Surgeons of British Columbia (CDSBC) was appointed pursuant to Section 38 of the *Health Professions Act (HPA)* to hear and determine allegations contained in an Amended Citation (Citation) issued pursuant to Section 37 of the *HPA* against Dr. Derek Duvall.

The hearing took place in Fort St. John, B.C. from April 16 - 18, 2012 and in Vancouver from May 7 – 10, 2012. Dr. Duvall did not attend the hearing. The College submitted evidence establishing that he had been properly served with the Citation pursuant to Section 37(2) of the *HPA*, meaning that he had notice of the date and location of the hearing. Accordingly, the Panel determined that it would proceed in his absence pursuant to Section 38(5) of the *HPA*.

The Panel heard sworn oral testimony from Dr. Alex Penner, an investigator at the CDSBC, who was qualified to provide expert evidence regarding the standards expected of a registrant practicing general dentistry. The Panel also carefully considered all of the evidence including affidavits from patients, reports and records from subsequent treating dentists and certified dental assistants, x-rays and models in connection with some allegations in the Citation. They also considered responses provided by Dr. Duvall to the complaints.

The Panel notes that the teeth numbers in the Citation included decimal points between the quadrant and tooth number. This is not the usual and customary method for describing particular teeth in the practice of dentistry. However the Panel will continue to include decimal points when identifying teeth, to be consistent with the Citation.

Finally, the allegations will be addressed in the order in which they appear in the Citation, except that numbers 12 and 17(a) and (b) are addressed later in this decision.

Further Amended Citation

During its deliberations, the Panel noted that paragraph 27 of the Amended Citation was missing a reference to clause 9 of the AUSPA. It sought submissions from counsel for the College as to whether paragraph 27 ought to be amended.

The Panel received the College's submissions on this point and considered them. It has decided to amend paragraph 27 to include a reference to clause 9 of the AUSPA. The Panel was advised that Dr. Duvall was provided with full disclosure of the evidence that would be led at the hearing. The Panel has considered the criteria set out in *CNR v. Imperial Oil Ltd., 2007 BCSC 1193 (CanLii)* and has decided to amend the Amended Citation so that it is consistent with the evidence that was before the Panel. The Further Amended Citation is attached to this decision as Appendix "A" and will be referred to throughout as the "Citation".

Onus and Standard of Proof

The onus of proof is on the CDSBC which must prove the offences according to the civil standard - proof on a balance of probabilities: *F(H) v. McDougall,* 2008 SCC 53 (CanLii). In particular, the Panel scrutinized the evidence bearing in mind the standard set out at paragraph 46 of *McDougall: "evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test".*

Incompetence

The majority of the offences in the Citation relate to allegations of incompetent dentistry practice.

In its decision, whenever the Panel makes a finding that the conduct in question is "incompetent', it has adopted the definition of "incompetence" formulated by the BC Supreme Court in *Mason v. Registered Nurses' Association of British Columbia* 1979 CanLii 419 as follows:

> *"Incompetence ....connotes 'want of ability suitable to the task, either as regards natural qualities or experience, or deficiency of disposition to use one's abilities and experience properly."*

Professional Misconduct

Some of the allegations in the Citation allege that Dr. Duvall committed professional misconduct. In this decision, when the Panel has determined that professional misconduct has been proven, it has taken into account the definition in Section 26 of the *HPA* which defines *"misconduct"* as *includes sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession.*

In her written and oral submissions, counsel for the CDSBC addressed the difference in meaning between unprofessional conduct and professional misconduct, and suggested that in this case, where the citation included allegations that did not involve competence issues, the conduct ought to be characterized as professional misconduct.

The phrase *"professional misconduct"* has been defined in various ways in the case law. As indicated, the definition includes *infamous and unethical conduct,* among other things. The Panel has examined the definition and is of the view that it includes conduct of a more serious or egregious nature. The Panel has used the phrase in that context later in this decision.

Citation #1

In or about 2007, as regards your patient, RC, you provided substandard care in the placement of a crown for tooth 3.7.

This allegation arose from a complaint from the patient, RC dated April 23, 2007. The Panel reviewed the complaint letter, Dr. DH's affidavit and report, the patient's chart and radiographs; and a response letter from Dr. Duvall. It also heard oral evidence from Dr. Penner.

Dr.D H saw RC on April 10, 2007 because a temporary crown placed on tooth 3.7 on April 2, 2007 by Dr. Duvall had come off. Dr. DH stated that the shape of the crown preparation was rounded and an x-ray revealed that decay was present in the tooth. Therefore the crown work would have to be redone.

Dr. Penner confirmed that a periapical radiograph revealed a dark area on the distal of tooth 3.7 consistent with decay. He said that decay must be removed from a tooth before preparing it for a crown. He also stated that the preparation for the crown was not done properly. The ideal shape for retention of a prepared tooth is a four to six degree incline to the occlusal. The further the preparation departs from that shape, the less likely the prepared tooth will retain the crown. In this case the preparation was shaped as a "round hump" which will not give proper retention for a crown.

The Panel examined Dr. Duvall's response. He admitted that he "may have missed possible caries" but disagreed that the crown preparation was improper. He did not address his preparation of a round hump or insertion of a temporary crown when decay was present on the tooth. He also mentioned endodontic treatment and a pulp issue. These were not relevant considerations to this complaint. Dr. Duvall's response did not provide any useful information regarding the allegations.

The Panel accepts the evidence of the College that the preparation of tooth 3.7 for a permanent crown was not acceptable in view of the obvious inadequate shape and decay revealed in the radiographs and the statements from Dr. DH and Dr. Penner that the prepared tooth was unlikely to hold a permanent crown. The Panel finds that the work performed by Dr. Duvall was sub-standard and is incompetent practice within the meaning of Section 39(1)(d) of the *HPA.*

Citation #2.

In or about 2007, as regards your patient, GL,

a. i. you permanently cemented a bridge to teeth 3.4 to 3.6 which you knew was damaged; and/or

ii. you misled the patient by advising him that the bridge could be repaired after insertion; and/or

b. you recommended replacement of the crowns for teeth 1.6 and 2.6, when that was unnecessary

The Panel reviewed GL's complaint letter and affidavit, Dr. DH's reports and affidavit, the patient's chart, radiographs, photographs and Dr. Duvall's response letter. It also heard oral testimony from Dr. Penner.

a (i) cementing the bridge to 3.4 and 3.6,

Dr. Duvall replaced a bridge to teeth 3.4 and 3.6 for GL on March 28, 2007. During the placement, the porcelain on bridge abutment tooth 3.6 was chipped. Dr. Duvall told the patient that the bridge could be repaired later and permanently cemented the bridge to the teeth. He did not advise the patient that there was a better chance of repair if the bridge was returned to the lab for repair before it was cemented.

Dr. Penner testified that a repair of a bridge when it is already in the mouth is not as aesthetically pleasing and is unlikely to last as long as if repaired before cementation. The appropriate step would have been to repair the bridge before insertion. Dr. DH also said that the bridge should have been repaired before it was inserted in the mouth.

Dr. Duvall agreed that he "should have removed the bridge when the porcelain fractured" but he was going to "perform a repair after consulting with the lab".

The Panel finds that Dr. Duvall should not have cemented the bridge before having it repaired. Dr. Duvall's statement that he was going to repair the bridge after consulting with the lab suggests that he did not know what to do, and that his decision to go ahead and permanently cement the bridge was based upon his own lack of knowledge. The provision of bridge work is basic dentistry practice. Dr. Duvall should have known what to do and in particular that the

bridge should have been repaired before it was cemented. The Panel concludes that Dr. Duvall's practice in this regard was incompetent within the meaning of Section 39(1)(d) of the *HPA.*

a (ii) misleading the patient regarding the bridge work

The CDSBC argued that Dr. Duvall's advice to the patient to proceed to cement the damaged bridge was intentional misconduct. It suggests that Dr. Duvall "ignored the best interest of the patient in order to rush the treatment to conclusion – to prefer his own interest to that of the patient" (paragraph 63, Written Submission).

The Panel is unable to conclude that Dr. Duvall intentionally misled the patient into proceeding with the bridge work because of his own self interest. The evidence established that Dr. Duvall's advice that the bridge could be repaired later was not appropriate and that the patient was not advised of the risk that the bridge could not be successfully repaired after cementation. However, there is no evidence to show how such poor advice somehow benefitted Dr. Duvall. There is no evidence of financial gain or other motive. The Panel must speculate about this. The evidence must be clear and convincing to support the allegation. In this instance that test is not met. The Panel dismisses the allegation in paragraph 2(a)(ii) of the Citation.

2(b) recommendation to replace crowns for 1.6 & 2.6

Dr. Duvall saw GL on June 20, 2006 and advised him that there was decay to teeth 1.6 and 2.6 requiring new crowns. The work was not performed that day. Later, GL saw Dr. D H and told him about Dr. Duvall's advice. Dr. D H examined the teeth using instruments and concluded that they did not require new crowns.

Dr. Penner reviewed the radiographs taken by Duvall on April12, 2006 for teeth 1.6 and 2.6. He explained there were radiolucencies at the distal of both teeth but that these were inconsistent with decay. They were consistent with a shape anomaly on the distal of both teeth. A subsequent radiograph of tooth 1.6 taken in 2007 showed no change in that tooth. He agreed with Dr. DH that the teeth did not require crowns.

In his response, Dr. Duvall stood by his advice that teeth 1.6 and 2.6 had decay.

The Panel is unable to accept Dr. Duvall's position in view of the clinical and radiographic evidence. In particular, Dr. Penner's evidence that there was no significant change to tooth 1.6 one year later is significant and is further evidence that there was no decay, which typically worsens as time passes.

The Panel finds that Dr. Duvall's advice that teeth 1.6 and 2.6 required new crowns was inappropriate and was incompetent practice within the meaning of Section 39(1)(d) of the *HPA.*

Citation #3

In or about 2006, as regards your patient, JF, your provision of a denture was substandard.

The Panel reviewed a letter of complaint and affidavit from JF, a report from Dr. DH, the chart, models, Dr. Duvall's response and heard oral testimony from Dr. Penner.

In this instance, the patient, JF, complained to the CDSBC that Dr. Duvall inserted an immediate denture that did not fit properly in August 2006. She returned to Dr. Duvall several times to have the problem fixed and experienced pain, swollen gums, bleeding and unsightliness. After eight months she went to Dr. DH who referred her to a denturist for a new upper denture and a partial lower denture.

The chart shows that Dr. Duvall did all of the preparatory work for a complete upper denture and a partial lower denture beginning in May 2006. The upper denture was delivered on August 4, 2006 and the lower denture on October 3, 2006.

In his affidavit, Dr. DH confirmed that the denture did not fit properly:

> *"The anterior flange and interior of the [upper] denture were ground heavily. The patient was only contacting on teeth 3.4 and 4.4, an anterior open bite was present and the posterior denture teeth were contacting the lower ridge (paragraph 81."*

Dr. Penner testified that there are a series of steps that should be taken to help the lab determine where the teeth on the denture should be placed. In addition to impressions, wax occlusal rims should be made to help determine the proper amount of opening and

relationship of the upper jaw to the lower jaw. The chart does not contain any indication that this step was followed. If it had been taken, the lab would have known where to place the teeth in an appropriate relationship.

Dr. Penner also stated that Dr. Duvall completed the upper denture when there was not enough room to construct a partial lower denture and that the upper and lower dentures should be made at the same time so that they can be made to fit properly. In JF's case, the teeth on the upper denture contacted the lower ridge because of inaccurate measurements. He noted that if a denture has an anterior open bite, a patient will be unable to bite through food properly.

In his response, Dr. Duvall admitted that the dentures did not fit and that his adjustments did not correct the problem. He blamed the poor fit on the lab.

The Panel notes from the chart that Dr. Duvall had an opportunity to recognize and address the problem of an inadequate fit because he took a new impression of the ridge on January 10, 2007 and relined the complete upper denture on January 16, 2007. However, the problem was not corrected. At that point he should have had new dentures made.

The Panel further notes a chart entry on March 27, 2007 in which JF was complaining about the dentures. The entry reads:

> *"Dr. D said he didn't know how to fix them."*

The Panel concludes that the poor fit should have been obvious to Dr. Duvall at the outset and he should not have inserted the denture. Later, when the patient returned he should have recognized that the dentures did not fit properly and had them remade. The course of events in this instance indicates that Dr. Duvall practiced incompetent dentistry within the meaning of Section 39(l)(d) of the *HPA.*

Citation #4

In or about 2006, as regards your patient, JH,

a. your provision of a crown for tooth 2.5 was substandard;

b. you provided substandard root canal therapy to tooth 2.5; and/or

c. you improperly placed an implant in the 2.5 position.

The Panel reviewed a complaint letter from the patient, reports from her regular treating dentist Dr. A, a report from Dr. D H, the chart, a model of the implant, radiographs, Dr. Duvall's response and heard oral testimony from Dr. Penner.

In July 2006 JH went to see Dr. Duvall regarding a severe toothache when her regular dentist was on holiday. Dr. Duvall performed a root canal and delivered a crown to tooth 2.5. She continued to have pain for which Dr. Duvall prescribed anti-inflammatory and antibiotic medication.

JH went to see her regular dentist, Dr. A, on January 25, 2007. He referred her back to Dr. Duvall regarding the root canal and advised that she may need a referral to a specialist. He took radiographs and his chart entry that day noted that tooth 2.5 was percussion sensitive and the margin of the crown was open on the distal. He further noted a radiolucency at the apex of the tooth. This is a sign of infection or trauma to the tooth.

When JH went back to Dr. Duvall on Jan 31, 2007, he extracted the tooth and placed an implant.

(a) The crown on 2.5

Dr. Penner reviewed the radiographs of tooth 2.5 dated January 25, 2007. He confirmed Dr. A's observation that the distal margin on the crown was open: He further stated that this should have been readily apparent to Dr. Duvall and that the open margin on the crown can re- infect the root canal.

(b) The root canal

Dr. Penner reviewed the root canal on the January 25th radiograph and testified that it revealed that Dr. Duvall failed to fill the root canal space at the tip of the tooth root when he performed the root canal. He explained that when a space is not filled bacteria can multiply and leak from the tooth. An inflammatory reaction can develop leading to pressure and pain. In this case the root canal was approximately 5 mm short of the apex.

(c) Placement of implant on 2.5

As to the placement of the implant on tooth 2.5, Dr. Penner presented a model prepared by Dr. DH which showed the implant was too far to the buccal (cheek side of the arch) and there was no apparent reason to place the implant in this position. The placement of the tooth was so far out of alignment that it would be very difficult to correct. Dr. DH was also of the opinion that the implant was too far to the buccal.

In his response letter, Dr. Duvall did not provide any meaningful explanation for the allegations regarding the root canal, crown or implant position.

The Panel has carefully examined all of the evidence regarding tooth 2.5. In the absence of any meaningful response from Dr. Duvall and in light of the evidence of Drs. A, DH and Penner, the model and radiographs, it has concluded that Dr. Duvall's treatment of tooth 2.5 was sub-standard in all three respects. The root canal did not extend to the appropriate length; the distal margin of the crown was open and the implant was in the wrong position. All of these deficiencies can lead to infection and discomfort for the patient.

Dr. Duvall's treatment was incompetent within the meaning of Section 39(1)(d) of the *HPA.*

Citation #5

In or about 2006, as regards your patient, ES, your provision of crowns for teeth 3.5 and/or 3.7 was substandard.

The Panel reviewed a complaint letter from ES, her chart, Dr. DH's' Affidavit, radiographs, Dr. Duvall's letter of response and heard oral evidence from Dr. Penner.

In this case, ES complained about dental work provided by Dr. Duvall to three teeth. The College proceeded in respect of two teeth - 3.5 and 3.7.

In January and February 2006, Dr. Duvall provided crowns to teeth 3.5 and 3.7. Dr. DH examined tooth 3.5 some time after the crown was delivered and noted that it had to be redone because the mesial margin was not adequate. He advised ES that she may need a root canal on that tooth and referred her to an endodontist.

Dr. Penner reviewed the radiograph of tooth 3.7 and confirmed that the crown was deficient on the mesial margin. He explained that the deficiencies on both crowns put the patient at risk for bacteria entering the teeth, potentially causing infection. He further explained that it is very important for crowns to fit properly because of the risk of infection and that if they do not fit properly, they should not be inserted.

The Panel reviewed Dr. Duvall's letter of response, which did not address the issue of the deficient margins to teeth 3.5 and 3.7.

The Panel finds that the allegation that the crowns delivered to teeth 3.5 and 3.7 were substandard has been proven and is incompetent practice within the meaning of Section 39(1)(d) of the *HPA*.

Citation #6

In or about February 2007, as regards your patient, ML, your provision of restorations to teeth 3.6 and /or 3.7 was substandard.

The Panel reviewed a complaint letter from ML, his chart, radiographs, a report from a subsequent treating dentist, Dr. M, a response from Dr. Duvall and heard evidence from Dr. Penner.

ML saw Dr. Duvall on February 28, 2007 at which time he provided two fillings to teeth 3.6 and 3.7. After the work was done ML went to the bush to work until June. While working he developed a toothache that was so severe he was taken to Smithers by helicopter for emergency treatment.

Dr M found that Dr. Duvall had failed to remove all of the decay from the teeth when he performed the restorations and that this was causing the pain. He further noted that the patient

was having difficulty cleaning the teeth because of the decay between the teeth below the restorations.

Radiographs of the teeth were taken before and after Dr. Duvall performed the restorations. Dr. Penner testified that these radiographs clearly show interproximal caries on teeth 3.6 and 3.7 before Dr. Duvall performed the restorative work. These caries should have been evident to Dr. Duvall and completely removed before he completed the restorations.

The Panel reviewed Dr. Duvall's response which did not address the matter of residual caries on teeth 3.6 or 3.7 after he performed the restorations.

Dr. Penner testified that in his opinion Dr. Duvall made no attempt to remove the decay on the distal of tooth 3.6 and the mesial of tooth 3.7 before he provided the restorations. In the chart, Dr. Duvall recorded that the decay was *"very deep may need RCT in future/crown"*.

The Panel is unable to determine whether Dr. Duvall failed to remove any decay at all before he performed the restoration work, or that he did not remove all of the decay. In either case the amount of decay would have been apparent to him and he should not have performed the restorations until all of the caries had been removed. By proceeding as he did, the teeth were at risk of further deterioration and the development of pain requiring emergency treatment.

The Panel finds that Dr. Duvall's provision of restorations to ML was substandard and is incompetent practice within the meaning of Section 39(1)(d) of the *HPA*.

Citation #7

In or about 2006, as regards your patient, LT, your provision of restorations to teeth 2.7 and/or 4.7 was substandard.

The Panel reviewed a complaint letter from the patient, a letter from her subsequent treating physician, Dr. C, the patient's chart, radiographs, a response letter from Dr. Duvall and heard testimony from Dr. Penner.

The evidence established that Dr. Duvall performed restorations to teeth 2.7 and 4.7 on November 14 and December 12, 2006. The patient was seen by Dr. C on May 17, 2007. He advised her that the restorations to both teeth would have to be replaced.

Tooth 2.7

As for tooth 2.7, Dr. C wrote that the restoration performed by Dr. Duvall on this tooth had a void under it. Dr. Penner reviewed the radiograph of tooth 2.7 and confirmed that there was a void of significant size beneath the restoration work performed by Dr. Duvall.

He explained that a void is an area that has not been filled with composite restorative material and that an unsupported filling is at risk of breaking. If it is small enough, a void may not cause trouble, but the void in this case was problematic because of its size.

In his response, Dr. Duvall stated *"I cannot tell whether they [both restorations] needed to be redone by looking at these x-rays.* "

The Panel finds that the evidence shows clearly that the restorative work performed by Dr. Duvall to tooth 2.7 was substandard and amounts to incompetent practice of dentistry within the meaning of Section 39(1)(d) of the *HPA.*

Tooth 4.7

In his letter to the CDSBC, Dr. C stated that when he saw LT on May 17, 2007, *"tooth 4.*7 *had a restoration with a loss of marginal integrity occlusally on the mesiolingual cusp incline."*

The x-rays do not show the area around tooth 4.7, so the Panel must rely on Dr. C's observation about the condition of the tooth. Dr. Penner indicated that he could not confirm from the radiograph that there were marginal deficiencies to the occlusal surface of the tooth. There was discussion between Dr. Penner and the Panel about other possible causes for Dr. C's conclusion, which were inconsistent with substandard dentistry practice.

Therefore the evidence in respect of substandard work on tooth 4.7 is not clear and convincing. The Panel is unable to conclude that Dr. Duvall's restoration to tooth 4.7 was substandard. This allegation is dismissed.

Amended Citation #8.

In or about 2006, as regards your patient, SS, your provision of veneers to teeth 1.3 through 2.3 was substandard.

The Panel reviewed a letter of complaint from TS (patient's mother), a letter and affidavit from Dr. DH, the patient's chart, photographs, a model, a response letter from Dr. Duvall and heard evidence from Dr. Penner.

Veneers provided by Dr. Duvall to TS' son for his six upper front teeth on August 18, 2006 had fallen off several times and were re-cemented by Dr. Duvall. A veneer is a thin porcelain cover on a portion of a tooth usually inserted for cosmetic reasons.

After Dr. Duvall left Fort. St. John, Dr. DH saw the patient. In his affidavit he stated among other things that the *"margins of the restorations of 1.1 and 2.1 were open, leaking and showing signs of staining and breakdown. The veneer on 2.2 had to be re-bonded again on July 3, 2007....[and] would not likely stay on due to its poor fit and open margins which compromised the retention. On August 29, 2007 I replaced the veneer with a porcelain crown."*

Dr. Penner explained the procedure to provide a veneer. A tooth is prepared by removal of the exterior and an impression is taken. The lab makes a veneer based upon the impression. The veneer is then applied to the tooth with a bonding agent, if it fits properly.

Dr. DH provided Dr. Penner with a model, photographs and the patient's chart. Dr. Penner reviewed this evidence and confirmed that the veneers applied to five of the six teeth did not fit properly. The margins of the veneers were either open or did not extend to the prepared margin of the tooth. Dr. Penner was unable to determine whether the veneer for the sixth tooth fit properly, because Dr. DH had replaced it with a crown.

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Dr. Penner testified that it is a dentist's responsibility to assess the fit of veneers. They are "tried in" and an instrument is used to feel the junction between the veneer and the tooth. A poor fit is readily apparent to the dentist. If veneers do not fit properly, the process must be done again, starting with a new impression.

Dr. Duvall's response did not address the issue of improperly fitting veneers for this patient.

The Panel has concluded that the evidence is clear and convincing that Dr. Duvall performed substandard dentistry in respect of five of the six veneers delivered to S S and is incompetent practice within the meaning of Section 39(l)(d) of the *HPA.*

Amended Citation #9

In or about 2007, as regards your patient, JW, you extracted four permanent first pre-molars without obtaining informed consent.

The Panel reviewed a complaint letter from MW (patient's mother), affidavits from MW, J W (the patient), and C O (a CDA), a letter from Dr. C (subsequent treating dentist), two letters from a subsequent treating orthodontist, Dr. JC, the chart, radiographs, a letter from Dr. Duvall and heard testimony from Dr. Penner.

The evidence clearly shows that four adult teeth were extracted by Dr. Duvall on January 24, 2007. In their affidavits, JW and MW deposed that Dr. Duvall did not advise them that he proposed removing adult teeth.

MW deposed that Dr. Duvall told her the teeth should be removed to make room for adult teeth, and that he did not show her a radiograph or mention that JW would require orthodontic work after this had been done. There was some discussion about the cost. She did not learn that permanent teeth had been removed until Dr. C examined JW later.

The January 24, 2007 chart entry reads: *"Mom can't afford ortho, will take out teeth to make room for other teeth".* There is no plan noted in the chart that day other than to remove the four baby teeth.

Dr. Penner testified that when a child's mouth is crowded, the treatment options are to remove teeth or to expand and enlarge the arch to accommodate existing teeth. In both cases orthodontic work is required and it would be usual for an orthodontic opinion to be obtained before advising a patient how to proceed. He said that if four adult teeth are removed and the space is left untreated, there is a risk of permanent collapse of the patient's facial profile which is aesthetically unpleasing. He would have expected to see notes in the chart about the risks, benefits and options for removing the teeth since it is an irreversible procedure.

Dr. JC confirmed that the permanent teeth had been extracted and that JW's profile is *"somewhat dished in"*.

The Panel noted an entry in the chart on November 30, 2006, before the teeth were removed, that says: *"refer to Dr. C"*. This entry does not contain any detail, but it might mean that there was some discussion about the need for an orthodontist after the teeth were extracted. However when Dr. Duvall responded to the complaint he did not indicate that there was such a discussion at any time, or that he had advised that the teeth should come out but that orthodontic work would be necessary. He wrote: *"Never in 35 years have I extracted the wrong teeth. Perhaps you would look into this matter and advise me. If I did so, I am truly sorry."*

The Panel notes that the chart does not include a treatment plan other than that the teeth were to be removed. The absence of such evidence corroborates MW's evidence that there was no discussion about the need for orthodontic treatment.

In the absence of a meaningful response from Dr. Duvall on this issue, the Panel has concluded that MW did not give informed consent to the removal of the teeth and that this failure to obtain informed consent is incompetence within the meaning of Section 39(1)(d) of the *HPA*.

Amended Citation #10

In or about 2006, as regards your patient, RW,

- **a. your provision of endodontic treatment to teeth 2.4 and/or 2.6 was substandard; and/or**
- **b. you failed to advise RW of all reasonable treatment options when the instruments broke within tooth 2.6 during treatment.**

The Panel reviewed a letter of complaint from RW, two letters from subsequent treating dentists Drs. C and L, the chart, radiographs, a response letter from Dr. Duvall and heard testimony from Dr. Penner.

(a) <u>Endodontic Treatment to 2.4 and/or 2.6</u>

Dr. Duvall performed root canals to teeth 2.4 and 2.6 for RW.

As to tooth 2.4, Dr. C examined it after the root canal was performed. He advised that it: *"was tender to percussion and non responsive to ice [and that} the fill appears to be 3-4mm short of the radiographic apex with some possible apical pathology."*

Dr. Penner testified that a tooth that does not respond to cold is not vital with a nerve response. He reviewed the periapical radiograph of tooth 2.4 from May 19, 2009 and confirmed Dr. C's observation that the filling material was at least 4mm short of the apex. He pointed out that there was no entry in the chart to explain this. Dr. Penner further stated that when a dentist is filling a canal, it will be readily apparent that the fill is not where it should be and that a final radiograph should be taken. It will indicate whether there is a problem with the fill. If there is, the dentist ought to repair it. He said that root canal treatments should extend to within 1 mm from the tip of the canal to prevent bacteria from entering the tooth causing infection.

In this case the option for RW was to perform another root canal or remove the tooth.

In his response letter regarding the endodontic treatment to tooth 2.4, Dr. Duvall agreed that it: *"was short of the apex and after this amount of time I cannot remember the reason for that. However, in the x-ray, it appears as if the canal was calcified.* "

Dr. Penner testified that the canal did not appear to be calcified. Other than to admit that the fill was short, Dr. Duvall did not provide any explanation to suggest that his work was performed to an appropriate standard in respect of tooth 2.4.

The practice issue with respect to tooth 2.6 is that files broke off within the root while it was being prepared by Dr. Duvall on June 19, 2006. This is confirmed by the entry in the chart that day.

On June 20, 2006 the chart records: *"we decided to finish it next week, observe and if it fails, extract"*. Dr. Duvall completed the endodontic work on tooth 2.6, leaving the broken files in place within the canal.

Dr. Penner testified that files of increasing size are used during a root canal to clean the canal. When this work is complete, the canal is filled with a sterile material. Sometimes a file breaks within the canal, which can impair a dentist's ability to properly clean it.

When a file breaks, a dentist will be aware that this has occurred and should inform the patient and advise of the treatment options. If the file breaks in the tip of the canal, it is possible that it can be left in place and will not cause any problems with infection.

The situation is different if a file breaks mid-canal, which was the case for RW. The radiographs show that the broken files were located within the mesiobuccal and palatal canals. Dr. Penner explained that the files were about sixty percent of the way down the canal so that there was a poor chance the tooth would be pain free (that the infection would heal). RW should have been referred to an endodontist for treatment. The files should not have been left within the canal.

Dr. Duvall's response to the problem with the files left in tooth 2.6 is not meaningful except to point out that he had been able to "save" teeth with broken files in other patients.

The Panel finds that the root canals performed on teeth 2.4 and 2.6 were sub-standard and amount to incompetent practice of dentistry within the meaning of Section 39(1)(d) of the *HPA.*

(b) Failure to advise the patient of Treatment Options - the Files in 2.6

In paragraph 10(b) of the Citation, the CDSBC alleges that Dr. Duvall did not advise RW of her treatment options regarding the broken files in tooth 2.6. Dr. Penner noted that the chart

did not contain any entry that the risks of leaving the broken files in the canal and the options regarding what to do about it were explained to RW and she did not mention such an explanation in her letter to the CDSBC.

Counsel for the CDSBC in her written submissions noted that there was no sworn evidence about this issue from RW, but suggested the Panel could reach a conclusion that Dr. Duvall failed to obtain informed consent regarding the files in the canal, based upon the absence of any record in her chart.

In the absence of sworn evidence from RW about what she was told, the Panel is of the view that there is insufficient cogent evidence upon which to conclude that Dr. Duvall did not advise her that he had broken the file in the tooth and what the options were.

The Panel finds that this allegation has not been proven.

Citation #11

In or about 2009, as regards your patient, J S, you provided substandard care in the placement of an implant in the 1.6 position.

The Panel reviewed a complaint letter and affidavit from the patient, her chart, photographs, a radiograph, letters from subsequent treating dentists Drs. T, A and D; a response letter from Dr. Duvall and heard evidence from Dr. Penner.

JS saw Dr. Duvall at the Chetwynd Dental Clinic. Among other things, she sought treatment for an infected tooth in the upper right area of her mouth. Dr. Duvall told her the tooth should be extracted and that she could have an implant. She opted for the extraction, but a few months later returned to Dr. Duvall and told him to place an implant. He placed an implant on August 4, 2009. A healing cap was placed on the implant that day.

JS deposed that during the placement of the implant, Dr. Duvall stated several times that it was important that the post not protrude into her sinus cavity. Before she left the clinic, he indicated that the post was not in the sinus cavity. The healing cap fell off on August 20, 2009.

JS returned to the clinic in November 2009, and learned that Dr. Duvall was no longer practicing there and the crown for the implant could not be found. During that winter, she suffered from several bouts of severe flu and cold. She also experienced steadily worsening pain at the implant site.

Finally, in May 2010, she was examined by Dr. A. He suspected that the implant had penetrated her sinus and was the cause of her problems with colds and flu. He referred her to Dr. T who confirmed from radiographic evidence that the implant placed by Dr. Duvall had penetrated her sinus cavity and had to be removed.

Dr. Penner testified that the sinus is not a sterile environment and that bacteria may enter an implant site causing infection if it is penetrated. He also explained that a dentist would know that an implant had penetrated the sinus at the moment of occurrence from the feel of the drill, and that when this happens the procedure should be stopped, the area allowed to heal and the implant inserted at a later date. He also said that a dentist must inform the patient of what has occurred and what the treatment options are.

Dr. Duvall's letter did not respond in any meaningful way to the allegation that he had penetrated the sinus cavity when he placed the implant in tooth 1.6.

The evidence clearly shows that Dr. Duvall's work in this instance was sub-standard and that as a result his patient suffered from pain and ongoing health problems. The Panel concludes that Dr. Duvall delivered incompetent dentistry services within the meaning of Section 39(1)(d) of the *HPA*.

Citation #13

In or about 2009, as regards your patient, JO, you

a. provided unnecessary endodontic treatment to tooth 1.1; and/or

b. provided the unnecessary treatment to obtain maximum insurance coverage for a crown for tooth 1.1.

The Panel reviewed a letter of complaint from Dr. SL, affidavits of Dr. SL and NB (CDA), the patient's chart and radiographs, a response from Dr. Duvall and heard testimony from Dr. Penner.

(a) providing unnecessary treatment to tooth 1.1

Dr. SL performed a restoration on tooth 1.1 for JO in June 2008. He returned to her dental clinic on October 21, 2009 complaining that the restoration had come out. He was seen by Dr. Duvall that day.

The tooth was asymptomatic and the patient wanted it smoothed or the filling replaced, but Dr. Duvall advised him that the tooth needed a crown, and that if he did a root canal, his insurer would approve a new crown. Dr. Duvall performed a root canal that day.

Dr.SL deposed that pre and post-operative radiographs show that endodontic treatment was not necessary for tooth 1.1.

The CDA in attendance deposed that Dr. Duvall told her outside the treatment room that *"if you root canal a tooth, insurance will pay for the crown.*" She also deposed that she did not perform any pulp vitality tests on this patient, but that she took a radiograph.

Dr. Penner testified that a filling that has fallen off does not indicate that there is need for a root canal. Normally a dentist will replace the filling or recommend a crown. A root canal is only necessary if the patient is complaining of pain. He confirmed Dr. SL's opinion that the radiographic evidence did not support the need for a root canal.

Dr. Penner testified that there was no evidence of periapical pathology so that a root canal was unnecessary. However, he agreed the tooth was so broken down that a crown would have been appropriate. He pointed out that the chart does not contain any indication that the patient was advised a root canal would be performed, that the treatment options were explained and the patient's consent obtained.

In his response letter, Dr. Duvall stated: *"It was my opinion, that with the difficult and failed restoration done by Dr. SL, the tooth was better with a crown. In addition, I was concerned that the pulp would be damaged and therefore did an endodontic treatment."*

In this case, the Panel is of the view that Dr. Duvall has provided a meaningful response to the allegation that a root canal was necessary, especially in light of Dr. Penner's evidence that the damage to tooth 1.1 was sufficiently substantial that a crown was a reasonable alternative to replacing a filling.

Although the tooth was asymptomatic when the patient presented, in view of the evidence that a crown was appropriate, one of the options was to perform prophylactic treatment to that tooth. The Panel is of the view that it was a reasonable option to perform the root canal in advance of symptoms manifesting. If symptoms manifested later, performing endodontic treatment after the crown has been placed would cause damage to the crown and build up.

The treatment record shows that on Oct 21, 2009, Dr. Duvall completed the root canal, prepared the tooth for a post and MIDBL composite. This means he did a post supported composite restoration to complete the restoration. He could not have done a post without previously doing the root canal.

The Panel is of the view that proceeding in this way was a reasonable treatment option, although not the only one. The Citation alleges that Dr. Duvall "provided unnecessary endodontic treatment". The Panel is unable to conclude that in the circumstances of this case, the treatment was unnecessary. This allegation is dismissed.

(b) providing unnecessary treatment to 1.1 to obtain maximum insurance coverage for a crown.

The College alleges that Dr. Duvall was over servicing the patient to maximize insurance coverage including his fees. However there was no evidence about the fee that was actually charged for this work, that it was paid or that it went into Dr. Duvall's pocket.

The Panel understands the College's concern about his statement to the CDA regarding "tricking" an insurer to obtain payment for a crown by performing a root canal, but in this case, since the Panel is unable to conclude that the plan that was followed was inappropriate, it is unable to draw an inference that the only reason Dr. Duvall proceeded as he did was to obtain financial advantage.

Accordingly, the CDSBC has failed to prove this allegation and it is dismissed.

Citation #14.

In or about 2007, as regards your patient, MH, you failed to properly prepare tooth 4.6 for a crown.

The Panel reviewed an affidavit and report from Dr. DH, the patient's chart, photographs and one radiograph of the tooth, Dr. Duvall's letter of response and heard oral evidence from Dr. Penner.

In this case, Dr. Duvall prepared tooth 4.6 for a crown on March 28, 2007. MH attended the clinic on April 16, 2007 so that Dr. DH could cement in the crown Dr. Duvall had prepared. Dr. DH was unable to perform the cementation because the crown did not fit properly. The lingual margin was 1.5mm off with a large ledge. Further the preparation was too cone shaped on the buccal or cheek side.

Dr. Penner testified that an ill-fitting crown may be due to an error in the impression taken by the dentist – in this case, Dr. Duvall - or an error by the lab that made the crown. In either case, when a crown does not fit, a new impression ought to be taken and the crown remade.

Dr. Penner reviewed the radiograph and confirmed Dr. DH observation that the shape of the preparation was very conical. He testified that the appropriate taper is four to six degrees and that if there is too much angle, there is less likelihood of good retention of the crown – in other words, the crown is less likely to stay in place.

In his response, Dr. Duvall stated: *"I have looked at the chart and x-rays and perhaps it is not a text book preparation. It is difficult for me to tell. As far as retention, the cement that I use is very adherent and usually assists in adjusting for a less than ideal preparation (relyx)*".

Dr. Penner pointed out that Dr. Duvall did not address the ledge in his response, and that cement with adhesive properties does not compensate for failing to prepare the crown correctly in the first place.

The Panel has reviewed all of the evidence and has concluded that the allegation has been proven. It is obvious from a review of the radiographic evidence that the preparation was too cone shaped. In his response, Dr. Duvall tried to deflect attention away from the issue by mentioning the type of cement he used, which is not responsive to the issue of a poor preparation.

The Panel has concluded that Dr. Duvall's dentistry treatment was incompetent within the meaning of Section 39(1)(d) of the *HPA.*

<u>Citation #15</u> As regards your patient, GB,

a. in or about 2006, you provided inappropriate treatment to tooth 3.6 by providing endodontic treatment to a periodontically compromised tooth; and/or

b. in or about 2007, following the extraction of tooth 3.6, you provided substandard treatment in the placement of an implant in the 3.6 position.

The Panel reviewed a report and affidavit from Dr. DH, the patient's chart, two radiographs, a response from Dr. Duvall, and heard testimony from Dr. Penner.

In this case, Dr. D H complained about the appropriateness of Dr. Duvall's decision to perform a root canal and restorative work on tooth 3.6. Because of severe periodontal disease, the appropriate treatment would have been extraction. Further, the root canal was poorly done prior to the extraction and the subsequent implant was mobile and improperly placed too close to tooth 3.7.

(a) Endodontic Treatment

Dr. Penner confined Dr. DH's concern about periodontal disease. He said that the radiographs revealed advanced periodontal disease on tooth 3.6 at the time Dr. Duvall did his

work. The Oct 24, 2006 radiograph (the day the root canal was performed) shows significant bone loss on the distal root of tooth 3.6 and exhibited furcal involvement (furcation is the area where the roots join the crown of the tooth.) Dr. Penner did not go as far as Dr. DH in that he suggested the periodontal disease should have been brought under control before considering, and if appropriate, proceeding with endodontic treatment.

In his response letter, Dr. Duvall acknowledged that there was infection around tooth 3.6, but stated that he would prefer to try the endodontic treatment and if it failed, give the patient a credit toward an implant. The Panel is of the view that this response does not make sense, because Dr. Duvall, in fact, delivered an implant as part of the treatment plan.

The Panel accepts the CDSBC's position that the treatment was inappropriate in view of the severely compromised periodontal condition of tooth 3.6. The chances of a successful prognosis for this tooth without comprehensive prior periodontal treatment were poor at best. Dr. Duvall's treatment was incompetent within the meaning of Section 39(1)(d) of the *HPA*.

(b) Placement of the Implant

Dr. DH deposed that the implant in tooth 3.6 was very mobile and was placed too close to tooth 3.7.

Dr. Penner confined that the placement of the implant in tooth 3.6 was in such close proximity to tooth 3.7 that its restoration would be difficult and perhaps impossible. He further pointed out that there was no apparent reason not to put the implant in the center position of the socket, which is the usual place and that placing the implant so close to tooth 3.7 meant that it would have been impossible to place a crown.

On the issue of the poor location and mobility of the implant, Dr. Duvall stated that it was normal for an implant to be mobile, and that it takes three months to integrate into the bone, and that if he had finished the treatment, he may have placed a second implant mesial to the one already inserted.

Dr. Penner refuted Dr. Duvall's response about a second implant saying that occasionally two implants are used to spread the weight or load of opposing teeth, but if this is the plan, it would normally be charted and the two implants would be placed at the same time.

The Panel rejects Dr. Duvall's response because the placement site of the implant was in infected bone in an inappropriate location. This is what caused the mobility. The mobility was not the normal expected result of the healing process.

Accordingly, the Panel finds that Dr. Duvall performed substandard treatment in the placement of the implant in tooth 3.6 which is incompetent dentistry practice within the meaning of Section 39(l)(d) of the *HPA.*

Citation #16

In or about 2007, as regards your patient, RK, you refused to provide emergency service when a temporary crown that you had placed earlier that day on tooth 4.7 was lost.

The Panel reviewed Dr. DH's report and affidavit, an affidavit from RK, her chart, a response letter from Dr. Duvall, the CDSBC Code of Ethics and heard testimony from Dr. Penner.

RK deposed that on February 6, 2007 she felt and heard a crack in her mouth and went to the Fort St. John Dental Clinic where Dr. Duvall examined her. He told her that she had cracked the tooth and should receive treatment right away. She returned to him the next day for a crown. On February 7, 2007 Dr. Duvall did the crown preparation and provided a temporary crown to tooth 4.7. This work is recorded in the chart.

RK deposed that after the work was completed, while driving home, the temporary crown came off. She returned to the clinic immediately. Dr. Duvall refused to fix the tooth saying he was busy, his assistant had gone and he had a flight to catch. She deposed that he blamed her for the problem and told her to return the following week for treatment.

RK could see that some of the clinic staff was putting on their coats. She was very upset by Dr. Duvall's conduct and attitude. When the freezing wore off she experienced worry and pain. She was afraid to return to the clinic the next day, but did so five days later when Dr. DH placed another temporary crown and a final crown several weeks later.

There is an entry in the chart dated February 12, 2007 made by the clinic manager confirming RK's complaint about what had occurred on February 7, 2007.

Dr. Penner referred to section 5.07 the Code of Ethics in force at the time: *"The primary consideration of members is the health and well-being of their patients.... Members have an obligation to consult with and provide dental emergency treatment to any member of the public, or, if they are unavailable, to make alternative arrangements ....A dental emergency exists if a person needs immediate attention to relieve pain or control infection or bleeding or if a person's health or well-being is otherwise immediately jeopardized* "

He stated that in view of RK's painful condition, her circumstances constituted an emergency and Dr. Duvall should have treated her or made an alternative arrangement for her.

Dr. Duvall responded that when the patient returned *"there was no operatory space or time to see her particularly late at night and I also had several patients there. I was also under pressure from the staff to close the office.*"

The Panel is of the view that Dr. Duvall's failure to provide assistance to RK was a breach of the Code of Ethics. His explanation that there was no operatory space available and that he had patients is not credible. Further his response was inappropriate. It was his duty to assist RK either by providing treatment or making an alternate arrangement for her. None of the reasons he gave for refusing to assist her are acceptable in an emergency such as this.

The Panel further notes that when RK returned to the clinic, her mouth was still frozen. It was an ideal time to re-cement or repair the temporary crown causing minimal further discomfort and removing the risk of infection and pain that a delay in repair would cause.

The Panel has concluded that Dr. Duvall's breach of the Code of Ethics is professional misconduct and is an offence pursuant to Section 39(1)(c) of the *HPA.*

Citation #18(b)

In or about 2006, as regards your patient, BC, you

b. provided inadequate restorations to teeth 5.5, 5.4, 6.5, 6.4, 7.5, 7.4, 8.4 and/or 8.5

In this instance the Panel reviewed the report and affidavit from Dr. DH, an affidavit from GC (patient's mother), the patient's chart, radiographs, a response letter from Dr. Duvall and heard testimony from Dr. Penner.

GC deposed that Dr. Duvall saw her daughter B in 2006. B was 7 1/2 years old at the time. Dr. Duvall advised that B would need fillings to eight teeth. This restorative work was performed by Dr. Duvall in April and July 2006. Some time later, GC took B to another dentist, Dr. M, who advised her that six of the eight fillings placed by Dr. Duvall required replacement. Dr. M took radiographs of the teeth before he replaced the fillings.

Dr. DH provided those radiographs to the CDSBC. He reviewed them and deposed that they show the fillings were insufficient. Dr. Penner testified the radiographs confirmed there was a lack of filling material between the tooth and the filling in teeth 5.5, 8.4, 8.5, 6.4, 7.4 and 7.5. He further pointed out that the provision of such restorations is basic routine dentistry and there was no apparent reason for the work to have been poorly performed.

In his response, Dr. Duvall said that the composite material used in Fort St. John was not of the same quality as that used in another dental office in Chetwynd. The Panel can not accept this explanation - if the filling material used was in fact inadequate, he should not have used it.

The Panel concludes that Dr. Duvall's provision of the restorations was inadequate in respect of the 6 teeth and is incompetent dentistry within the meaning of Section 39(1)(d) of the *HPA.*

Citation #19

In or about 2006, as regards your patient, CO, you provided substandard care in the placement of a crown on tooth 3.6.

The Panel reviewed Dr. DH's report and affidavit, the patient's chart, a radiograph, Dr. Duvall's response and heard testimony from Dr. Penner.

The patient, CO, was a certified dental assistant who worked for Dr. Duvall at Fort St John Dental Clinic.

Dr. Duvall placed a crown on tooth 3.6 on December 22, 2006 that did not fit properly. On a recall examination on April 4, 2007, Dr. DH examined the tooth and took a periapical radiograph of it. He deposed that *"on examination of Ms. O, the mesial of 3.6 had gingival inflammation, irritation and the papilla crowded out. The radiograph revealed a 2 to 3 mm overhanging mesial margin. On April 4, 2007, I redid the crown."*

Dr. Penner reviewed CO's chart and radiograph. He confirmed there was a 2 to 3 mm overhang on the mesial of the crown. This overhang would have been apparent to Dr. Duvall on the tryin and the crown should not have been permanently placed in the mouth. It should have been re-fabricated. When the patient went to Dr. DH for the placement, the mesial had gingival inflammation, irritation and the papilla was crowded out due to this overhang.

In his response Dr. Duvall acknowledged that the crown needed to be redone but suggested he did not have the opportunity to do so. Dr. Penner pointed out that if Dr. Duvall had planned to redo the crown, there was no need to wait four months to do so, because a crown takes about one week to prepare.

The Panel has carefully examined Dr. Duvall's response. It does not address the issue of the overhang or the problems this caused for the patient.

The Panel has concluded the provision of a crown is a part of basic dentistry. There is no reason to insert a crown that does not fit properly and this would have been apparent to Dr. Duvall. It

was not noted anywhere in the treatment plan that Dr. Duvall planned to replace the crown in the future.

The Panel finds that the placement of the crown on tooth 3.6 was sub-standard dentistry practice by Dr. Duvall and is incompetence within the meaning of Section 39(1)(d) of the *HPA*.

Citation #20

In or about 2006 and 2007, as regards your patient, D B , your provision of a complete upper denture was substandard.

The Panel reviewed a report and affidavit from Dr. DH, the patient's chart, a radiograph and one photograph, Dr. Duvall's response letter and heard oral testimony from Dr. Penner.

Dr. Duvall was asked to provide the patient with a complete upper denture (CUD) and an immediate complete lower denture. He took impressions for these on December 19, 2006 and performed a try-in on March 28, 2007. The patient went to the clinic to see Dr. DH on April 16, 2007 for the insertion of the CUD.

Dr. DH observed that the CUD was non functional. It had no anterior labial flange. The ridge in the upper anterior region was soft, boggy and mobile. Further Dr. Duvall had taken the final impression for the upper denture over an erupted root fragment in the area of tooth 2.8 which needed extraction.

Dr. Penner reviewed the photograph and confirmed that the flange was inadequate. This means that suction cannot be achieved so the denture will not fit.

Dr. Penner further confirmed that the photograph revealed hyperplastic tissue, which is tissue created or left when bone resorbs after extractions. It is soft and movable which makes it difficult to take an accurate impression. He confirmed Dr. DH's evidence, that the patient should have been referred to an oral surgeon to have the tissue removed before the denture was made.

The third problem apparent on the radiograph was the presence of an erupted root of tooth 2.8. Dr. Penner testified that this should have been removed before taking an impression because if it

is left in the mouth there is a risk of infection which can ultimately lead to removal of the tooth root, which would alter the fit of the denture.

In his response, Dr. Duvall did not address the problem of the missing anterior labial flange to the CUD, or the erupted root of tooth 2.8. As to the issue of the hyperplastic tissue he stated that the patient's *"old dentures caused his hyperplastic tissue and ... that new dentures would lessen this scenario"*. On this latter point, Dr. Penner testified that new dentures could not address a problem of this magnitude.

The Panel has examined all of the evidence pertaining to this patient. Dr. Duvall's response does not provide a reasonable explanation for failing to remove the hyperplastic tissue and does not address the other practice issues. The allegation that the provision of the CUD to DB was substandard is proven and is incompetent practice within the meaning of Section 39(1)(d) of the *HPA.*

Citation #21

In or about 2007, as regards your patient, EP, you provided substandard care in the provision of a crown to tooth 4.7.

The Panel reviewed a report and affidavit from Dr. DH, the patient's chart, two radiographs, a response letter from Dr. Duvall and heard oral testimony from Dr. Penner.

Dr. DH stated that a full gold crown (FGC) for tooth 4.7 did not fit. The lingual margin was inadequate. The preparation, performed by Dr. Duvall on March 21, 2007, was pyramid shaped and had no retention. He stated that the build up needed posts and/or retention pins and that he would have to do the work over. He also deposed that *"a crown was not a viable option on this tooth long term"*.

Dr. Penner reviewed pre and post-operative radiographs and confirmed Dr. DH's opinion that the preparation was cone shaped. .

In his response, Dr. Duvall did not address the problem of his inadequate preparation work in a meaningful way.

The Panel has examined all of the evidence and finds that Dr. Duvall's provision of the crown was sub-standard and is incompetent practice within the meaning of Section 39(1)(d) of the *HPA.*

Citation #22

In or about 2007, as regards your patient, M P ,

- **a. you recommended crowns for teeth 3.6 and 4.6 even though the treatment plan was inappropriate due to the periodontal condition of the teeth;**
- **b. you failed to inform the patient of her serious periodontal condition;**
- **c. you improperly prepared teeth 3.6 and 4.6 for the crowns; and/or**
- **d. in the preparation of tooth 4.6, you damaged tooth 4.7.**

The Panel examined Dr. DH's report and affidavit, the affidavit of MP, her chart, four radiographs, Dr. Duvall's response letter and heard oral testimony from Dr. Penner.

a. Crowns for Teeth 3.6 and 4.6 & Periodontal Disease

MP deposed that Dr. Duvall treated her in 2007. He told her that she needed crowns on teeth 3.6 and 4.6. She agreed to have the work done and had several appointments for the preparation. At no time did Dr. Duvall advise her that she had periodontal disease associated with the teeth. In April 2007, Dr. D H saw her and advised her that both teeth had periodontal disease. By this time, Dr. Duvall had prepared a crown on tooth 4.6, but had not yet done so for tooth 3.6. Dr. D H placed a temporary crown on tooth 4.6 and referred MP to a periodontist for further treatment of tooth 4.6.

Dr. Penner confirmed Dr. DH's opinion that the two teeth had periodontal disease. He said that the radiographs show that the periodontal disease was advanced and should have been treated before the crown work was done. He also pointed out that there was no indication in the chart that the periodontal disease was discussed with the patient. She should have been advised of it and referred for treatment.

In response to this aspect of the complaint, Dr. Duvall blamed the dental hygienist for inaccurate charting. Dr. Penner doubted that the dental hygienist's work was relevant and pointed out that the extent of the periodontal disease should have been apparent on Dr. Duvall's examination of the radiographs and dental hygienist's probe findings.

The Panel cannot accept Dr. Duvall's suggestion that the problem was caused by the dental hygienist. It is of the view that the dentist is ultimately responsible to properly advise a patient and to review a dental hygienist's work. Further, even though the dental hygienist's chart entries were different from Dr. DH's, they were indicative of periodontal disease, which Dr. Duvall ought to have addressed.

The Panel finds that Dr. Duvall's advice to place crowns on teeth 3.6 and 4.6 without initially treating the periodontal disease was inappropriate and is incompetent dental practice within the meaning of Section 39(l)(d) of the *HPA.*

b. Failure to Inform of Periodontal Condition

As noted above, MP deposed that she was not advised by Dr. Duvall that she had periodontal disease and there is no indication in the chart that this issue was discussed with her.

Dr. Duvall did not address this issue in his response.

The Panel finds that the CDSBC has established that he failed to inform her of her condition and obtain informed consent to the proposed treatment. This is incompetent dentistry practice within the meaning of Section 39(1)(d) of the *HPA.*

c. Improper Preparation for Crowns

The Panel notes that the CDSBC did not pursue this allegation in respect of tooth 3.6 and will not address it further.

As to tooth 4.6, Dr. DH deposed that *"the preparation on 4.6 was conical and non-retentive."* Dr. Penner confirmed that the radiograph for tooth 4.6 shows that the preparation for the crown was conical and non-retentive.

Dr. Duvall did not address this allegation in his response letter.

The Panel has decided that the preparation for crown 4.6 was improperly done and 1s incompetent dentistry practice within the meaning of Section 39(1)(d) of the *HPA.*

d. Damage to tooth 4.7

The CDSBC alleges that while preparing tooth 4.6, Dr. Duvall damaged tooth 4.7. Paragraph 272 of the CDSBC written submission says *"Dr. Penner testified that the mesial of tooth 4.*7 *appears to have damaged during the preparation of 4.6. This is confirmed in the pre and post preparation radiographs.*"

The Panel has decided that this allegation has not been proven.

Although the radiograph shows damage to tooth 4.7 following the procedure, it is minimal. On occasion such minimal damage occurs without poor practice on the dentist's part. In this case, the CDSBC has not established by clear and convincing evidence that the damage to that tooth was caused by improper practice by Dr. Duvall.

Therefore the Panel dismisses paragraph 22(d) in the Citation.

Citation #23

In or about 2007, as regards your patient, GO, you extracted 11 teeth without sufficient radiographic information.

The Panel reviewed Dr. DH's report and affidavit, the patient's chart, five radiographs, Dr. Duvall's response and heard testimony from Dr. Penner.

In this case, Dr. DH deposed that Dr. Duvall extracted eleven teeth and made plans for complete upper and lower immediate dentures without obtaining sufficient information in advance.

Dr. Penner agreed with Dr. DH's concern. He explained that before extractions are performed, a dentist requires radiographic information that shows the full length of a tooth including the root. This information is necessary so that the dentist will know what the implications of tooth removal on neighboring anatomical structures will be. The two bitewing radiographs Dr. Duvall reviewed did not show the complete roots of any of the upper or lower teeth that he extracted.

In his response, Dr. Duvall stated *"I do not recall the circumstances of why more x-rays were not taken. As far as the extractions being done, there seemed to be no reason why I should not have done them."*

Dr. Duvall's response does not address his decision to proceed when he was missing important information. This suggests that he did not understand the significance of obtaining adequate information before extracting teeth.

The Panel is satisfied that Dr. Duvall proceeded with the tooth extractions without sufficient information and that this is incompetent practice within the meaning of Section 39(1)(d) of the *HPA.*

Citation #24

In or about 2007, as regards your patient JC, you failed to properly place a post in tooth 1.2.

The Panel reviewed Dr. DH's report and affidavit, the patient's chart, four radiographs, Dr. Duvall's response letter and heard oral testimony from Dr. Penner.

Dr. DH complained that a post inserted by Dr. Duvall on tooth 1.2 was too short. The radiograph confirmed Dr. DH's concern.

Dr. Penner agreed with Dr. DH's opinion. He explained that a post is used after a root canal to assist in creating a build-up upon which a crown will be placed. A post should extend as far below the gum line as the crown will extend when completed for stability.

He explained how a post is placed – the canal is prepared with a drill. The gutta purcha is removed, the post is inserted and fit in, and then cemented. During this process the dentist will be able to see whether the post is long enough.

Dr. Penner said that the radiograph for tooth 1.2 with the post in place shows it extends 3 to 4 mm into the root of the tooth. There is a 4 mm void between the tip of the post and the gutta percha. This is too short and compromises the stability of the tooth.

Dr. Penner explained that the insertion of a post is part of a general dentistry practice. It is commonly done. He could see no reason from the radiograph why the post was not placed properly.

The Panel notes that apparently no radiograph was taken prior to Dr. Duvall's treatment, which also indicates that he was attempting to place a post without sufficient radiographic information.

Dr. Duvall's response regarding this complaint was that *"he would have liked to get this post down further, however, was unable to do so"*. This explanation is not helpful. It does not offer a reasonable explanation for placing a short post in the tooth, when to do so is a departure from an appropriate standard of dentistry.

The Panel finds that Dr. Duvall's placement of the post was not properly done and is incompetent dentistry within the meaning of Section 39(1)(d) of the *HPA*.

Amended Citation # 25

In or about 2007, as regards your patient GS,

a. you performed unnecessary and inappropriate treatment by placing a crown on tooth 3.3, when the tooth was only minimally damaged;

b. your preparation on tooth 3.3 was substandard.

The Panel reviewed Dr. DH's report and affidavit, the patient's chart, a radiograph, a model, Dr. Duvall's response letter and heard oral evidence from Dr. Penner.

The patient, 17 years old, was in a car accident and chipped the incisal edge of tooth 3.3. Dr. DH deposed that the chip was *slight.* She saw Dr. Duvall who recommended a crown for tooth 3.3. In Dr. DH's opinion, the crown was unnecessary because the damage was so slight. He further pointed out that the preparation for the crown was cone shaped.

The patient followed Dr. Duvall's advice and had a crown placed on tooth 3.3.

a. Unnecessary and Inappropriate Provision of a Crown to 3.3

Dr. Penner confirmed Dr. DH's observation that the initial damage to tooth 3.3 after the accident was slight and did not require a crown. He referred to the pre-treatment model of the tooth and pointed out that the damage in question could be described as a "flake". It was barely visible and could have been repaired by smoothing with a series of composite polishing discs.

b. Substandard Preparation on 3.3

Dr. Penner confirmed Dr. DH's observation that the crown preparation was cone-shaped. He explained that the crown preparation on the model was very short and conical in shape so that it was only minimally retentive. As a result, the patient will require future treatment because of the poor work.

Dr. Duvall did not provide a meaningful response to either issue. He stated, among other things. *"I am not sure of the issue here."*

The Panel finds that the CDSBC has established that the provision of a crown was both unnecessary and inappropriate and that the preparation work for the crown was substandard.

Indeed, Dr. Duvall's response letter suggests that he does not understand what proper technique is, or that the best treatment in this case was to do nothing or smooth the tooth. The evidence suggests that Dr. Duvall has no understanding as to when it is appropriate to prepare and deliver a crown.

His treatment of the patient in this case was incompetent within the meaning of Section 39(l)(d) of the *HPA.*

Citation #26

In or about 2007, as regards your patient RH,

a. you provided endodontic treatment and a crown for tooth 3.6 even though the treatment plan was inappropriate due to the patient's periodontal condition; and/or

b. you improperly prepared tooth 3.6 for the crown.

The Panel reviewed Dr. DH's report and affidavit, the patient's chart, a radiograph, Dr. Duvall's response letter and heard oral testimony from Dr. Penner.

a. Providing Endodontic Treatment for a Compromised Tooth

Dr. DH deposed that Dr. Duvall provided endodontic treatment to tooth 3.6 for this patient on January 25, 2007. The patient attended the clinic on May 17, 2007 to have the crown cemented, and Dr. DH saw him. His opinion was that there was a poor prognosis for the tooth because of periodontal disease and loss of tooth structure. His opinion, documented in the chart, is that it was inappropriate to proceed with a crown in view of the periodontal disease. The patient decided to proceed with the crown in any event.

Dr. Penner confirmed Dr. DH's opinion. He explained that the chart indicates that on January 3, 2007, when Dr. Duvall saw the patient there was decay on existing crowns for teeth 3.6, 3.7 and 3.8. However there was no mention of the periodontal condition of the teeth and no periodontal charting was recorded.

Dr. Penner agreed with Dr. DH's concerns about the provision of a crown to tooth 3.6 in light of the periodontal disease. He said that the disease was sufficiently severe that it should have been brought under control before providing a crown.

Dr. Duvall said in his response letter *"tooth 3.6 was not ideal"*. He says that he and the patient decided to proceed with the crown and that he would have come to an agreement with the patient if the tooth was lost. However, there was no charting about a discussion with the patient regarding the need to control the periodontal disease before proceeding and what the risk to the

patient would be. Dr. Duvall did not address the issue of the severity of the disease in his response or in the chart, and stated that it was appropriate to follow a course of trying the crown anyway. The clinical findings regarding the extent of the periodontal disease do not support Dr. Duvall's judgment to place the crown prior to appropriate periodontal treatment.

The Panel finds that the provision of endodontic treatment to tooth 3.6 was inappropriate and is incompetent practice within the meaning of Section 39(1)(d) of the *HPA.*

b. improper preparation of tooth 3.6 for a crown

Dr. D H deposed that *the composite build-up on the tooth is cone-shaped and minimally retentive.*

Dr. Penner confirmed Dr. DH's observation. He said that the x-ray showed that the composite build up on the tooth was conical in shape and minimally retentive. Dr. Duvall's letter was not responsive to this issue.

The Panel finds that the crown preparation was poorly done and is another example of incompetent dentistry practice within the meaning of s.39(l)(d) of the *HPA.*

Amended Citation# 17(a) & (b)

You behaved inappropriately toward patients as illustrated by the following:

a. in or about 2007, you hugged RK

b. in or about 2006, you asked patient BC, her mother and/or her grandmother to sit on your lap.

The Panel reviewed the affidavits of RK, BC and GC, a photograph and the clinical evidence referred to elsewhere in this decision regarding the dental treatment of RK and BC.

a. RK

RK deposed that she saw Dr. Duvall for the first time on February 6, 2007. At the end of her first appointment with Dr. Duvall, while still in the treatment room, Dr. Duvall gave

her an unwanted hug. She stated that she was *"shocked by this. It made me uncomfortable and I did not·appreciate it.* **"**

There was no reason in the circumstances to suggest that RK was a nervous person who required comfort from her dentist. Even if she did, as Dr. Penner testified, a touch to comfort a patient may be reasonable, but if given, it must be done within acceptable professional boundaries. He suggested that a touch on the shoulder during difficult treatment might be appropriate, but that a hug went too far.

Dr. Duvall did not address this issue in his response letter.

The Panel accepts the CDSBC's position that the hug to RK was inappropriate in the circumstances. There was no reason for it in the context of treatment, or in the relationship with Dr. Duvall since this was the first time he had met RK. **It** was not a long-term patient-dentist relationship.

This kind of behaviour is unethical and unacceptable from a dentist/patient relationship point of view. The Panel finds that Dr. Duvall's conduct is professional misconduct within the meaning of Section 39(l)(c) of the *HPA.*

b. inappropriate request to C family to sit on Dr. Duvall's lap

GC deposed that her 7 1/2 year old daughter B had a series of appointments with Dr. Duvall. On the last of these appointments, her mother (B's grandmother) was in town, and she attended the clinic with B and GC. At the end of the appointment, Dr. Duvall told her that he wanted a photograph of B sitting on his knee. GC deposed that she felt uncomfortable, but that she humored Dr. Duvall. A photograph of B sitting on Dr. Duvall's knee is attached as an exhibit to her affidavit.

In addition, GC deposed that Dr. Duvall asked if she (GC) and her mother would like to sit on his knee. They were shocked. GC never returned to Dr. Duvall's clinic.

Dr. Duvall did not address this matter in his letter of response.

Both GC and her mother were uncomfortable with Dr. Duvall's suggestion to sit on his lap. It was an unwelcome suggestion. The Panel notes that there was a power imbalance between Dr. Duvall and GC, which is why she felt she had to humor him.

The Panel finds that Dr. Duvall's conduct was inappropriate and is a serious breach of the professional relationship between a dentist and his or her patient. It shows a lack of respect for the patient and demonstrates serious error in judgment. There was no possible rationale for the requests in respect of any of the women. This conduct is professional misconduct within the meaning of Section 39(l)(c) of the *HPA.*

Citation #12 & 27

12. In or about 2009, you failed to provide Dr. D with a copy of a Revised Agreement and Undertaking made between you and the College dated November 5, 2003 ("AUSPA"), contrary to the terms of the AUSPA.

27. You breached your undertakings to the College as set out in the AUSPA… [Sections 8(j), (k), (n) & section 9]

Dr. Duvall entered into an agreement with the CDSBC called an *Acknowledgement and Undertaking of Dr. Derek Duvall with Supporting Physicians Agreements* ("AUSPA) on November 5, 2003. (The AUSPA was amended in February 2005, but the amendment was minor and is not relevant to these allegations.) The Citation alleges that Dr. Duvall breached numerous provisions of the AUSPA, but the CDSBC proceeded only in respect of Sections 8 (j), (k) and (n) and Section 9.

The relevant sections of the AUSPA are:

> *8(j) to provide a copy of this AUSPA to any CDSBC member…in whose practice I may be working,·*
>
> *8(k) not to provide dental services to patients unless and until the CDSBC member referred to….has provided their written agreement to the CDSBC to report the following to the CDSBC:*

(i) any breach by me of these undertakings known to them; and

(ii) any significant quality of care, judgment, or interpersonal issues involving me;

8(n) to voluntarily submit to a CDSBC chart review at my expense, once per year for 5 years following the date of my registration and licensure, which chart review will be conducted by an inspector of the CDSBC's choosing ...

9 agree that Dr. L and Dr. C may provide reports and information and otherwise communicate with the CDSBC as set out in the agreements of Dr. L and Dr. C below, and that I will bear any expense associated with these reports/communications, which is not covered by my medical insurance, and I will take all reasonable steps to ensure that Dr. L's regular reports to the CDSBC are received by the CDSBC in a timely manner.

The Panel reviewed a complaint letter, the AUSPA, affidavits from Drs. D, SL and DH, a series of correspondence between the CDSBC and Dr. L, letters from Dr. AD and Dr. E, pleadings in a related civil matter, and heard oral evidence from Dr. Penner. Dr. Duvall did not provide a response to the CDSBC regarding these allegations.

Dr. Penner provided the Panel with Dr. Duvall's history as a registrant of the CDSBC.

He was first registered in 1973 and continued until 1992. He registered and worked in Alberta and then reapplied for registration in BC in 2001. There was a prior history of complaints about Dr. Duvall in BC, and some difficulties in Alberta, as a result of which the CDSBC negotiated an AUSPA signed on November 5, 2003 and amended in February 2005.

The AUSPA is a detailed agreement containing several conditions the CDSBC believed would ensure that Dr. Duvall would practice safely. When this AUSPA was signed, it had been determined that Dr. Duvall suffered from a [redacted]. Among other things, the agreement required him to remain under [redacted] care, take his medications and permit his physician to provide reports to the College.

Section 8(j) of the AUSPA required Dr. Duvall to *"provide a copy of this AUSPA to any CDSBC member in whose practice I may be working"*.

The CDSBC alleges that Dr. Duvall failed to comply with this requirement.

The Panel reviewed the Affidavits of Drs. D, DH and SL in this regard.

In paragraph six of his Affidavit, Dr. DH deposed that when preparing for the hearing, he was provided with a copy of the AUSPA and asked whether he knew of it when he hired Dr. Duvall as an associate in his clinic. Dr. DH did not recognize the document. He further deposed that after Dr. Duvall began working at the clinic he gave him (Dr. DH) an envelope containing papers, which he said had something to do with the CDSBC, but Dr. DH could not depose at this time as to whether they contained the AUSPA. Otherwise, Dr. Duvall did not bring the conditions in the AUSPA to his attention.

The CDSBC argues that even if the envelope contained the AUSPA, Dr. Duvall had an obligation to bring the AUSPA to the attention of any dentist that hired him and that the handing of an envelope without discussion does not meet his obligation. The Panel agrees that Dr. Duvall did not comply with his obligation to provide a copy of the AUSPA to Dr. DH. Assuming that the envelope contained the document, Dr. Duvall was obligated to explain to the principal dentist, Dr. DH, what the terms of the AUSPA were and what obligations Dr. DH was required to meet pursuant to it (see paragraph 8(k) of AUSPA).

Dr. SL is one of the three dentists who complained to the CDSBC about substandard practice of Dr. [redacted] . In her affidavit she deposed that at no time did Dr. Duvall *"disclose to me that he was subject to any conditions upon his ability to practice.*"

She was provided with a copy of the AUSPA by the College during the investigation and confirmed that Dr. Duvall had not provided a copy of it to her.

The Panel reviewed a complaint and Affidavit from Dr. D. She purchased the dental practice in Chetwynd where Dr. Duvall was working as an associate. She terminated his employment for various reasons about five weeks after she took over the practice.

She deposed that after she terminated his employment she learned that he was subject to the AUSPA that required him, among other things to disclose to her that he was subject to certain conditions upon his ability to practice. She said that Dr. Duvall did not at any time disclose those conditions to her. College counsel provided her with a copy of the AUSPA. She deposed that she had never seen the document.

In his response, Dr. Duvall suggested that the agreement he signed was *"included in the sale of the practice"* and that Dr. D *"did not perform due diligence when she purchased the practice* ". He suggested that she complained about him because she wanted him to work more and he had refused.

Dr. Duvall's explanation is not acceptable. Clause 8(j) of the AUSPA clearly requires him to provide the agreement to any dentist he works for. **It** does not entitle him to hope that a dentist purchasing a practice where he is working will stumble across it.

The Panel finds that the allegation in paragraphs 12 and 27(j) of the Citation have been proven.

He explained that paragraph 8(k) required Dr. Duvall not to provide dental services *"unless and until the CDSBC member referred to in (h) has provided their written agreement to the CDSBC to report to the College any breach of the AUSPA and any "significant quality of care, judgment, or interpersonal issues...* ".

Dr. Penner told the Committee that apart from some limited information from two dentists, the CDSBC did not receive any written agreements from dentists in accordance with paragraph 8(k) and therefore assumed that Dr. Duvall was not practicing.

The CDSBC was mistaken in this regard because it later became clear from material filed by Dr. Duvall's lawyer in other proceedings in October 2010 that he had worked in several dental clinics in various communities around BC.

The Panel finds that Dr. Duvall failed to comply with the requirement in Section 8(k) of the AUSPA, given that no letters or other communication was received from any of the many dentists Dr. Duvall worked for while the AUSPA was in place.

Section 8(n) of the AUSPA required Dr. Duvall to submit to a chart review for 10 patients once a year for five years.

The CDSBC takes the position that Dr. Duvall breached section 8(n) of the AUSPA given that only one chart review was performed when it required him to submit to a chart review once per year for five years. Dr. Penner testified that one such review was performed in December 2005. He said that since the CDSBC mistakenly thought he was not working because it did not receive letters from employing dentists, Dr. Duvall was in breach of the requirement to submit to annual chart reviews.

The Panel does not accept the CDSBC's position on this point.

While Dr. Duvall may have made it difficult for the CDSBC to contact him to arrange a chart review, the Panel is of the view that the CDSBC fell short of its obligation to pursue him. They continued to renew his license each year when only one chart review was conducted in 2005. The AUSPA required a chart review to occur each year for five years from 2003 forward.

The AUSPA was between both the CDSBC and Dr. Duvall. The terms do not require Dr. Duvall to initiate the chart review. It was a term that required action on the part of both parties given that the CDSBC was going to select the inspector. The CDSBC's position that he breached the agreement puts the entire obligation regarding chart review on Dr. Duvall when the CDSBC had a role to play and did not do so.

The Panel is of the view that this charge has not been proven.

Finally, the CDSBC alleges that Dr. Duvall breached the requirement in Section 9 of the AUSPA to permit his physicians to submit regular reports to the CDSBC regarding his [redacted] health and related issues.

The evidence revealed that after the AUSPA was signed there was some compliance with this requirement and reports were received from Dr. L. However, Dr. L advised the CDSBC by letter dated January 12, 2010 that Dr. Duvall withdrew his consent to Dr. L to provide these reports in 2009. Later, by letter dated April 12, 2010, Dr. L wrote to the CDSBC and advised that this instruction was reversed. Finally on May 7, 2010 the CDSBC received a

letter from Dr. L to the effect that Dr. Duvall had again instructed him not to comply with S. 9 of the AUSPA.

It is clear to the Panel that apart from some early reporting to the CDSBC by Dr. L, this term of the AUSPA was breached by Dr. Duvall.

The CDSBC submits that Dr. Duvall's breach of various provisions of the AUSPA is professional misconduct.

The Panel agrees. Dr. Duvall's failure to comply with the terms of the AUSPA is professional misconduct. The CDSBC has an obligation to protect the public from dentists practicing below an acceptable standard for any reason. In this case, they attempted to strike a balance that would achieve this objective while at the same time taking into account Dr. Duvall's illness. The CDSBC provided him with an opportunity to earn a livelihood despite his past history. Dr. Duvall violated the trust the CDSBC placed in him and placed his own interest before that of his patients with serious consequences given the evidence of many of them who endured unnecessary pain and discomfort and additional dental treatment because of his incompetent practice. This conduct may be characterized as professional misconduct within the meaning of the *HPA.*

By the Discipline Committee:

_____ _____

Dr. Arnold Steinhart, Chair Date

_____ _____

Leona Ashcroft Date

_____ _____

Dr. John Gerscak Date

Appendix "A"

College of Dental Surgeons of British Columbia

Further Amended Citation

TO: Derek Duvall
c/o Mr. G. Pyper
Gerhard Pyper Law Corporation
Barristers & Solicitors
200-5455 152nd Street
Surrey, BC V3S 5A5

TAKE NOTICE that a Panel of the Discipline Committee (the "Panel") of the College of Dental Surgeons of British Columbia (the "College") will conduct a hearing under s.38 of the *Health Professions Act* RSBC 1996 c.183 (the "Act").

The purpose of the hearing is to inquire into your conduct and competence as a dentist. The College alleges that you:

a. have not complied with a standard, limit or condition imposed under the Act;
b. have committed professional misconduct or unprofessional conduct;
c. have incompetently practised dentistry; and/or
d. suffer from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs your ability to practise dentistry.

The Hearing will be held from Monday, April 16 to Friday, April 27, 2012, at the Quality Inn Northern Grand Hotel, 9830 100th Avenue, Fort St. John, BC, VlJ 1Y5, and from Monday, May 7 to Friday, May 11, 2012 at the Hyatt Regency Hotel, 655 Burrard Street, Vancouver, BC, V6C 2R7. The hearing will commence each day at 9:30 a.m.

You are entitled to attend the hearing and may be represented by legal counsel. If you do not attend the hearing, the Panel is entitled to proceed with the hearing in your absence and, without further notice to you, the Panel may take any actions that it is authorized to take under the Act.

Further particulars of the allegations against you are:

1. In or about 2007, as regards your patient, RC, you provided substandard care in the placement of a crown for tooth 3.7.
2. In or about 2007, as regards your patient, GL,
   a. i. you permanently cemented a bridge to teeth 3.4 to 3.6 which you knew was damaged; and/or
      ii. you misled the patient by advising him that the bridge could be repaired after insertion; and/or
   b. you recommended replacement of the crowns for teeth 1.6 and 2.6, when that was unnecessary.
3. In or about 2006, as regards your patient, JF, your provision of a denture was substandard.
4. In or about 2006, as regards your patient, JH,
   a. your provision of a crown for tooth 2.5 was substandard;
   b. you provided substandard root canal therapy to tooth 2.5; and/or
   c. you improperly placed an implant in the 2.5 position.
5. In or about 2006, as regards your patient, ES, your provision of crowns for teeth 3.5 and/or 3.7 was substandard.
6. In or about February 2007, as regards your patient, ML, your provision of restorations to teeth 3.6 and /or 3.7 was substandard.
7. In or about 2006, as regards your patient, LT, your provision of restorations to teeth 2.7 and/or 4.7 was substandard.
8. In or about 2006, as regards your patient, SS, your provision of veneers to teeth 1.3 through 2.3 was substandard.
9. In or about 2007, as regards your patient, JW, you extracted four permanent first pre-molars without obtaining informed consent.
10. In or about 2006, as regards your patient, RW,
    a. your provision of endodontic treatment to teeth 2.4 and/or 2.6 was substandard; and/or
    b. you failed to advise R W of all reasonable treatment options when the instruments broke within tooth 2.6 during treatment.

11. In or about 2009, as regards your patient, JS, you provided substandard care in the placement of an implant in the 1.6 position.

12. In or about 2009, you failed to provide Dr. D with a copy of a Revised Agreement and Undertaking made between you and the College dated November 5, 2003 ("AUSPA"), contrary to the terms of the AUSPA.

13. In or about 2009, as regards your patient, JO, you

    a. provided unnecessary endodontic treatment to tooth 1.1; and/or

    b. provided the unnecessary treatment to obtain maximum insurance coverage for a crown for tooth 1.1.

14. In or about 2007, as regards your patient, MH, you failed to properly prepare tooth 4.6 for a crown.

15. As regards your patient, GB,

    a. in or about 2006, you provided inappropriate treatment to tooth 3.6 by providing endodontic treatment to a periodontically compromised tooth; and/or

    b. in or about 2007, following the extraction of tooth 3.6, you provided substandard treatment in the placement of an implant in the 3.6 position.

16. In or about 2007, as regards your patient, RK, you refused to provide emergency service when a temporary crown that you had placed earlier that day on tooth 4.7 was lost.

17. You behaved inappropriately toward patients as illustrated by the following:

    a. in or about 2007, you hugged RK; and/or

    b. in or about 2006, you asked patient BC, her mother and/or her grandmother to sit on your lap.

18. In or about 2006, as regards your patient, BC, you

    a. provided substandard care by replacing fillings on teeth 8.4 and 8.5, instead of performing the required restorations on teeth 5.4 and 5.5; and/or

    b. provided inadequate restorations to teeth 5.5, 5.4, 6.5, 6.4, 7.5, 7.4, 8.4 and/or 8.5.

19. In or about 2006, as regards your patient, CO, you provided substandard care in the placement of a crown on tooth 3.6.

20. In or about 2006 and 2007, as regards your patient, DB, your provision of a complete upper denture was substandard.

21. In or about 2007, as regards your patient, EP, you provided substandard care in the provision of a crown to tooth 4.7.

22. In or about 2007, as regards your patient, MP,

a. you recommended crowns for teeth 3.6 and 4.6 even though the treatment plan was inappropriate due to the periodontal condition of the teeth;

b. you failed to inform the patient of her serious periodontal condition;

c. you improperly prepared teeth 3.6 and 4.6 for the crowns; and/or

d. in the preparation of tooth 4.6, you damaged tooth 4.7.

23. In or about 2007, as regards your patient, GO, you extracted 11 teeth without sufficient radiographic information.

24. In or about 2007, as regards your patient JC, you failed to properly place a post in tooth 1.2.

25. In or about 2007, as regards your patient GS,

a. you performed unnecessary and inappropriate treatment by placing a crown on tooth 3.3, when the tooth was only minimally damaged;

b. your preparation on tooth 3.3 was substandard.

26. In or about 2007, as regards your patient RH,

a. you provided endodontic treatment and a crown for tooth 3.6 even though the treatment plan was inappropriate due to the patient's periodontal condition; and/or

b. you improperly prepared tooth 3.6 for the crown.

27. You breached your undertakings to the College as set out in the AUSPA, including one or more of the following:

> "(a) to see Dr. L at least once every two months and comply with Dr. L prescribed drug therapy…;
>
> (b) to obtain prescriptions from Dr. L in a timely manner, and not to allow myself to be in a situation where I am forced to choose between self-prescribing or going without my prescribed medication;

(d) to fully comply with the random valproate level testing regime… and to bear any expense associated with this testing regime (which is not covered by my medical insurance);

(f) to cease the practice of dentistry if I am no longer being treated by Dr. L, unless and until I have obtained the CDSBC's written agreement to an alternative arrangement with another physician;

(j) to provide a copy of this AUSPA to any CDSBC member (as identified in (h) above) in whose practice I may be working;

(k) not to provide dental services to patients unless and until the CDSBC member referred to in (h) above has provided their written agreement to the CDSBC to report the following to the CDSBC:

(i) any breach by me of these undertakings known to them; and

(ii) any significant quality of care, judgement, or interpersonal issues involving me;

(n) to voluntarily submit to a CDSBC chart review at my expense, once per year for five years following the date of my registration and licensure, which chart review will be conducted by an inspector of the CDSBC's choosing...

9. agree that Dr. L and Dr. C may provide reports and information and otherwise communicate with the CDSBC as set out in the agreements of Dr. L and Dr. C below … and I will take all reasonable steps to ensure that Dr. L regular reports to the CDSBC are received by the CDSBC in a timely manner"

The Discipline Committee is constituted under the Act and the College's Bylaws thereunder. Copies of the Act, the *Dentists Regulation*, BC Reg 415/2008, and the College's Bylaws are attached to this Citation, and you are particularly referred to s. 37-39 of the Act and part 10 and schedules G and H of the Bylaws.

FURTHER TAKE NOTICE that after completion of the hearing under s. 38 of the Act the Panel of the Discipline Committee may, under s. 39 of the Act, dismiss the matter or

determine that you;

a. have incompetently practiced dentistry;
b. have committed professional misconduct or unprofessional conduct;
c. have not complied with a standard, limit, or condition imposed under the Act;
d. have not complied with the Act, a regulation, or a bylaw; and/or
e. suffer from a physical or mental. ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs your ability to practise dentistry.

This Citation is issued at the direction of the Inquiry Committee of the College under section 37 of the Act.

This Amended Citation is issued at the direction of a panel of the Discipline Committee of the College under Bylaw 10.03(2)(c) made February 29, 2012

This Further Amended Citation is issued at the direction of a panel of the Discipline Committee of the College under Bylaw 10.03(2)(c) made August 10, 2012.

COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA

_____

Jerome Marburg, Registrar

_____

Date

from Dr. L to the effect that Dr. Duvall had again instructed him not to comply with S. 9 of the AUSPA.

It is clear to the Panel that apart from some early reporting to the CDSBC by Dr. L, this term of the AUSPA was breached by Dr. Duvall.

The CDSBC submits that Dr. Duvall's breach of various provisions of the AUSPA is professional misconduct.

The Panel agrees. Dr. Duvall's failure to comply with the terms of the AUSPA is professional misconduct. The CDSBC has an obligation to protect the public from dentists practicing below an acceptable standard for any reason. In this case, they attempted to strike a balance that would achieve this objective while at the same time taking into account Dr. Duvall's illness. The CDSBC provided him with an opportunity to earn a livelihood despite his past history. Dr. Duvall violated the trust the CDSBC placed in him and placed his own interest before that of his patients with serious consequences given the evidence of many of them who endured unnecessary pain and discomfort and additional dental treatment because of his incompetent practice. This conduct may be characterized as professional misconduct within the meaning of *the HPA.*

By the Discipline Committee:

Dr. Arnold Steinhart, Chair	Date
Leona Ashcroft	Date
Dr. John Gerscak	August 20, 2012 Date

from Dr. L to the effect that Dr. Duvall had again instructed him not to comply with S. 9 of the AUSPA.

It is clear to the Panel that apart from some early reporting the CDSBC by Dr. L, this term of the AUSPA was breached by Dr. Duvall.

The CDSBC submits that Dr. Duvall's breach of various provisions of the AUSPA is professional misconduct.

The Panel agrees. Dr. Duvall's failure to comply with the terms of the AUSPA is professional misconduct. The CDSBC has an obligation to protect the public from dentists practicing below an acceptable standard for any reason. In this case, they attempted to strike a balance that would achieve this objective while at the same time taking into account Dr. Duvall's illness. The CDSBC provided him with an opportunity to earn a llivelihood despite his past history. Dr. Duvall violated the trust the CDSBC placed in him and placed his own interest before that of his patients with serious consequences given the evidence of many of them who endured unnecessary pain and discomfort and additional dental treatment because of his incompetent practice. This conduct may be characterized as professional misconduct within the meaning of the *HPA.*

By the Discipline Committee:

Arnold Steinbart

Dr. Arnold Steinbart, Chair

/8 20/2-
Date

Leona Ashcroft

Date

Dr. John Gerscak

Date

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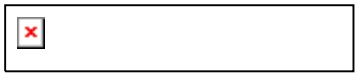
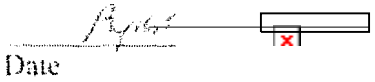
By the Discipline Committee:

Dr. Arnold Steinbart, Chair Date





Dr. John Gerscak Date