NEWFOUNDLAND & LABRADOR DENTAL BOARD
2021 ANNUAL REPORT

Board Meetings

In 2021 the Board held meeting on November 2021.

Dental Board Membership:

Dr. Jerome Johnson	Chair
Dr. Linda Blakey	Vice Chair
Dr. Marina Sexton	Dentist
Dr. Sneha Abhyankar	Dentist
Dr. Paul Hurley	Dentist
Mrs. Paula Parsons	Registered Dental Assistant
Mr. Craig Finch	Registered Dental Technician
Mrs. Joan Lamswood	Public Representative
Mr. Martin Harty	Public Representative

Registration and Licensing as of January of 2020 and 2021

	2020	**2021**
General Dentists	206	205
Specialists	31	31
Dental Assistants	278	301
Dental Technicians	26	26

Financial Report

2021 saw a reduction of fees for all persons who relicensed from 2020. 2022 saw a return to the previous year's fee structure with no increase. As the Radiation surveys carried over from 2020 to 2021 revenues and expenses are reflective of entries regarding surveys will continue into 2022 until the NLDA takes over management of the surveys. The auditor must provide guidance on this transfer but for now the Board will maintain ownership of equipment until that guidance is given.

Mandatory Continuing Education

All registrants with the Board were subject to audit in 2021 for the first time ever. No one could have predicted that Covid 19 would have caused so much difficulty for registrants and auditors for the

difficulties encountered during the audit. The audit committee deserves great praise for successfully concluding the audit without having to refer anyone forward to the Board.

At the last meeting of the Board Dr. Simms presented his report and has agreed to continue with that CE Committee going forward. The Board owes Dr. Simms its gratitude both for his years on the Board and his role as Chair of the Board, the Continuing Education, and the Complaints Authorization Committees. Dr. Simms and CE Committee must now formalize any changes to existing program for next cycle and what the audit procedure will be.

Canadian Dental Regulatory Authority Federation

After the turmoil of 2020 CDRAF seemed to be headed in a better direction in 2021 with hope going forward into 2022 for a positive year. All financial issues regrading funding seem resolved for the near future with no evidence of withholding of fees for supporting third party providers.

The core issue coming from as far back as 2017, the National Specialty Examination, hopefully is working its way forward with NDEB/RCDC now making a strong commitment to collaboration on making the Assessment a joint effort.

On October 15, 2021, the Executive Director reported on the Working Group on National Competency Standards. He is anticipating that the final document would be considered at the CDRAF Board meeting in August 2022. Each DRA has until July 2022 to review the document.

The NDEB has been diligently working on a new Assessment center in Ottawa for the holding of the Equivalency Process. The new Test Center is almost complete following delays with the pandemic and recent protests in Ottawa. The (ACS) Assessment of Clinical Skills which many may be familiar with will now become the National Dental Examination on Clinical Competence (NDECC).

The Commission on Dental Accreditation of Canada (CDAC) has been cooperating with the (GRSC) Governance Review Steering Committee and CDRAF with transition to an independent body by next year.

The Process for Recognition of a New Dental Specialty Step 2 requires the final application for recognition by a party. In November the Canadian Academy of Dental Anesthesia (CADA) was received and posted on the CDRAF website. It was circulated to involved stakeholders, including dental specialty associations and provincial and territorial governments. Submissions were to be submitted by March 1, 2022. The CDRAF will review final submissions and CADA's response for consideration to determine whether the proposed specialty meets the "Criteria for the Recognition of a New Specialty" at its fall 2022 meeting.

CDRAF was presented with a copy of an email message from CDA requesting updates on national legislation affecting dentistry within its jurisdictions that can be shared with FDI for a survey it is conducting. Only responses were for vaccine mandates and that was recorded for B.C., P.E.I. and Federal Government employees.

Report of the (CAC) Complaints Authorization Committee

A. Discipline Hearing of November 2021.

On January 15, 2021, an allegation was filed with the CAC regarding conduct of the Respondent Dr. Louis Bourget. On May 17, 2021, following proper investigation a Statement of Charges was referred to the Disciplinary Panel of the Newfoundland and Labrador Dental Board which eventually led to the hearing of November 20, 2021.

(NOTICE OF THE DISCIPLINE ORDER AND DECSION CAN BE FOUND ON THE WEBSITE OF THE NLDB.)

B. A complaint was received from the father of a patient about hidden fees charged, waiting 30 minutes without being told why; and charged $468 for removal of two teeth and being charged extra for sutures and charged for emergency exam when they waited two weeks. The father said he discussed the matter with the office, and they changed the exam fee to regular fee and gave a $14.00 credit. The Registrar explained that fees for extraction could vary greatly and without seeing the dental records it was impossible to determine a fair fee for services which otherwise could well be within a normal range of fees for two extractions. Range was ($200-$639) by the NLDA Fee Guide. Father was advised that to properly investigate any issues, the Board would need the name of the patient to access dental records. Despite this request for his son's name the father did not provide or respond to a similar follow up request. No further action was taken, and no allegation was filed.

C. An investigation was made of an allegation filed regarding issues of competency in treatment, patient abandonment, redress or apology from the Respondent and payment for work around future dental work required. The patient was in care for an orthodontic problem related to an impacted canine. The Complainant became frustrated from the lack of success over a lengthy period of time and in the opinion of the (CAC) the Respondent should have done more to expedite follow-up care when the canine was removed finally, despite the fact they had parted ways with the Complainant. The CAC gave a Caution to the Respondent and advised an apology was in order. Further, the Committee was of the opinion, given the length of time the canine guidance took without successful eruption, it required reflection by the Respondent and far greater attention to this and the alternative of extraction and implant placement in future. The (CAC) gave a second Caution for the Respondent to consider in future that the time element must be a more significant factor in treating cases concerning canine guidance.

D. A parent requested assistance stating that she had been advised by her daughter's orthodontist that when treatment was initially started in 2018 that the quote was for her entire treatment. 3 years later she has re-located and claims she was told further treatment may be required and wanted money back from old dentist. She reached out to the previous provider but apparently has had no success in getting remuneration for what she claims is unfinished work. The parent was advised by her lawyer to reach out to the Board to see if the Board can be of assistance before proceeding to legal action. The parent was advised it was not the function of the Board to seek recovery of funds but to investigate complaints regarding billing, fraud, or unnecessary treatment etc. and a complaint must be properly filed that could

require disciplinary action but not recovery of funds unless findings of professional misconduct led to a referral to a hearing. Advice was requested but no complaint was received, and no further action was taken.

E. A patient complaint was filed as an allegation against a dentist for negligence when a broken tooth ultimately created facial swelling and required emergency surgery to resolve. The patient had visited the dentist during the early stages of the pandemic regarding the broken tooth but was deferred treatment or referred to other clinics open at the time. It was the opinion of the Committee that the tooth should have been dealt with in a timelier fashion because of the potential danger it presents. The CAC gave the dentist a Caution to take more definitive steps in managing potential infections to avoid unnecessary consequences.

F. A patient complaint was filed as an allegation with regards to two examinations from separate dentists. Dental records were reviewed, and it was determined by the CAC that while there were differences of opinion that they were not significant in diagnosis. The request of the Complainant was for the CAC to determine which dentist had the correct diagnosis and therefore the other dentist should refund money. The Complainant was advised if they had read the Complaint Form, they would be aware that the Board does not have authority to provide financial compensation directives for complainants. The allegation was dismissed.

G. A patient complained that both she and her daughter were provided with misdiagnoses relating to the extent of dental caries present in their mouths and the resulting potential for unnecessary dental services. Copies of all available dental records were examined by the CAC and opinions were given by two other dentists and information provided by the Complainant questioning the diagnosis given by the Respondent. The CAC supported the decision to have an Oral Radiologist provide insight and commentary on the radiographs provided by the Respondent. During the investigation the Registrar interviewed the Complainant and found her articulate and cooperative whereas the Respondent when interviewed by the CAC was found to be defensive, at times to literature that did not particularly support his diagnosis. And, the Respondent when questioned was generally evasive and soon thereafter the interview was terminated with little accomplished. At least half of the treatment planned had already been completed before a complaint was filed. The Committee could therefore only use radiographic interpretation to assess that work. The rest of the treatment plan could be analysed, and two dentists appointed by the Committee did just that. The Committee, given all information and with the radiographic analysis, determined that many amalgam fillings probably should not have been deemed ready for replacement as well as fewer of the new fillings were probably required. The Committee considered the statement of the Respondent that a caries assessment had been done and a less invasive process should have been considered if not undertaken. And also, the Respondent's opinion that the last person to see the patient is ultimately responsible for all that may transpire subsequently in diagnosis is not always the mantra of the regulator. Preservation of tooth structure is important, and less invasion plays a major role in good dentistry. It was the opinion of the CAC that the Respondent did over treat both individuals in this case and that to avoid possible future regulatory intervention by over treating is unacceptable. The CAC therefore believed the Respondent deserved to be issued a Caution for over treating the two patients.

The Committee was also of the opinion that the Complainant was not given an accurate assessment to make an informed choice on treatment of a less invasive nature and this resulted in a loss of trust and confidence in this dentist and the profession in general. Veracity is one of the primary ethical principles the profession must operate under. Understandably there will be different opinions, but the Committee feels this was lost on the Respondent.

Finally, the CAC issued a Caution for the generally unnecessary replacement of amalgam fillings. That opinion was supported by all the other practitioners (6) who in some way, were able to make at least a partial diagnosis of the two patients. The attempt to justify the replacement of any amalgam filling should follow what the Canadian Dental Association has to say about their replacement which in essence is that only when absolutely necessary, and in this case "leaky" as assessed by the Respondent without proper context may still have an extremely long lifespan. The Committee believed that to be the case here.

H. There is no way to measure its effect by specific cases, but some may be more significant than others. In this case a patient made a complaint about a dentist injecting Demerol into her system, and she believed it had great consequences for her over a lengthy period. Her claim that it caused severe long-standing effects in her well-being, and she only became aware when informed by police that she had been given the Demerol by a dentist. To provide further details there was a request of dental records from the dentist named and the Registrar found no evidence nor the need for the use of Demerol for this patient. The patient was advised that perhaps she had some reaction to the local anesthetic or other additive it contained, but not Demerol. The discussion with the patient ended with agreement that at this late date further investigation would not likely resolve the matter but that future use of anesthetics may be the point of concern.

I. On September 16, 2021, an email to the Board office was directed to all Board members and included copies of receipts and notes from a dental office. The email was from a person other than the person appearing in the notes or receipts. The sender of the email was advised of Dental Act requires that the patient or appointed agent provide the Complaint and to visit the Board website on making a Complaint. The matter appeared to be a dispute over fees covered by a dental plan. Despite the warning and proper protocol this originating person expected a review and investigation of someone else's matter. The Board received no formal complaint from the patient or their appointed agent. No further action taken.

J. An individual provided a lengthy email regarding dental treatment she had in two locations. The statement provided indicated they wished to speak with an analyst or dentist to assess her care and provide direction as to how she should proceed with her future care. She said that by making a formal complaint the Board should provide a dentist to direct that care. The Registrar directed the person to the website of the Board to explain the Complaint Form of the Board and the Complaint process. Following this advice, the person then replied requesting information about dental codes and the legality of how they occur, but no completed Complaint form. No further action taken.

K. A patient started the complaint process by emailing the Board that he had been dismissed from an office on suspicion of taking drugs. The medical record indicated that the dentist requested a drug

screen, but it also indicated that when he went to the hospital, he became irate and left. The report also stated that he had to have the screening completed before dental work could take place. The patient was told to complete the Complaint Form, but he said he did not have a computer. The Board sent out the information required. He never responded to the request to file a complaint. No further action taken.

L. A complaint received by the Board and an allegation filed regarding unexpected work done on a young man without parental consent. In considering the allegation the CAC considered the patient record, age of the patient, regular history of care, the consent usually given, familiarity with patient and parents, the statements of the Respondent, and the phone interview with the Registrar.

The patient showed reasonably regular visits to the clinic involved but with another dentist. Given that the patient and the parents expected one filling and not 5 or 6 the Committee felt that more effort should have been given to advise the parents of the treatment plan despite the opinion that the young man was of age (just barely) before consent was reasonably given. The Committee noted that given the supposed extent of dental caries present that no accompanying set of bitewing radiographs were taken. The Committee was surprised to hear the response that the Respondent did not need radiographs to diagnose occlusal caries and that the complete examination would be done later. Apparently, time was of the essence when the appointment was only booked for one filling.

In the phone interview the Respondent did express the desire for better case management rather than being the caretaker of patients and was planning better case management in future.

As hopeful as the Committee is to his better ways, they were of the opinion that there were reasonable grounds to believe the Respondent engaged in conduct deserving sanction by failing to provide informed consent on costs to the reasonable party (parents)and failing to adequately diagnose radiographically for possible extension of dental caries. It issued a Caution under the Dental Act and By-Law no. 5 Article 6.

“Failing to properly inform the patient or the guardian of the full extent of treatment advised and an accurate estimate of the total costs involved.

M. The Office of Registrar received an email regarding advertising on the website of a dental office in the Mount Pearl / St. John’s area. Following a review by the Registrar the office was contacted and amendments made. No further action required.

N. A patient undergoing cancer treatment was referred for dental care at a general dentist’s office by a medical practitioner. The dentist subsequently referred the patient to the specialist who had previously treated the patient before with concern of their medical condition. The patient was approved for treatment, but the specialist unfortunately became unavailable. The specialist was able to transfer care to a general dentist. The patient became irate by the delay and the fact that a general dentist could provide treatment. The patient accused some involved of attempted murder and in three separate complaints requested the Board file attempted murder charges against three dentists with the RCMP. The Complainant also accused one of the receptionists involved in his management of various

inaccurate statements and claimed to have a recording of those statements. When requested by the Registrar to hear the recording he refused and said he will await his lawyer's advice on the use of the recording. An investigation of the allegations indicated that the Complainant had been offered treatment with another specialist but refused to travel to another location despite the fact he had to travel for the first specialist. In its conclusion the CAC found that although there was a delay of two months during year end and also with the Pandemic there was no malice or negligence on anyone's part and dismissed the three complaints. A concluding statement from the Complaint stated his consideration of hiring a lawyer to sue the Board despite having previously told the Registrar of legal advice about the disposition of a telephone recording. With regards to the charges of attempted murder the Complainant was advised to seek legal advice or otherwise approach the RCMP themselves.

O. A complaint related to the Special Measures Order under Covid19 was received from government when a dental practitioner failed to self-isolate following travel. However, on investigation by the Registrar it was determined that despite the error the dentist believed he had complied under a previous order which had since changed. The Registrar made contact with DOHCS officials to see if a resolution could be found. During the process, the dentist was cooperative and agreed to follow all rules going forward. The government response was in the spirit of resolution and the Registrar made the decision to take no further action.

P. An allegation was filed following a complaint that a child with a faulty space maintainer was experiencing pain and trauma but was refused to be seen at their regular clinic because supposedly the dentist present did not do space maintainers. The patient then went to another clinic and quickly had the issue resolved. On hearing the Complainant went elsewhere, an appointment was then offered at the original clinic. The Committee decided that as the child had not at least been given an examination at the original clinic to determine if any treatment could be done, the decision initially was not responsibly taken. The CAC Cautioned the dentist to review the ethical definitions for emergency care outlined in the Code of Ethics. The Committee noted that the dentist has over a long career never had a previous complaint and realized the mistake after the fact that the child should have at least been examined.

Q. The Registrar received a letter of complaint from a person who believed they had been overcharged for root canal therapy. The Complainant asked for any guidelines for fees and maximum allowable fees. The Complainant provided copies of some of his dental record which included a Standard Dental Claim Form for the recent dental work performed. On reviewing the form, it was discovered that an error was made in the claim submission as the tooth, a lateral incisor and was billed as a multi-rooted tooth and at a greater fee. The Complainant was advised of this fact, and it was recommended that they return to the dental office in question to address the issue before any further action. On two occasions the Complainant had thanked the Registrar for the assistance in the matter. The Registrar deemed the matter resolved since following his advice nothing further was heard from the Complainant.

R. A letter of complaint was received by the Board from a woman who stated she received a note from the dentist in the parking lot of a dental office. On the note she found his name and phone number. The dentist later sent her a text message that he had given her the incorrect number and provided his right

number. All this information related to the matter was provided by the Complainant. The Complainant had visited the dental office the day in question with her three children and the dentist alleged by giving her the note that he only wished to be open to discussing some orthodontic issue one of the Complainant's children may have. Unfortunately, the Complainant and her husband did not take this approach favourably and nor did the CAC. The CAC found that the Respondent engaged in conduct deserving of sanction and COUNSELLED that the Respondent had over-stepped an ethical boundary in his actions and that in future he must use the business office or the operatory to deliver messages or consultations to patients. Also, as a new practitioner that he seek greater mentorship from the Primary Dentist with whom he was employed.

S. Based on opinions expressed in an allegation of professional misconduct against two Respondents and their Professional Dental Corporation the Office of the Registrar engaged in an investigation to determine if their conduct involved negligence and fell below the standard of care required under the circumstances. The foundation of the allegation involved an assumption by the Complainant that the Respondents and/or their PDC were in some way responsible for encouraging or facilitating the professional misconduct of a third party. A thorough investigation of all matters related to the allegation uncovered no evidence to support any of the details of the allegation. When the Complainant was provided the results of the investigation, they were silent on all issues indicating all matters under properly investigated. The CAC having carefully considered all information provided were of the opinion there were no reasonable grounds to believe the Respondents had engaged in conduct deserving of sanction and dismissed the allegation.

T. In March of 2021 the Registrar received a Complaint against three individuals only two of whom are licensed by the Newfoundland and Labrador Dental Board. The Complainant was advised that as only two Respondents exist for the possibility of discipline by this Board, he should first remove the third as a Respondent and to make separate complaints against the other two individuals. This present report is in reference to one individual. The allegation against this Respondent was that inappropriate fees, increasing fees without notice, poor financial management and the support of a condescending attitude of the receptionist. Dental records were received from the Respondent and with an extensive document entitled "patient history". Accompanying the records was an 11-page response to the allegation. The investigation concluded and the CAC determined that the allegation covered 11 issues put forward by the Complainant some of which were either old or now unproven or not specific to the overall allegation of professional misconduct. The Committee acknowledged that the Complainant did provide factual information that fees had risen but there was no proof that any dentist was constrained by a specific fee guide or schedule or must maintain their fees as per third party wishes be they employers or insurers. Subsequently all issues related to fees were dismissed without a valid finding. The CAC did however find a problem with the transition of the patient leaving the practice and entering another practice. The Complainant gave instructions on leaving that his dental record be "transferred" to a new office immediately as he had an appointment there in a couple of days. The old office apparently tried to do that electronically but failed to accomplish the transfer even though technically by legislation they had no cause to do but also had 30 days provide a copy of the Complainant's record. However, against the specific direction of the Complainant before he was dismissed, the old office contacted the new office

about the failure of transfer and some costs related to new radiographs incurred by the Complainant. What should have happened is the old office should have just provided the Complainant with a copy of their record. The Complainant claims he was bad-mouthed in phone conversations supposedly related to transfer of records and costs. Transfer of records is appropriately done when there is an agreeable new custodian such as taking over a practice etc. Not when there is a dispute. A copy of a record in 30 days is all that is required. The patient can then see the record and if they find disparaging remarks to have them removed. What was done here was in the words of the Complainant was unethical and in the opinion of the CAC inappropriate and against one wish of the Complainant to not communicate with the other office but then to “transfer his records” without direction on how to proceed leaves the method open of transfer open to interpretation.

It was the decision of the CAC to dismiss 8 articles of the allegation not dealing with “transfer” but in those three articles of the allegation the Committee believes the Respondent engaged in conduct deserving of sanction and gave a Caution on each article. They are failing to properly transfer dental records; allowing the receptionist to speak to the new office without patient permission and personally speaking to the new dentist without consent.

U. The second allegation arising from the previous section (T) was against the new dentist for eventually also dismissing him from his practice as did the Respondent in section (T). Once having transferred to the new dentist the Complainant questioned in this allegation what impetus was received from phone calls from the previous office that led in his present dismissal. The Complainant alleged it was only because of those conversations the dismissal occurred but evidence existed that along with what could have been said the complainant did bring to the new office issues that should have been managed by him. For example, a better transfer of his record in a reasonable time frame. The new dentist in response to the allegation indicated they did not appreciate the tone of the Complainant but with an allegation about the cost of radiographs willingly agreed to address the requested outcome of the Complainant and provide an apology to uphold the dismissal. The Complainant however did not like the apology because it did not include another family member who as it happens was not a client of the Respondent but rather that of another dentist in the same office. The Complainant asserted that the Respondent had a duty to consult with the other dentist and by not doing so had constructively dismissed the family member from that practice as well. The CAC failed to see cause for a finding of this allegation and dismissed it. The Complainant responded to this outcome by alleging that all members of the CAC were corrupt. It is noted that the Complainant had been made well aware that any dismissal is subject an appeal, but no such appeal has occurred.