IN THE MATTER OF THE DENTAL DISCIPLINES ACT, 1997 and AMENDED FORMAL COMPLAINT dated January 17, 2018 and AMENDED September 21, 2018 regarding Dr. Hoda Hosseini formerly of Saskatoon, Saskatchewan, RAISING PROFESSIONAL ISSUES

BETWEEN:

The College of Dental Surgeons of Saskatchewan

-and-

Dr. Hoda Hosseini

DECISION OF HEARING PANEL OF THE DISCIPLINE COMMITTEEE ON THE SUBSTANTIVE ISSUES

THE DISCIPLINE COMMITTEE HEARING PANEL:

Mr. Bruce Gibson, Chair of the Hearing

Dr. Hilary Stevens, Discipline Committee Chair

Dr. Raj Bhargava, Member of the College

Dr. Alan Heinrichs, Member of the College

Ms. Nancy Croll, Appointee of the College Council

APPEARANCES: For the Professional Conduct Committee: Mr. Sean Sinclair and Mr. Dustin Gillanders

On Behalf of Dr. Hoda Hosseini: Mr. Scott Hopley and Ms. Kara Moen

DATES OF Hearing: October 3-5, 2018

DATE OF DECISION: November 26, 2018

A. INTRODUCTION/FORMAL COMPLAINT

1. This case involves the conduct of Dr. Hoda Hosseini (Dr. H). Specifically, the charges in the AMENDED Formal Complaint (Ex P1) address matters of alleged professional incompetence and breaching the bylaws of the College.

2. The Professional Conduct Committee recommended the Discipline Committee hear the Formal Complaint to determine whether Dr. H is guilty of professional incompetence involving the provision of dental treatment to [redacted] between approximately July 7, 2014 and January 9, 2015. It is alleged Dr. H displayed a lack of knowledge, skill or judgment, and/or disregarded the welfare of [redacted]. The Formal Complaint stipulates on or about July 7, 2014 Dr. H, being a qualified specialist in periodontics, placed a dental implant in the # 36 area. The same was removed on January 9, 2015 and a new implant was inserted. The body of the implant transected the inferior alveolar nerve canal and resulted in trigeminal nerve, third branch injury to [redacted]. The Formal Complaint alleged the intrusion of the implant into the inferior alveolar nerve canal was avoidable with proper planning; and a competent specialist dentist would have recognized the intrusion when the implant was placed, and the implant ought to have been removed at that time. These allegations are alleged to be contrary to s. 26 of *The Dental Disciplines Act ,1997* and paragraph 9.2(2)(x) of the College Bylaws.

3. The hearing of this Complaint before the Hearing Panel of the Discipline Committee was conducted October 3-5, 2018 in Saskatoon Saskatchewan. Dr. H was present throughout and represented by legal counsel. A plea of not guilty was entered on Dr. H's behalf for the record.

4. *Viva Voce* evidence was heard from the complainant, [redacted] and the respondent Dr. H. Three experts were qualified and provided opinion evidence via video-conference call. Dr. Robert G. Wagner (Dr. W) testified on behalf of the Professional Conduct Committee (PCC). Dr. Elizabeth Anne Toporowski (Dr. T) and Dr. Keyvan Abbaszadeh (Dr. A) testified on behalf of the respondent.

5. A Court Reporter was present at the Hearing to record the evidence. Counsel for the PCC and the respondent agreed to file a Joint Book of Exhibits (Ex J1 containing 74 pages). Additional exhibits for each party were also filed. Both parties filed Written Submissions on October 19, 2018. The parties agreed to bifurcate the Hearing and address the issue of penalty, if required, at a later date.

B. EVIDENCE-SEQUENCE OF EVENTS/BACKGROUND

[redacted]

6. The following is an overview of the evidence concerning . indicated was referred to City View Periodontal Centre (City View) in Regina, Saskatchewan by dentist, . Dr. H was employed at City View and first met her on January 15, 2014. was assessed by Dr. H and the possibility of a dental implant was discussed with . agreed a risk benefit discussion took place between and Dr. H. On January 15, 2014 executed a consent for periodontal surgery (page 20 of exhibit J1). acknowledged consented to extraction of tooth number 37, bone grafting and implant placement at site 36. In the consent, further acknowledged understood complications could result from the proposed periodontal surgery and related procedures. The consent form stipulated, in part, on occasion the periodontal surgery and related procedures could result in permanent tingling/numbness of the jaw, lip, tongue, teeth, chin or gum. testified had no intention at the outset of getting a partial plate. wanted the first, and eventually the second implant, because thought nothing could go wrong. did not recall any discussion about bone loss prior to the placement of the second implant. agrees would have asked Dr. H to extract and replace the implant on the same day and she indicated she could do that. also testified there was a discussion with Dr. H where indicated preferred to have the work done in one day in order to limit travel to Regina.

7. returned to City View on July 8, 2014, at which time Dr. H surgically extracted tooth number 37 and placed an implant at tooth site number 36 (the "first implant"). returned to City View for follow-up care on July 14 and July 23, 2014. No significant issues were reported in the clinical notes (p. 30 of Ex. J1). On December 19, 2014 implant number 36 was uncovered and a healing abutment was placed (p. 31 of Ex J1). On January 7, 2015 significant cortical bone loss around the first implant was discovered. Consequently, Dr. H advised the first implant should be removed (p. 31 of Ex J1). agreed to have the first implant removed and testified followed Dr. H's advice and relied upon her knowledge. did not recall a possible discussion with Dr. H about potential bone grafting prior to placing the second implant. was aware Dr. H planned to immediately put in a replacement implant. This was preference to reduce his amount of travel. The removal of the first implant and replacement with a second implant occurred on January 9, 2015 (p. 31 of Ex J1). testified following the implant replacement, was aware x-rays were taken. recalled Dr. H reviewed the x-rays and informed there was enough room between the implant and the nerve and there would be no problem. The second implant stayed in. testified was not offered the option by Dr. H of removing the second implant. stated if Dr. H had suggested the implant should be removed, would have followed her advice.

8. agreed, despite there being no clinical notes to indicate a call was made to on the evening of January 9, 2015, such a call did occur, and reported some improvement. A follow-up appointment occurred on January 15, 2015. Dr. H was not in attendance. Additional follow-up calls were made by City View staff to on January 21 and 28, 2015. Further, attended at City View on April 21, 24, and May 4, 2015. also attended at City View following Dr. H's departure from City View on August 20, 2015. These follow-up attendances and calls are found in the clinical notes from City View commencing at page 31

of Exhibit J1. The notes taken relating to any experience of numbness and pain noted by ███ █ indicate:

a) January 15, 2015- "pt having II lip numbness but improving…dr b checked numbness with explorer told pt will get better over time.

b) January 21, 2015- "the numbness is a 5."

c) January 28, 2015- "numbness is 3… getting better every day…pt to call us if stops improving ap."

d) April 21, 2015- "Numbness totally gone- pt has full feeling on lower lip. however slight alteration anterior with pins and needel (*sic*) feeling. HOWEVER reports it is getting better every day."

e) April 24, 2015- no reference to numbness.

f) May 4, 2015-no reference to numbness.

g) August 20, 2015- "patient still reports feeling numbness in mand ant area, says it is feeling better than it originally had Started in January."

9. When the clinical notes were reviewed with ████ ██ testified having no specific knowledge of the referenced conversations. ██ indicated ██ was certain ██ condition had not improved during this time. ██ stated the problems started right away following the second implant and never left. There was a tingling and freezing sensation of the gum that never went away. ██ stated any improvement in ██ condition stopped in June 2015. In ██ testimony, ██ more readily adopted the comments of April 19 found at page 33 of Exhibit J1:

a) April 19, 2016- "since the day it was placed it has been bothersome. Pt thought it would get better over time. but it didn't.…pt stated. I can't even chew on that implant or the left side of my mouth…pt says it even hurts to ████… ██ said alsow(*sic*). I (*sic*) cannot enjoy kissing ██ grandchildren."

10. On May 26, 2015 ██ family dentist, ███████ placed the crown on the second implant. ████ testified ██ advised ███████ about the numbness ██ was experiencing. ██ ██████ clinical notes on July 28, 2015 stipulate "quad 3 still feels numb to patient" (Ex D1).

11. ████ further elaborated on ██ status during a very emotional testimony. ██ described ██ symptoms like "somebody punched ██ in the face." ██ stated it feels like the "lip is frozen all the time. The bottom areas of the gums are very sensitive, and salt makes it burn like it's on fire. It's that way constantly. If I touch the area I get a pins and needles feeling." ████

wanted the Committee to know just what a terrible experience ■ had been through and ■ didn't want any others to go through the same experience. ■ indicated this had a major impact on ■ life and ■ had incurred expenses related to the implants.

12. As referenced, ■ still attended at City View following Dr. H's departure. ■ attended without a referral and requested an appointment to discuss the removal of the second implant. ■ testified ■ advised City View it was bad and not getting better. ■ recalled seeing "two or three different doctors" but could not recall if ■ was one of them. ■ testified the City View dentists told ■ there was plenty of room between the second implant and the nerve. When ■ asked them about removing the second implant, the dentists advised they did not have the necessary equipment and removal might make ■ condition worse. ■ was advised to contact Dr. H and address the problem with her. ■ testified ■ never made any attempt to do so.

13. ■ referred ■ to ■ and on May 4, 2016 a Cone Beam Computed Tomography (CBCT) 3-D image was taken. ■ testified this showed the implant was at the nerve. ■ advised ■ ■ could end up with more damage if the implant was removed. On September 1, 2017 ■ went to see Dr. Wagner who removed ■ implant a few months later.

Dr. Hoda Hosseini

14. This is an overview of Dr. H's evidence. Dr. H graduated from the University of Manitoba (U of M) Dental School in 2006 in the top 5% of her class. Henceforth, graduating from the periodontics specialty program at the U of M in 2012. Between her graduate and undergraduate program, she practised in Ontario for several years eventually working in London, Ontario with ■ and began to learn about dental implants from him. She was approached to start lecturing on dental implants. She helped dentists taking the Hands-on Training Course at ■ clinic with the placing of implants in their patients. She is currently an Assistant Professor in the graduate periodontal program at the U of M. She is involved in treatment planning seminars and clinical supervision. In her sessions, she helps residents place surgical implants. She testified this work helps her keep up to date on the latest research. She takes continuing education and filed as exhibit D6 in these proceedings is a copy of the Manitoba Dental Association program printout. It shows she has taken numerous courses and has also taught courses on dental implants and other related areas.

15. Since her undergraduate dental training, she estimates she has placed 400 to 500 dental implants. In her residency, she estimated she completed 30 to 40 implants and that presently she places approximately 50 to 60 dental implants annually. She also estimates that for each of the past two years she has supervised approximately 40 implant placements.

16. Dr. H was licensed in Saskatchewan from 2012 to 2016. She has been practising in Winnipeg since 2017.

17. In reviewing her clinical notes, commencing at page 30 of exhibit J, ■ was referred by ■ ■. Dr. H examined ■ and noted an extensive medical history. ■ had previously undergone heart surgery and there was a concern about blood pressure. She obtained a medical consult prior to dental surgery. She testified she initially discussed alternative options with ■ but ■ insisted ■ wanted an implant versus a partial denture. Further, she discussed the pros and cons of an implant with ■. She was advised by the specialist physician she could proceed with dental surgery for ■ after March 31, 2014. On July 7, 2014 ■ came back to have the dental procedure. She testified she extracted tooth number 37, cleaned the socket, placed bone material in the socket and started preparing site 36 for a dental implant that was 5 mm in width and 10 mm in height. X-rays taken were to assess site number 36 (p. 71 of Ex J1). She testified in the middle picture there was an 8 mm indicator pin which assisted her in obtaining a reading of the location of the implant in the bone. She stated she was aware this measurement was magnified, and she divides the actual size of the indicator pin with the measured size on the x-ray. She knew that point A to point B is 8 mm. She measured the x-ray and the computer software did the calculation. She indicated she performed the calculations on the computer for ■. She placed a "groovy implant" at bone level and bone grafted over the surgical site.

18. In reviewing her clinical notes of December 19, 2014 (p. 51 of Ex J1), Dr. H testified she made an incision to uncover the number 36 site. She torqued the first implant to make sure it didn't move and assessed the quality of the soft tissue. An x-ray was taken, and she noted the crestal bone area now appeared darker and not as intact. This caused her concern because if any part of the crestal bone is lost there would be lack of long-term stability. Upon ■'s attendance at the clinic on January 7, 2015 she advised ■ they needed to replace the implant to maintain long-term stability. Dr. H testified she discussed options with ■ including implant removal, a bone graft and then waiting for 4 to 6 months before proceeding with another implant. She was adamant she advised ■ this was the safest approach. She also advised ■ she felt she could replace the old implant with a longer implant and be able to avoid the nerve. ■ made it clear to her ■ wanted to proceed with a longer implant and have the work done on the same day. An x-ray was taken on January 7, 2015 (p. 68 Ex J1). She testified she measured and calculated the available bone height and it was her opinion she could safely increase the implant length. On January 9, 2015 she performed her regular pre-operative assessment. She removed the implant and obtained her measurement based on the periapicals (p. 63 Ex. J1). She replaced the first implant with a 13 mm implant. 1.5 mm was a polished collar and would stay above the bone. In her testimony, she indicated because the radiograph is taken on an angle, the images are shortened and although it seemed like she was on the nerve, it was her opinion she wasn't because of the shortened image. She drilled 14 mm for a 13 mm implant. The 1 mm extra she advised was needed to have a place for drainage. At the time, it was her opinion the second implant was in a safe place.

19. During the second implant procedure, extra bleeding was noted. However, based on her calculations and coupled with no change in the consistency of the hardness of the bone while drilling, and because she thought the anaesthetic was wearing off, Dr. H testified it was her opinion she was still fine. Following the procedure, she sent upstairs to a different office for a panoramic radiograph to verify the position of the implant (p. 61 of Ex J1). She testified although it looked like the implant overlapped the nerve, other things were noted. She saw a reverse smile. She advised that if a panoramic view is taken with the patient's head tilting down or up, you get a distortion. A reverse smile means vertical distortion. Also, she noted one side of the jaw joint appeared larger than the other. It was therefore her opinion distortion was present and distortion in regular panoramic film could be in the 20 to 25% range. Based upon her assessment, she felt she could have been behind or in front of the nerve canal. She did not feel she was in the canal but "possibly dancing on the nerve." She discussed with the possibility of numbness due to the close approximation to the inferior alveolar canal. She gave the option of removing the implant or keeping the implant in place and monitoring. chose to keep the implant. Although not included in her clinical notes, she agrees with 's testimony she called that night from her home. She noted advised her was feeling some numbness, but it was improving.

20. Dr. H further testified because the panoramic image (p. 61 Ex J1) showed some distortion, she could have sent for another panoramic image if she had clinical concerns. She also agreed you could possibly obtain a CBCT. Although the images from the panoramic radiograph raised some concerns for Dr. H, she testified they were not determinative in her mind. She carried on based upon what she heard from the patient, radiographic interpretation and her clinical assessment. She did not think the nerve was transected and believed the numbness would only be transient.

21. As outlined above in 's overview, Dr. H agreed the clinical notes indicated a hygienist and a periodontist checked and followed up with on January 15 and the chart indicated things were improving. On January 21 and 28, 2015 the hygienist noted in the chart advised things were getting better. Dr. H was aware of those entries. The hygienist name is and her initials in the chart appear as . The C1H6 designation in the clinical entries is the hygienist's signature in code. Dr. H testified that the clinical note of April 21, 2015 indicated the numbness was gone. Dr. H relied upon this to indicate things were improving. Further, she testified the implant was stable and on April 24, 2015 she performed soft tissue grafting around the implant. In a letter to (p.28 Ex J1) she indicated it was her opinion the implant was a success. In her testimony Dr. H advised the date on this letter is incorrect and it was likely sent on or around April 20, 2015 when the radiograph was forwarded.

22. Dr. H testified having seen the 3-D images (Ex P6), there was now no question the second implant went into the nerve. She admitted during all her calculations she forgot to take into account the initial crestal bone loss that had occurred after placement of the first implant and prior to placement of the second implant. She took her measurement from the top of the crestal bone, but she missed in her calculations the bone at the top was not there

anymore (bone-height loss had occurred). To her credit, Dr. H admitted this was a big mistake in her calculations. She further stated if she thought the implant had been in the canal, she would have taken it out. Based upon her follow-up with [redacted] during the evening of January 9, she did not think there was anything untoward. She feels she has learned a lot from this mistake. It has reminded her of what is important and what needs to be taken into account in her assessments. She stated this was a mistake that was not done with any intention.

23. Dr. H was asked what she would do now in a clinical implant situation when placing an implant in close proximity to an adjacent tooth and upon radiographic exposure it showed implant/root overlap, therefor not supporting the clinical assessment. She indicated she would rely on her clinical assessment and carry on. She explained the drilling into the root would feel differently than drilling at the bone. If clinical and radiographic evidence do not concur, and on a periapical radiograph there was an overlap on the implant and tooth, she would have a CBCT done after the implant was placed.

24. Dr. H testified in her career she has only had two implants experience failure and had to be removed. The experience involving [redacted] was the first. [redacted]'s second implant was the first time she'd ever removed an implant and immediately placed a new implant in the same site. Dr. H commented on the role both the clinical assessment and radiographs play. Her evidence was she was taught the radiograph is to support the clinical assessment. She stated the x-rays may not be an accurate representation of what is in the mouth and there is more value to be gained in the clinical assessment. When asked what she would do now if the radiograph and the clinical assessment are different, she advised a more cautious approach would be to take a CBCT and possibly remove the implant.

25. In moving forward, Dr. H commented on how to avoid this mistake from happening again. Presently in her clinic, they have a CBCT machine and any implant surgery done on the mandible would involve obtaining a CBCT before she begins to plan her approach. She felt she did everything she could in planning for [redacted], but she did not have 3-D imaging available. She went on to indicate that from this incident she has learned to be more careful and not to rely too much on patient feedback. She testified sometimes patients downplay what they are feeling. She always teaches her students that in order to do better pre-planning when performing procedures in the mandibular area, a CBCT should be obtained. She testified in hindsight, if a CBCT had been available at the clinic in the same building where she had the panoramic image taken, she would have chosen the CBCT.

26. It should be noted Dr. H did not see [redacted] after April 24, 2015. She departed from the clinic after July 2015 and set up a clinic in Saskatoon. There was a restrictive covenant between herself and City View and she was not to contact any patients of the clinic.

C. EXPERT EVIDENCE

27. Three expert witnesses were called. Dr. Wagner for the PCC and Drs. Toporowski and Abbaszadeh on behalf of Dr. H. No objection was taken by either counsel with respect to qualifying each expert.

<u>Dr. Robert G. Wagner</u>

28. Dr. W was qualified as an expert to give evidence on the process and standards concerning implants including preplanning, planning, placing and addressing complications that arise after implant placement. His *Curriculum Vitae* was filed as an exhibit (Ex P 2). He is a fellow of the Royal College of Dentists of Canada in Oral and Maxillofacial surgery. He is a diplomat of the American Board of Oral and Maxillofacial Surgeons. He undertook to provide a second opinion on a referral from the College of Dental Surgeons of Saskatchewan (CDSS). He met with [redacted] and assessed the implant work performed by Dr. H. He observed the radiographic and physical findings and could not guarantee any positive outcome for the patient. [redacted] wanted the implant removed and Dr. W performed the procedure. He did his own analysis and reported his findings to the CDSS. He testified his review was done on an impartial basis and he is not biased. Filed as exhibit P4 is a statutory declaration signed by Dr. W stipulating this nonpartisan approach. Dr. W testified the removal of the implant he performed did not impact his opinion or impartiality. He has no close relationship with [redacted] and carried out no further work for [redacted]. Dr. W testified an oral surgeon undergoes an additional two years of training compared to a periodontist.

i) Placement of implant

29. Dr. W stated he can place implants. Periodontists can place implants and so can a general practitioner. It is the same standard of care that must be undertaken by dentists, periodontists and oral surgeons. The standard is what an average careful dental practitioner would do when performing implant surgery. All must meet the same standard. Dr. W testified the standard of care requires performing a CBCT, being a 3-D x-ray, at the outset so the dentist can visualize where the inferior alveolar nerve canal is.

30. Dr. W saw [redacted] on September 1, 2017. The information he reviewed was transmitted to him by the CDSS. He testified the CDSS does not send him too much information with the referral in order to not influence his opinion. He believed he did eventually receive the entire chart from City View. He was not provided with the opinions of Drs. A or T. A question was raised with respect to Dr. W's notes and how they did not reflect the same wording as in the opinion letter (Ex P5) he subsequently dictated on the same day he saw [redacted]. It was put to him the note indicated the nerve was compressed and he couldn't tell if the implant was in the canal or over the nerve. Dr. W stated his assistants are writing notes as he's

speaking and examining the patient. The notes may not accurately reflect what he dictated later but he acknowledged he is now left with the notes. He explained, there are some things you don't want to say in front of the patient that may "paint a very bleak picture." Nevertheless, he testified he had the 3-D x-ray in front of him when he dictated his letter to the college on the same day he saw ████. He stood by his opinion. Dr. W has given opinions for the CDSS before, but his testimony in these proceedings was the first time he had provided evidence before the Disciplinary Committee.

31. Exhibit P6 is the CBCT taken by Dr. W on September 1. The three views on the right-hand side give a cross section to help with measurements. Dr. W testified the second implant was placed in the canal at the very least, but most likely transecting the canal. The implant was located at tooth number 36. The dark area underneath the teeth is where the canal is, and, in his opinion, it was easily visible on the CBCT. The implant was all the way into, if not past the canal. He testified this was "not a narrow miss in placing the implant." The minimal standard is 2 mm between the end of the implant and the top of the nerve canal. Dr. W testified Dr.Packota's report (p. 44 Ex J1) shows consistent findings. At page 1 of Dr. Packota's diagnostic imaging report approximately 3.7 mm of the inferior end of the implant is noted to be located within the inferior alveolar (mandibular) canal. Dr. W performed his own measurements and testified the implant chosen was too long for the anatomical recipient location. He stated the maximum implant length he would have placed would have been 5.5 mm. The length of implant Dr. H placed was 13 mm. Dr. W indicated the most common size of an implant is 8 to 10 mm. The area where the implant was to be placed was narrow and short and, in his opinion, a 5 to 5.5 mm implant was appropriate. He went on to testify such lengths are very precise, and implants come with small incremental adjustments in length. You measure from the top of the bone and to where the canal is, and you subtract 2 mm. He indicated even if the implant had been perfectly level and there had not been any loss of bone an 8.5 mm implant would be the longest you would use. If an implant is too long and impinging on the inferior alveolar nerve canal or the nerve, there would be permanent numbness of the lower lip and chin. In the worst-case scenario, you could get dysesthesia, a nerve injury resulting in noxious stimuli where normal pressure on the lip could present as burning.

32. Dr. W's written opinion was filed as exhibit P5. Here, he talks about the exam of ████: CL 1 occlusion which is a normal bite pattern, number 36 dental implant and crown in good condition. The CBCT(ICAT) diagnoses that the body of the implant transects the inferior alveolar nerve. At page 2 of his report he provides his impression and reiterates nerve injury secondary to the implant placement into and past the inferior alveolar nerve canal.

33. Dr. W testified bone grafting could have been done to increase bone width and height prior to second implant placement. In his opinion, if the practitioner is uncomfortable with placing a short implant, then the practitioner should advise the patient to not get the implant. Page 62 of exhibit J1 is a picture of the 13 mm implant placed. Dr. W found there was a lack of judgment and therefore a breach in the standard of care. This included not performing a CBCT at the outset, by not bone-grafting and the length of the implant chosen. Irreversible harm was caused. There was an adverse outcome to what could potentially have

been avoided. He testified if you don't have access to 3-D x-ray's it is still possible to determine the length of the implant to be utilized. One takes a panoramic view and uses stainless steel beads where the implant is to be placed. Panoramic radiographs can have a standard of error of up to 25%. Therefore, the beads need to be placed where the implant is to be inserted so the calculated measurement is accurate. Calipers can be used intra-orally to determine the width of the bone. In his opinion, regardless of whether 3-D imaging is performed, one can avoid transecting the canal. He found the implant choice and placement was a serious error and avoidable. Dr. W's biggest concern was the length of the implant chosen. He testified he has performed approximately 2000 implants and has never had an implant that transected the nerve like this one. He stated the standard of care between a periodontist and an oral surgeon is the same. Dr. W indicated Dr. H did not generally demonstrate a lack of knowledge. She demonstrated a lack of judgment when she made the errors. It was his opinion, Dr. W's first error was not to have a CBCT taken. Her second error was failing to accurately measure the bone present and the length of the implant chosen.

34. Dr. W testified that when considering removing and immediately placing another implant, the same parameters and criteria are used as when placing an implant in native bone. He reiterated, there is a zone of safety. One is not to go past a 2 mm guideline between the end of the implant and the alveolar canal.

ii) *Removal of implant*

35. Dr. W testified the periapical radiograph is taken on an angle and therefore would not give you a good length measurement. He stated, trying to identify the exact location of an implant placement from a periapical radiograph or a standard radiograph is a very difficult thing to do. If you are having trouble assessing where the implant is to be located, you should have a CBCT taken. You could, however, use a panoramic radiograph with stainless steel beads to assess.

36. Dr. W agreed ████ was seen by a series of dentists at City View and they would have had access to the same x-rays as Dr. H. When it was put to Dr. W a series of dentists looked at the x-rays and didn't see a problem, he responded it was not his role to determine whether those dentists didn't meet the standard of care.

37. In Dr. W's opinion, the third error by Dr. H was the decision to not immediately remove the implant. The implant should have been immediately removed once it was recognized as transecting the nerve canal or at least it should have been backed out to a proper level. If this were only a compression injury, then the implant could have remained with possible improvement in symptoms. Since the implant goes through the inferior alveolar canal, the nerve injury will likely be permanent. With appropriate postoperative radiographs in combination with clinical findings such an intrusion could have been noted and the implant could have been removed or backed out to the appropriate level. In reviewing the panoramic radiograph (p. 61 Ex J1), Dr. W noted the implant was out of proportion to the roots of the adjacent teeth. He stated the implant appeared to be going into the nerve lines. This panoramic radiograph suggested to Dr. W there might be a problem. He also noted

there was some discussion about excessive bleeding. If noticed, it was his opinion that would be out of the ordinary. If one is observing increased bleeding on instrumentation, then Dr. W was of the opinion a CBCT should be taken and an assessment made. He stated, if he had a panoramic radiograph like page 61 of exhibit J1, he would immediately remove the implant, particularly if there was increased bleeding. He advised because the artery sits on top of the nerve, the increased bleeding would indicate a violation of the inferior alveolar canal space and you cannot leave this implant in. It needs to at least be backed out. This is a decision the dentist should make and not left to the patient to decide. The standard is to remove the implant or back it up to 2 mm out of the nerve canal. In Regina, you can send a patient to get emergency 3-D radiographs. This can be done the same day. In his opinion, there is a greater chance of healing, if the implant is removed right away. Because ████'s implant had been left in place for a substantial period of time, no improvement was expected in ██ condition. In the recommendation portion of Dr. W's opinion (Ex P5), he states the standard of care was not followed in this case. It was a breach of the standard not to recognize the implant was placed into the nerve and to not remove the implant immediately and now there was no opportunity for potential healing. The nerve injury for ████ will be permanent.

iii) Objection by the PCC

38. During Dr. W's cross-examination, he was asked for his opinion on whether Dr. H was professionally incompetent. Counsel for the PCC objected to the question on the basis such questioning would usurp the function of the Dental Discipline Committee. Counsel indicated it was not up to Dr. W to make that determination, further stipulating a determination under section 26 of *The Dental Disciplines Act* on whether Dr. H is to be found professionally incompetent was the whole crux of the case. He further submitted it would be up to this Committee to determine, based upon all the evidence, just what the standard of care was and whether a finding of professional incompetence had been made out pursuant to section 26 of the *Act*. Counsel for Dr. H argued the ultimate question issue was dead at law and he could ask questions surrounding section 26 of the *Act*. He argued he was not just asking for a legal opinion but asking for a factual opinion based upon the standard of care. The Committee retired to discuss the issue and ruled to uphold the PCC's objection. The Committee held it was their role, as with any self-regulating body, to review the actions of their peers under their governing legislation. Pursuant to section 26 of the *Act,* professional incompetence is a question of fact, but it is a factual determination that is made by the entire Committee based upon all the evidence. It is the Committee that assesses the evidence and determines this question. Counsel were allowed to pursue questioning touching upon the knowledge, skill and judgment exercised by Dr. H. Although expert opinion reports were filed by consent (Exs. P5, D4 and D8), based upon the ruling by the Committee on the ultimate question of professional incompetence, the Committee has accorded no weight to any conclusions or comments provided by the experts in their reports on the specific question of incompetence.

Dr. Elizabeth Toporowski

39. Dr. T was qualified to give opinion evidence on the standards, knowledge, skill and judgment in planning for and placing of implants. There were no objections to her qualifications and her *Curriculum Vitae* was entered as exhibit D3. She graduated with distinction from the University of Saskatchewan's College of Dentistry in 1976. Her certificate of periodontics was obtained in 1987 from Dalhousie University. Her opinion dated September 13, 2018 was filed as exhibit D4. It lists the documents reviewed by Dr. T in arriving at her opinion. In her opinion letter, she responded to numerous questions posed.

i) Placement of implant

40. She states Dr. H treated the patient with the watchfulness, attention, caution and prudence a reasonable and competent periodontist would exhibit in the same circumstances. She felt Dr. H's clinical notes were an accurate record and reflected her treatment clinically, including follow-up and [redacted]'s responses. Specifically, it was her opinion the clinical notes of December 2014 were indicative of careful planning. Further, the notes of January 7 presented options for bone and tissue grafting and the rationale for possible removal and replacement of previous placed implant number 36. Despite the fact she did not take any issue with Dr. Garnet Packota's report indicating the second implant had entered the alveolar canal by 3.7 mm, it was still her opinion, using clinical and radiographic information, Dr. H correctly determined measurements indicating adequate space was available for the selected implant without impinging on the inferior alveolar canal. When asked whether she would agree the implant transected the nerve, she thought that was too strong of language and she would only agree the implant was in the inferior alveolar canal. When asked whether it is an acceptable outcome for implant surgery to have some degree of intrusion into the nerve canal, Dr. T indicated it depends on the degree of intrusion. Dr. T testified she did not take independent measurements and concluded Dr. H performed the correct measurements based upon the clinical notes. These notes found at pages 30 – 33 of exhibit J1 do not record measurements taken by Dr. H.

41. In her opinion, Dr. H did not breach the standard of care expected of a periodontist by failing to recognize the intrusion of the implant in the inferior alveolar canal when it was placed. Her rationale included the following: very dense bone was noted during placement of the original implant number 36 in July 2014; in dense bone it would be more difficult to clinically detect drill or implant intrusion into the canal and Dr. H did not notice any change in hardness of the bone during the drilling for the replacement implant. Since increased bleeding was noted at the time of implant placement, a panoramic radiograph was taken. In reviewing the record, Dr. T noted Dr. H indicated the implant was in very close approximation to the inferior alveolar nerve canal. She further stated the use of three-dimensional radiographs produced by CBCT technology was not standard protocol for periodontist's placing implants in Saskatchewan in 2014 – 15.

ii) Removal of implant

42. In Dr. T's opinion, the noted increased bleeding could have been due to the local anaesthetic wearing off or due to cutting bone very close to the nerve canal or due to intrusion into the nerve canal. She testified it would be extremely difficult to state with certainty inferior alveolar nerve intrusion had occurred or the degree of it. With increased bleeding at the site during bone of preparation, she agreed with Dr. H's rationale of giving ████ the option of leaving the implant in place and performing follow-up beginning on the evening of surgery. In her opinion, Dr. H's follow-up was consistent with the standard of practice of all periodontists practising at the clinic where both Dr. T and Dr. H had been employed.

43. Dr. T testified virtually every surgeon and periodontist has had clinical experience with nerve injuries due to surgical procedures. X-rays and clinical judgment determine whether to remove an implant. In her opinion, Dr. H did not breach the standard of care expected because she immediately informed the patient of possible nerve damage resulting in numbness and because of this uncertainty gave the patient the option to have the implant removed immediately, undergo bone grafting and have another implant placed in six months following healing. The other option provided was to wait and watch carefully to determine if an injury had occurred and the degree of healing that may take place. Her review indicated the clinical notes reported some nerve disruption with healing occurring over time. She reviewed the notes of follow-up at the clinic with ████ and noted ██ comments concerning continual improvement and less numbness. She commented on the note of April 21, 2015 indicating the "numbness was totally gone." She felt this was a good outcome and any surgeon would be happy with the result.

iii) Working Relationship with Dr. H.

44. Dr. T testified she worked with Dr. H at City View beginning in 2012 and there was no concern with her practice when she worked with her. They often had the same patients and she had not heard any patient complaints about Dr. H. She was involved in hiring Dr. H and admitted she had a limited social relationship with her outside of the office in the same way she had with all other doctors that were doing locums at the clinic. She stated although she had a professional relationship with Dr. H and acted at times as her mentor, she believed she could provide opinion evidence on an objective basis.

45. Dr. T admitted she spoke with Dr. H approximately two years prior to giving her evidence at this hearing. She spoke with Dr. H about the case when she became aware of ████'s complaint. She learned of the complaint through ████████ at City View. She testified Dr. H contacted her requesting her to give an expert opinion. Dr. T conceded she could not comment all steps taken by Dr. H were carefully recorded, and options given because she wasn't present during the conversations and treatment. She also conceded where she indicated in her opinion Dr. H was compassionate, this was based on personal observation when working with her at the clinic and not information that was demonstrated in the clinical notes. When asked in hindsight if she still believed she was not advocating for Dr. H, Dr. T did not have a response. On re-examination, however, she stated she could constructively criticize the work of colleagues.

Dr. Keyvan Abbaszadeh

46. Dr. A was qualified to give opinion evidence on best practices of a prudent practitioner concerning oral surgery knowledge, skill and judgment, including placement of dental implants. His *curriculum vitae* was filed as exhibit D7. He is Board-Certified with a fellowship in the Royal College of Dentists of Canada in Oral and Maxillofacial Surgery and is a diplomat of the American Board of Oral and Maxillofacial Surgeons. He has been licensed by the Royal College of Dental Surgeons of Ontario since 1997 with a specialty license in Oral and Maxillofacial Surgery. He has been an Adjunct Clinical Professor at the University of Western Ontario since 1999. Detailed training and presentations in his specialty areas are more fully particularized in his CV. Filed as exhibit D9 is a letter dated July 25, 2018 from counsel for Dr. H to Dr. A requesting a formal opinion concerning the subject complaint. He was specifically asked a series of questions (Ex D9). In preparing his opinion, entered as exhibit D8, Dr. A outlined the documents he reviewed.

47. Dr. A was asked to comment on the standard of care used in the practice of dentistry and what is expected. Simply put, he stated the standard of care is that of what a prudent, reasonable and responsible practitioner would do. There is no exact definition. It is a doctor who looks out for the patient's best interests. There is a duty to inform the patient of any outlined treatment risks and potential complications. Dr. A viewed the standard of care as a fluid concept. It is what the norms are and what your peers do. Practice guidelines provide a framework for the practitioner based on science then one must defer back to the norm and standard of care to what the average competent person would do and what is acceptable treatment. One must not be reckless or undertake procedures one is ill trained for. In his opinion, sometimes complications happen to good doctors. He commented this was a "one-off complication" and Dr. H's conduct was not done with an indifference to harm.

i) Placement of implant

48. Dr. A was asked whether Dr. H breached the standard of care expected in proper planning by not proceeding with a bone graft before placing the second dental implant on January 9, 2015. In his opinion, the need for a bone graft is a clinical decision and depends on the desired location of the implant for the final form and function needed from the prosthesis. Grafting of this site would not necessarily increase the vertical bulk of bone. Based upon the information he was provided, Dr. H discussed the options with ████ on whether to proceed with the second implant or bone graft and delay placement of the second implant. It was his opinion, Dr. H measured the space available and chose her implant-placement with plans of avoiding the canal. It was his opinion failure to use a bone graft did not amount to a breach in the standard of care. Nevertheless, Dr. A concludes in an ideal situation, the site should have been grafted to increase width and address the defect of the original implant with appropriate healing time before second implant placement. He felt this was especially important in ████'s case as tapered implants were used.

49. He was asked whether Dr. H chose the incorrect implant among the options available and whether that was something a reasonably prudent periodontist would do in the exercise of their clinical judgment. In discussing standard of care, in his written opinion (Ex D8), he stated Dr. H could have considered a shorter implant in the area and this may have mitigated some of the postoperative issues. He further states, if the implant choice is based on the periapical films, one needs to take into account the film angulation for shortening or elongation of the images. In his opinion, it would not be a breach of the standard of care to use a longer fixture with the acknowledgement of the specific site issues.

50. Dr. A was asked whether a prudent practitioner would measure the amount of bone available for the second implant, taking into consideration there had been bone loss between the placement of the first implant and the placement of the second implant. In his opinion, a prudent practitioner would treat every implant placement as if it was a new one. The measurement should be made every time. This would include taking into account bone loss because you are measuring the amount of bone you have to work with. Dr. A was of the opinion there was an unfortunate mathematical misadventure in this case. The information he received when providing his written opinion did not include Dr. H admitting she had failed to calculate the cortical bone loss when measuring the bone available for placement of the second implant.

51. Dr. A indicated he has performed between 1000 and 1500 implants. He acknowledged the second implant entered the nerve canal and perhaps went through the canal. He could not quantify the number of cases where the implant entered the nerve canal but conceded there are very few cases. He agreed this does not happen very often and he has personally not seen this occur. He agreed the standard of practice is to employ a 2 mm buffer zone between the end of the implant and the inferior alveolar nerve canal. Dr. A testified the radiographs he was provided were not very accurate and consequently he could not make his own independent measurements. He agreed a shorter implant should have been chosen and that a 3.7 mm intrusion into the canal is a surgical misadventure. He agreed the approach taken by Dr. H was unconventional. He reiterated 3-D imaging is not the standard and it was his opinion it was not necessary for Dr. H to do more planning than what she did. He agreed there are other options, including bone grafting, that could have been utilized but the patient requested a minimal number of visits. He could not fault her for how she continued caring for ████ following the second implant.

ii) Removal of implant

52. Dr. A was asked whether on January 9, 2015, after reviewing the two-dimensional images and considering the patient's clinical situation, whether there was a breach in the standard of care in not immediately removing the second implant. Would a reasonably prudent periodontist provide the patient with the option of leaving the second implant in place and monitoring progress rather than immediately proceeding to remove the implant? In his opinion, the expected course of action when one is concerned with injury to the inferior alveolar nerve (IAN) during implant placement, is to remove the implant. However, where

the circumstances are equivocal, and the surgeon is unsure if the canal space is violated, 3-D imaging would be useful before the implant is removed. Although he provides no factual basis, he opines getting a 3-D image could have resulted in a few days delay in this case. He states even though CBCT imaging is quite helpful, it is not the standard of care and is not readily available in most dental practices.

53. He offered an opinion in relation to whether during providing services to the patient on January 15 where lip numbness is reported, coupled with the two-dimensional x-ray, whether it would have been immediately apparent to a reasonably prudent periodontist the implant had been placed into and passed through the inferior alveolar nerve canal. Despite the fact Dr. H had identified increased bleeding as a possible indication the IAN may have been approached or violated, Dr. A focused upon ████ reporting considerable improvement in the first 12 to 19 days post surgery. Consequently, he surmised one could assume the neuro- sensory disturbance may not have been due to clear injury to the nerve and therefore may be transient. Here, a clinician would be faced with a dilemma. There could be a risk of further injury to the nerve during the removal of the implant especially if the implant/nerve contact is intimate. Therefore, in his opinion, in a case where the patient is reporting improvement, a wait and see approach may be reasonable, although not conventional. Dr. A took exception to Dr. W's conviction that based on two-dimensional imaging it was immediately apparent the implant was placed into and passed through the nerve canal. Nevertheless, Dr. A agreed with Dr. W the nerve was most likely either partially or fully transected due to the CBCT results. Consequently, in the case of removal of such an implant, even if done immediately, it may not have yielded a better outcome. He observed Dr. H clearly encountered some unanticipated difficulties. He stated, one could fault her for the implant fixture selection, or immediate replacement of the suspect implant, and not obtaining 3-D imaging prior to surgery. Nevertheless, whenever she identified an issue, she did not ignore it. She communicated all findings with the patient immediately and was present for patient follow-ups. He concludes regardless of any surgical misadventure, Dr. H's actions were consistent with that of a competent practitioner.

D. INTERPRETATION OF PROFESSIONAL INCOMPETENCE

54. The Discipline Committee's role is to determine, based upon the facts, whether professional incompetence within the meaning of *The Dental Disciplines Act, S.S. 1997* c. D-4.1 (the *Act)* has been made out. Counsel for both parties provided written submissions calling for the Committee to interpret the governing legislation differently.

55. Dr. H is charged with, *inter alia*, professional incompetence pursuant to section 26 of the *Act*. The *Act* defines professional incompetence in section 26 as follows:

26 Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment, or a disregard for the welfare of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:

(a) continue in the practice of that member's profession; or

(b) provide one or more services ordinarily provided as part of the practice of that member's profession;

is professional incompetence within the meaning of this Act.

i) Overview of Submissions on behalf of the PCC

56. Counsel for the PCC invites this Committee to interpret professional incompetence broadly. A "wide and inclusive" approach to professional regulation ensures a regulator is not restricted when dealing with conduct that requires protection of the public (*Nanson v. Saskatchewan College of Psychologists,* 2013 SKQB 191).

57. Further, they submit section 26 is a non-exhaustive definition and the Committee should not become focused on the examples found in section 26. Consequently, the Committee is not limited to the examples provided in section 26. Non-exhaustive definitions do not purport to displace the meaning that defined term would ordinarily have (*Sullivan on the Construction of Statutes* p. 73). Counsel submits the Committee is not limited to a finding of incompetence only where subsections (a) and (b) of section 26 are met. The Committee has authority to determine if particular conduct fits within the general category of being incompetent.

58. An interpretation of section 26 should not greatly restrict the framework of what could constitute professional incompetence. A purposive analysis is a regular part of statutory interpretation to be relied upon in every case (*Sullivan*, *ibid* p. 261). The function of section 26 of the *Act* must be interpreted within the broader purpose of the *Act's* disciplinary scheme. The legislature, pursuant to section 34 of the *Act*, has given the Committee wide powers of discipline ranging from simply reprimanding the member to expelling the member from the association. Further, the Committee can make any other order it considers just. The threshold to trigger even moderate consequences for the member, is a finding of professional incompetence. Then, pursuant to ss 34(1), the Committee is free to make one or more orders involving a wide range of options or sanctions depending on the severity of a given act of incompetence. The PCC urges a finding of repeated incompetence is not consistent with the disciplinary scheme found in the Act. Because of the range of orders available to the Committee, the legislative scheme intended to allow for an imposition of sanctions even for mild and isolated incidents of incompetence.

59. Counsel for the PCC submits professional incompetence is demonstrated within the meaning of the *Act* where a member displays "a lack of knowledge, skill or judgment" at any time, regardless of a pattern of behaviour and without consideration to a member's history or record of care. Rather, a pattern of behaviour speaks to the appropriate penalty after guilt has been established (*Morton v. Registered Nurses Assn. (N.S.)*, 1989 CarswellNS 227, para. 41).

60. In support of their position, counsel relies upon a previous decision of this Committee in the *Dr. Maged Etman* case for the proposition the Committee there found three separate counts of professional incompetence rather than simply finding Dr. Etman incompetent

generally. In further support of this approach, counsel cites a case where our Court of Queen's Bench affirmed a hearing panel's decision involving a nurse. The court determined professional incompetence could be found in relation to specific medical procedures based on a single act. Consequently, the hearing panel there was able to determine the nurse was professionally incompetent in only two of three incidents. Separate instances of incompetence were used to determine penalty (*Ratzlaff v. Assn of Licensed Practical Nurses (Saskatchewan)*, 2000 SKQB 3).

61. Repetition of behaviour that continues to demonstrate a lack of knowledge skill or judgment is more appropriately considered when determining penalty. It is not a prerequisite to a finding of incompetence. Counsel asserts it would be "unfathomable" if the PCC was required to "idly stand by and wait for practising dentists to repeat mistakes and cause harm to the public on more than one occasion and over time before they were able to take action."

62. They submit, it is presumed a legislature does not intend its legislation to have absurd consequences (*Bohachewski v. Bohachewski*, 2018 SKQB 229 at para. 20). Under a consequential analysis, the legislature cannot have intended section 26 to "hamstring" this Committee. ████ should not be deprived of a remedy against Dr. H because of a single incident and not a pattern. Further, the PCC should not be prevented from seeking a professional sanction due to incompetence until further patients potentially suffer and a pattern of poor professional judgment or service has been established.

63. To protect the public and achieve the PCC's statutory goals, the PCC must be able to act proactively when a member demonstrates a lack of knowledge, skill or judgment, rather than act reactively after a pattern of incompetence has already been established.

64. Finally, counsel argues the placement of a comma between "a lack of knowledge, skill or judgment" and "a disregard for the welfare of a member of the public…" Should be read as providing two separate examples of professional incompetence. One requires simply a lack of knowledge skill or judgment. The other must demonstrate a disregard for the welfare of a member of the public, to an extent that demonstrates the member is unfit to either continue in the practice of that member's profession or provide one or more ordinary services.

ii) Overview of Submissions on behalf of the Respondent

65. Counsel submits as with all self-governing bodies; this Committee has been empowered for the purposes of protection of the public (*Rocket v Royal College of Dental Surgeons (Ontario)*, 1990 2 SCR 232).

66. The respondent's position on statutory context is succinctly stated. "The display of a lack of knowledge, skill or judgment, and/or a disregard for the welfare of a member of the public is not, in and of itself, sufficient to constitute a finding of professional incompetence. The

impugned conduct in question must be of "a nature or to an extent" that demonstrates the member is unfit and at the very least restricted in what they are allowed to practice."

67. They submit their definition fits with the College's mandate to protect the public through the disciplinary process. A finding of professional incompetence is a finding the member is unfit and a threat to the public and therefore must be restricted from practice in some form.

68. The respondent also relies upon the previous decision of this Committee in *The College of Dental Surgeons of Saskatchewan v Dr. Maged Etman* to support their view of how s. 26 of the *Act* should be interpreted. They submit where the College previously made a finding of professional incompetence, it did so based on factors which elevated an error from a surgical misadventure to an egregious violation of professional standards to the extent it made the member unfit to practice. In support of this interpretation, they note in the *Etman* case this Committee assessed several allegations of incompetence noting that errors "may occur from time to time" but it was several enumerated errors that elevated the conduct to one of professional incompetency.

69. Counsel submits the definition of professional incompetence is not a catch-all provision to reprimand a dental professional for mistakes made during one's practice and that negligence in performance of professional duties may not be severe enough to amount to incompetence (Law Reform Commission of Saskatchewan. *Handbook on Professional Discipline Procedure*, 2017 CanLIIDocs 207).

70. Signs of incompetence include a "want of ability suitable to the task", a "deficiency to use one's ability and experience properly which may include habitual carelessness, disposition and temperament" and "lacking the qualities needed to give the effective professional services" (Casey, James *The Regulation of Professions in Canada* (1994 Carswell) 13-12, 13-13).

71. Exercising one's professional judgment, which turns out to be incorrect is not necessarily outside the range of possible courses that a reasonably competent professional might choose to make and therefore is not necessarily professional incompetence. A nurse can make a mistake or even be guilty of malpractice and remain competent to practice (*Matheson v College of Nurses (Ontario)* 1979, CarswellOnt 747, 107 DLR (3d) 430 (Ont Div Ct) affirmed in 1980 CarswellOnt 1475 (ONCA)).

72. Counsel provided a list of *indicia* that point to incompetence or unfitness in the medical profession:

-A pattern of carelessness or mistakes. Incidents taken together can show inadequate skill or judgment and may indicate professional incompetence if sufficiently severe (*Mason v Registered Nurses Association of British Columbia*, 1979 CarswellBC 190 (BCSC) at para. 44).

-Failing to respond to advice regarding shortcomings. This may be evidence of a professional's failure to improve their training or their willingness to learn from mistakes. It can indicate a lack

of care for their patient and a corresponding safety concern for the public (*Mason, ibid* para. 37).

-Failure to stay current with techniques which can mean you're falling below an acceptable standard of care. It may be indicative of an attitude of disregarding the best interests of the patient (*SOCI Bayang v College of Physicians and Surgeons (Ontario)*, 1993 CarswellOnt 785 (Ont Ct of Justice) at para 44).

-Indifference to, or lack of concern for the welfare of the patient. This can be an indicator of incompetence when combined with an act of gross negligence. Such indifference may correspond with failing to respond to advice on shortcomings *(Pillai v Messiter [No. 2]* (1989), 16 NSWLR, cited in *Osif, Re,* 2008 CarswellNS 960(Hearing Committee of the College of Physicians and Surgeons of Nova Scotia).

-A single surgical misadventure might constitute incompetence if it amounts to gross negligence. Counsel submits a failure to meet the standard of care and medical malpractice not amounting to gross negligence does not meet the standard of incompetence. Mere negligence is not enough for a finding of unfitness. There must be a failure amounting to gross negligence. The definition of unfit member in the PEI *Medical Act* makes it clear the physician's transgression must be of such a nature and extent to make it desirable to either restrict or terminate the physician's ability to practice (*Swart v College of Physicians and Surgeons of PEI,* 2014 PECA 20). Counsel points out the definition of "unfit member" in the referenced PEI Medical Act runs parallel to that of "professional incompetence" in the Saskatchewan context. Section 2(y) of the PEI *Medical Act* states: "unfit member" means a member who has demonstrated a lack of knowledge, skill, or judgment or a disregard for the welfare of the patient, of a nature and extent making it desirable in the interests of the public or the member that he no longer be permitted to practice or that his practice be restricted."

iii) The Committee's Analysis on Interpretation of Professional Incompetence

73. The interpretive variations of section 26 of *The Dental Disciplines Act*, submitted by counsel, have not, to this Committee's knowledge, previously been argued before it. The Committee has given careful consideration to both interpretations and finds the overall concern this legislation is meant to address is one of public protection through regulation of the practice. Interpreting incompetence broadly supports this approach and ensures this Committee is not restricted when dealing with conduct requiring public protection (*Nanson, supra*).

74. As outlined above, the respondent submits: "The display of a lack of knowledge, skill or judgment, and/or a disregard for the welfare of a member of the public is not, in and of itself, sufficient to constitute a finding of professional incompetence. The impugned conduct in question must be of "a nature or to an extent" that demonstrates the member is unfit and at the very least restricted in what they are allowed to practice." The Committee does not agree. This logic ignores the role the Committee must perform in protecting the public by being able to review the specific conduct of dental practitioners licensed under the *Act,*

where a member of the public has been harmed through specific steps taken during a procedure. Simply put, occasions will arise where a lack of knowledge, skill or judgment is demonstrated, and a procedure is performed in an incompetent manner. The Committee finds it is not limited to a finding of incompetence only where subsections (a) and (b) of section 26 are met; section 26 is a non-exhaustive definition (*Sullivan on the Constructions of Statutes*) which allows the Committee to determine if specific conduct fits within a general category of professional incompetence. Nevertheless, it may still be demonstrated the particular practitioner has continued to practice and has performed similar procedures without incident. It may also be shown they have upgraded their skills and education. Consequently, they may have shown they are fit to practice and provide such services but can still be found to have acted in an incompetent manner.

75. As noted at paragraph 69, the respondent submits the definition of professional incompetence is not a catch-all provision to reprimand a dental professional for mistakes made during one's practice. For this proposition they rely, in part, upon the *Handbook on Professional Discipline Procedure from the Law Reform Commission of Saskatchewan* (2017 CanLIIDocs 207). However, the *Handbook* specifically stipulated what constituted misconduct or incompetence was outside the scope of the *Handbook* (at p. 15).

76. The respondent references the *Matheson* decision for the proposition an exercise of professional judgment, which turns out to be incorrect, is not necessarily outside the range of possible courses a reasonably competent professional might choose and therefore is not necessarily professional incompetence (Paragraph 8 *Matheson*). This decision is not overly helpful to the Committee in interpreting section 26 of our *Act*. We agree with the PCC's interpretation of the case. Although in *Matheson* the discipline Committee could find a member incompetent where they displayed a lack of knowledge skill or judgment or disregarded the welfare of the patient, a finding of incompetence required the disciplinary panel to revoke the member's certificate because the nurse in the case was found unfit to continue in practice. That is not the case in our *Act*. Section 34 provides for a wide range of discipline options that do not require revocation of one's license. Further, there is no additional form of governance for review of single acts by a member in Saskatchewan under *The Dental Disciplines Act*.

77. The respondent cites *Swart v College of Physicians and Surgeons of PEI* for the proposition a single surgical misadventure might constitute incompetence if it amounts to gross negligence. Although there is some discussion on gross negligence, the case specifically addresses the definition of an "unfit member" under the specific *Medical Act* in question. The definition made it abundantly clear a physician's transgression had to be of such a nature that it was desirable to restrict or terminate the physician's ability to practice before they could be found unfit. Again, the court in this case, was concerned with the Committee's finding the doctor in question was unfit to practice. Nevertheless, in the case before this Committee under our *Act,* the question of whether a lack of competent knowledge, skill or judgement is shown does not necessarily translate into a finding Dr. H's license should be revoked or she should not be allowed to perform certain procedures.

78. The respondent relies upon the *Mason* decision for the proposition to be found incompetent, a pattern of carelessness or mistakes or a failure to respond to advice regarding shortcomings are necessary. However, the specific disciplinary provision reviewed in *Mason* allowed for numerous forms of and avenues to discipline a member based on a single act of misconduct. It was on this basis the court concluded incompetency, required a pattern of carelessness because individual acts could also be disciplined. The *Act* in *Mason* provided no definition of incompetence whereas the *Act* this Committee is tasked with enforcing does provide such a definition. This Includes showing a lack of knowledge, skill or judgment that does not necessarily involve a suspension or revocation of license which was the outcome in *Mason*. Consequently, the *Mason* case is of limited assistance to this Committee.

79. Both the PCC and the respondent rely upon a prior decision of this Committee in the *Maged Etman* case. The PCC submits this decision supports their interpretation of the legislation because the Committee found three separate counts of professional incompetence for Dr. Etman in relation to different patients rather than simply finding Dr. Etman generally incompetent. There were three separate counts of incompetence, however, each included numerous examples of poor judgment and skill. Although in relation to one patient the Committee in Etman commented errors "may occur from time to time", the Committee found there were several enumerated errors that elevated the conduct to one of professional incompetency. This eventually resulted in Dr. Etman not being licensed or otherwise being permitted to practice dentistry in Saskatchewan until he met the standard licensure qualifications. His ability to perform certain dental services was also restricted until he completed a course of studies. The Committee finds the *Etman* decision clearly holds this Committee, in applying the legislation, can determine whether professional incompetence has been made out in relation to specific treatment procedures afforded a particular patient.

80. The respondent lists *indicia* they submit demonstrate incompetence or unfitness in the medical profession. These include: a pattern of carelessness or mistakes; failing to respond to advice regarding shortcomings; failure to stay current with techniques and an indifference to the welfare of the patient. The Committee agrees such *indicia* are helpful where there is a consideration as to whether the evidence has demonstrated a member is unfit to continue to practice in their profession or provide one or more services. The Committee finds such a pattern is, however, not necessarily required to find knowledge, skill or judgment has been exercised in an incompetent manner.

81. The Committee finds the interpretation of section 26 must consider the overall purpose of the legislation and be interpreted within the broader purpose of the *Act's* disciplinary powers found in section 34. There, this Committee can make one or more orders covering a wide range of options or sanctions based upon the severity of a given act of incompetence. The Committee does not accept the argument that to make a finding of incompetence under section 26, there must be evidence of repeated incompetence. The Committee finds because of the range of orders available to it, the legislature intended to allow for an

imposition of sanctions even where mild and isolated incidents of incompetence are found. A pattern of behaviour is more appropriately addressed when it comes to sentencing (*Morton, supra*).

82. This Committee adopts the rationale found in *Ratzlaff supra*. There our Court of Queen's Bench, when applying legislation identical to section 26 of *The Dental Disciplines Act*, determined professional incompetence could be found in relation to specific medical procedures based on a single act.

83. This Committee agrees with the statutory interpretation principle, a legislature does not intend its legislation to have absurd consequences (*Bohachewski, supra*). It cannot have been the legislature's intent to deny a member of the public a remedy because they have only been harmed through a single incident and not a pattern of conduct. It defies logic that this Committee could be precluded from determining a sanction for an act of professional incompetence until others are harmed and a pattern of poor professional knowledge, skill or judgment has been made out. This Committee must be able to review such conduct and, where necessary, make an appropriate order.

E. ISSUES TO BE DETERMINED

84. The onus is on the PCC to establish on a balance of probabilities Dr. H is guilty of professional incompetence (*F.H. v McDougall* [2008] S.C.R. 41). This Committee is cognizant of the same and confirms our findings are made on a balance of probabilities.

85. The evidence established Dr. H is a dentist with a specialty practice limited to periodontics. Her conduct is to be assessed considering the conduct of other ordinary specialists, who have a reasonable level of knowledge, competence and skill expected of practitioners in her field (*Ter Neuzen v Korn*, [1995] 3 SCR 674; *Wanner v Abed* 2018 SKQB 59).

86. The Committee retains jurisdiction to hear and determine matters involving former members of the College of Dental Surgeons of Saskatchewan pursuant to sections 25.1 and 25.2 of the *Act* (*Etman, supra,* at paras. 52-53).

i) Was the intrusion of the implant into the inferior alveolar nerve canal avoidable with proper planning and has professional incompetence been established?

87. Dr. W testified the standard of care requires a CBCT image being taken at the outset, so the dentist can visualize where the implant is to be placed. Even if you don't have a CBCT it is still possible to determine the length of the implant to be utilized. In his opinion, a panoramic view can be taken, and stainless-steel beads are inserted where the implant is to be placed. Because panoramic radiographs can have an error of up to 25%, the beads need to be placed where the implant is to be inserted so the calculated measurement is accurate. This was not done.

88. Dr. W emphasized the need for proper planning at the outset, so it is clear what maximum length of implant could be used and still remain in the safety zone. He testified based upon his own measurements and review, it was a breach in the standard of care to use a 13mm implant considering the amount of recipient bone available for ████. He testified as to the adverse impact choosing too long of an implant can have on the patient and a competent practitioner should have identified the amount of recipient bone available when selecting the length of implant during the planning stages.

89. Dr. W stated this was not a narrow miss. The implant was all the way into, if not passed the alveolar canal. The minimal standard for safety is a 2 mm distance between the end of the implant and the top of the nerve canal. In reviewing Dr. Packota's diagnostic imaging report, he noted approximately 3.7 mm of the inferior end of the implant was located within the inferior alveolar (mandibular) canal. He testified the implant was too long for the anatomical recipient location. The maximum implant length available was approximately 5 to 5.5 mm.

90. Dr. W found there was a breach of the standard of care and harm caused that was irreversible. Such an adverse outcome could potentially have been avoided. It was his opinion, Dr. H demonstrated a lack of judgment when she made her first error to not have a CBCT taken. He found Dr. H's second error was choosing an implant length where there was not sufficient bone present for its placement.

91. Dr. T stated the use of three-dimensional radiographs produced by CBCT technology was not a standard protocol for periodontist's placing implants in Saskatchewan in 2014 – 15. Despite the fact Drs. H, W and A all agreed a 2 mm buffer zone is standard practice when placing an implant, Dr. T was unable to agree. Dr. T was of the opinion, based upon her review of the clinical notes, Dr. H was careful in her planning. Dr. T simply concluded Dr. H performed the correct measurements using clinical and radiographic information and correctly determined adequate space was available for the second implant without impinging on the inferior alveolar canal. She continued to hold that opinion on questioning despite the fact she did not take any issue with Dr. Garnet Packota's report indicating the second implant had entered the inferior alveolar canal by 3.7 mm.

92. Dr. A testified the failure by Dr. H to perform a bone graft on the site for the implant, allow for healing and delay the placement did not amount to a breach in the standard of care. He does, however, agree this would have been the ideal approach but Dr. H had discussed the options with ████ who wished to proceed on the same day.

93. In Dr. A's opinion, a prudent practitioner would measure the amount of bone available for the implant, taking into consideration there had been bone loss between the removal of the first implant and the placement of the second implant. In his opinion, a new measurement should be made every time because you are measuring the bone you have available to work with. He found there was an "unfortunate mathematical misadventure" in this case.

94. Dr. A has not personally seen an implant entering and perhaps passing through the nerve canal. He agrees such an occurrence is very rare. The standard of practice is to employ a 2 mm buffer zone between the end of the implant and the canal space. He testified the radiographs he was provided were not very accurate and he was not able to perform his own independent measurements. He agreed a shorter implant could have been chosen and that a 3.7 mm intrusion into the canal is a "surgical misadventure."

95. Analysis by Committee-- Dr. H was candid in her testimony. She now readily acknowledges the second implant entered the nerve in the inferior alveolar canal. She admitted during her calculations, she neglected to take into account the initial crestal bone loss that had occurred after placement of the first implant. She testified she took her measurement from the top of the crestal bone but missed in her calculations the bone at the top was no longer present. She did this, despite the fact the very reason for placing the second implant was due to the loss of crestal bone following the first implant.

96. The facts in this case clearly establish the second implant's intrusion into the alveolar canal by more than 3.5 mm. This Committee finds, such an intrusion, demonstrates a lack of knowledge and judgment in treatment planning and skill in implant placement. Both Dr. W and Dr. A testified when placing an implant, the minimal standard for safety is a 2 mm distance between the end of the implant and the top of the nerve canal. Despite labelling it as a "surgical misadventure," it was Dr. A's opinion a prudent practitioner would measure the amount of bone available for the implant, taking into account bone loss had occurred between the first and the second implant placement. This was not done by Dr. H.

97. The Committee does not find Dr. H's failure to obtain CBCT imaging before placing the second implant is a breach of the standard of care. The Committee, however, agrees with Dr. W this was not a narrow miss and the second implant was all the way into, if not passed the inferior alveolar canal. The Committee finds Dr H, in utilizing a 13 mm implant, chose an implant that was too long for the anatomical recipient location thus further demonstrating a lack of knowledge and judgment in her treatment planning. Correct measurement of the available bone and corresponding selection of the appropriate implant size is crucial. Intrusion into the inferior alveolar canal is one of the most egregious errors a practitioner placing implants can make. This Committee agrees with the testimony of Dr. W this was clearly a breach of the standard of care and the harm caused to ████ was irreversible. Further, as referenced, Dr. A found a prudent practitioner would measure the size of bone available, accounting for bone the loss that had occurred, and select an appropriate implant size.

98. Dr. W testified, based upon his own measurements and review, a 13mm implant was too long for the amount of recipient bone available for ████. It was his expert opinion the same should have been identified by a competent practitioner in the planning stages and a shorter implant chosen. The Committee agrees with the opinion of Dr. W. Although Dr. A testified Dr. H could have considered a shorter implant in the area, he concludes her implant choice was based on the available radiographs. In determining implant length, he testified a

practitioner needs to consider the film angulation for shortening or elongation of the images. He concludes Dr. H would not breach the standard of care by using a longer fixture with the acknowledgement of the specific site issues. The Committee finds that Dr. A concluded if there is sufficient bone available a longer implant can be chosen and utilized. The evidence of Dr. W, coupled with the failure of Dr. H to take into account bone loss in her measurements, supports our finding, on a balance of probabilities, a 13 mm implant had a reasonable probability of causing nerve damage when placed and a shorter implant should have been chosen, taking into account the crestal bone loss that had occurred.

99. The Committee has determined to not give any weight to the testimony of Dr. T concerning the planning, placement and decision on removal related to the second implant, based upon our concerns outlined above in paragraphs 40, 44, 45 and 91. Throughout her testimony, the panel found Dr. T appeared to be advocating for Dr. H. Even when faced with the established fact the inferior alveolar canal had been penetrated by 3.7 mm, she refused to acknowledge the same. At one point, Dr. T could not answer whether she felt her report could reasonably be viewed as unbiased. The Committee also questions the veracity of Dr. T's evidence because of the working and social history she had with Dr. H. Further, the Committee finds her evidence suspect based upon the fact Dr. H recruited Dr. T to give evidence on her behalf and they had previous discussion about the case. Although the Committee analyzes the evidence of Dr. T below, these concerns remain, and no weight is given to her testimony.

ii) Would a competent specialist dentist have recognized the intrusion when the implant was replaced and is a failure to so recognize the intrusion and remove the implant at that time incompetence within the meaning of the Act?

100. Dr. W testified the intrusion into the inferior alveolar canal was clearly visible from the panoramic radiograph taken following the second implant placement (Ex. P7) and the standard of care required the immediate removal of the implant once the intrusion was identified. In reviewing the panoramic radiograph, he noted the implant was out of proportion to the roots of the adjacent teeth. This panoramic radiograph suggested to him there might be a problem. Dr. W further opined where a periapical radiograph is utilized, it is done on an angle, does not allow for good vertical measurements, and further exploration when placing an implant should be undertaken and this can include taking a CBCT.

101. It was Dr. W's opinion if he had a panoramic radiograph like page 61 of exhibit J1 (and in exhibit P7), he would have immediately removed the implant, particularly if there was increased bleeding. He was of the view, this was a decision the dentist should make, and it should not be left up to the patient. In his opinion, it was a breach of the standard of care to not remove the implant or at least back off the implant short of the IAN canal, leaving no opportunity for potential healing and thus the nerve injury to ████ would most likely be permanent.

102. Dr. T believed it would have been extremely difficult to state with certainty inferior alveolar nerve intrusion had occurred or the degree of it. Nevertheless, Dr. T was of the opinion Dr. H did not breach the standard of care expected because following placement of the second implant she immediately informed of possible nerve damage. Further, because of this uncertainty, she felt it was appropriate for Dr. H to give the option to have the implant removed immediately, which declined. The increased bleeding could have been due to the local anaesthetic wearing off, due to cutting bone very close to the nerve canal, or due to intrusion into the nerve canal. It was her opinion continued monitoring of was appropriate in the circumstances based upon a review of the clinical notes and some measure of improvement occurring over time.

103. Dr. A was of the opinion where one is concerned with injury to the inferior alveolar nerve during implant placement, the expected course of action is to remove the implant. When, however, the surgeon is unsure if the canal space is violated, CBCT imaging would be useful before consideration is given to removing the implant. Nevertheless, his opinion was 3-D imaging was not the standard of care and may not have been not readily available to Dr. H. He took exception to Dr. W's conviction, based on two-dimensional imaging, it was apparent the implant was placed into the nerve canal. Nevertheless, he agreed it was subsequently discovered the nerve was most likely transected either partially or fully.

104. Dr. A observed because the clinical notes indicated improvement in the first 12 to 19 days post surgery, a wait and see approach might be reasonable although not conventional. Consequently, at this point, he felt a clinician would be faced with a dilemma. Now there could be a risk of further injury to the nerve during the removal of the implant. Dr. A stated one could fault Dr. H for the implant fixture selection, or immediate replacement of the suspect implant and not obtaining 3-D imaging prior to surgery. He concluded her actions were consistent with that of a competent practitioner.

105. Analysis by Committee-- the evidence is clear Dr. H noted increased bleeding following the placement of the second implant. The evidence showed there could be several reasons for increased bleeding including the local anaesthetic wearing off, a difference in bone density near the nerve canal or an intrusion into the nerve canal and hitting the inferior alveolar artery. Nevertheless, the panel finds the increased bleeding did raise a concern with Dr. H and should have raised a concern that intrusion into the nerve canal may have occurred. As a result, Dr. H sent to have a panoramic x-ray to obtain a more accurate image of the implant placement. The panoramic x-ray photocopy is found at page 61 of exhibit J1 and in exhibit P7.

106. Both Dr. A and Dr. W agreed if issues were noted following the placement of an implant, further investigation was required by a competent practitioner. Although Dr. A was of the opinion intrusion into the nerve canal was not evident from the panoramic view, Dr. W's opinion was the panoramic radiograph found at p. 61 of exhibit J1 and in exhibit P7, coupled with increased bleeding, called for the immediate removal of the implant. Both Dr. A and Dr. W agreed where one is concerned with injury to the inferior alveolar nerve during implant placement, the expected course of action is to remove the implant. The

Committee notes Dr. H testified because the periapical radiographs were taken on an angle, the images were shortened, the panoramic radiograph appeared distorted and consequently she decided to not immediately remove the implant. Although it seemed like she was on the nerve with the second implant, it was her opinion she was still in a safe zone because of her clinical confidence and the perceived radiographic short comings. The fact Dr. H felt it was prudent to take a panoramic radiograph following the second implant placement supports the Committee's view Dr. H was concerned this implant was in very close proximity to the nerve or at a minimum impinging on the 2mm safe zone. The Committee finds Dr. H failed to exercise good judgment when she did not give adequate weight to the requested panoramic radiograph. Further, if she was concerned about the quality of the radiograph, it would have been prudent to seek better radiographic confirmation of the implant location. Better respect of and correlation between radiographic images and clinical assessment at this stage was crucial. Identifying the intrusion into the alveolar canal and immediate removal of the second implant provided the best potential for healing and minimizing nerve damage.

107. The Committee agrees it was reasonable, once the decision was made to leave the second implant in place and the patient was reporting improvements, to monitor patient symptoms. The Committee, however, finds the real concern was on the day of the second implant placement, Dr. H decided to leave the second implant in place. The Committee has reviewed exhibit P7, the radiographs in Ex. J1, the evidence of the experts and finds a competent practitioner faced with the same circumstances should have opted for immediate removal of the second implant. Undertaking immediate implant removal, where implant placement has over-extended the implant safety zone, is the most prudent course of action and the ramifications where one does not follow the most prudent course are serious. The Committee finds this lack in clinical judgment impeded the healing potential of the nerve and consequently a higher chance of irreversible damage. Dr. H testified at this stage, she advised ████ of possible nerve impingement and gave the option of immediately removing the implant or leaving it in place and monitoring progress. Dr. W was of the firm opinion such a decision should not be left to the patient. The Committee finds that a patient attends at a specialist's office for their expert advice and treatment. Where there is increased bleeding and at least the potential of implant intrusion into the nerve canal, the decision on the need for a definitive diagnosis and the safest course of action is one for the specialist.

108. Both Dr. A and Dr. T were of the opinion CBCT imaging was not the standard of care. Dr. W was of the opinion a CBCT should have been taken before implant placement and after implant complications. Nevertheless, Dr. H testified because the panoramic image (page 61 Ex J1) showed some distortion she could have sent ████ for another panoramic image, if she had clinical concerns. She also agreed you could possibly obtain a CBCT image. Although the images from the panoramic radiographs raised some concerns, she testified they were not determinative in her mind. She carried on based upon her clinical assessment. The Committee finds a competent practitioner, when faced with such a situation, should have undertaken further testing whether it be a second panoramic

image or a CBCT which, as Dr. W testified, was available in Regina on the same day. Collaborating a definitive radiographic diagnosis along with a clinical assessment is the most prudent approach.

109. The Committee finds the evidence of was honest and sincere. indicated was certain condition had not improved over time. Nevertheless, testified having no specific knowledge of conversations evidenced in the clinical notes, where there was indication improvement was being noted between January 15 and August 20, 2015. The clinical notes include comments from a dental hygienist and from Dr. H. Although the Committee has concerns with the approach taken by Dr. H immediately following the implant, it accepts likely under-reported symptoms and the clinical notes recorded are likely accurate. The Committee finds Dr. H's follow-up with , once the decision was made to leave the second implant in place, was appropriate. The Committee's concerns, however, remain on the course of conduct undertaken by Dr. H on the day of the placement of the second implant and failure to remove the same.

iii) Committee Conclusions

110. We have carefully reviewed the evidence before us and have reached the following conclusions, on a balance of probabilities, concerning the allegations contrary to section 26 of *The Dental Disciplines Act* and sub-paragraph 9.2(2)(x) of the *Bylaws* (Ex. P1).

111. The Committee does not find professional incompetence has been established demonstrating Dr. H is unfit to continue in the practice of her profession or provide one or more services ordinarily provided as part of the practice of her profession. Nevertheless, as outlined below, the Committee finds professional incompetence has been demonstrated in relation to her treatment of . With respect to the continuation of her practice, the Committee finds that since her treatment of , she has proceeded to upgrade her skills through education (Ex. D6) and has successfully placed numerous implants. Indeed, the PCC concedes they are not arguing Dr. H is an incompetent practitioner generally but rather she acted incompetently in her care of . The Committee, however, does wish to comment on one concern. Dr. H testified she would rely upon her clinical assessment, where the radiograph did not support the clinical assessment. She advised she was taught the radiograph was "to support the clinical assessment" and x-rays may not be an accurate representation of what is in the mouth. She testified there was more value to be gained in the clinical assessment. The Committee is troubled by such a conclusion, and as outlined above, where the radiograph and clinical assessment are different the Committee finds further exploration should be undertaken so that a more definitive assessment can be reached. Nevertheless, when asked what she would do now, if the radiograph and clinical assessment are different, she advised she would take a more cautious approach and request a CBCT. The Committee finds such a diagnostic test should be at the pre-planning or planning stage of implant placement, not post-operatively after the relatively irreversible step of having placed the implant has occurred. Nevertheless, in her testimony, upon further questioning from the Committee,

she indicated prior to placing an implant on the mandible, she currently performs a CBCT at the outset of her planning so that implant placement is more precise. The Committee finds Dr. H was incompetent in her care of ████, however, she has recognized this grave error. Although the Committee still has some concerns, as referenced above, Dr. H has demonstrated she has taken the necessary measures to avoid such a "misadventure" in the future and the public's welfare is not at risk.

112. The Committee relies upon the same evidence, used in determining incompetence pursuant to the *Act,* in finding Dr. H practiced her profession in a way that she was unable to give full force and effect to her training, experience and judgment as acquired during her education, being contrary to 9.2(2)(x) of the *Bylaws.*

113. With respect to the treatment of ████, the Committee finds the intrusion of the second implant into the inferior alveolar canal was avoidable with proper planning. Dr. H's failure to take into account the bone loss evident following the first implant, when measuring the bone available for the second implant, and choosing a 13 mm implant where there was insufficient space for the same, displayed a lack of knowledge, skill or judgment and is professional incompetence within the meaning of *The Dental Disciplines Act* and contrary to 9.2(2)(x) of the *Bylaws.*

114. With respect to the treatment of ████, the Committee finds Dr. H's failure to undertake further exploration to determine whether there had been implant intrusion into the nerve canal, where increased bleeding was noted and the panoramic image, at the very least, showed a possibility of intrusion into the nerve canal displayed a lack of knowledge, skill or judgment and is professional incompetence within the meaning of *The Dental Disciplines Act* and contrary to 9.2(2)(x) of the *Bylaws*. The Committee finds a competent specialist dentist would have recognized the intrusion when ████'s implant was replaced, and failure to remove the implant also displayed a lack of knowledge, skill or judgment and is professional incompetence within the meaning of *The Dental Disciplines Act* and contrary to 9.2(2)(x) of the *Bylaws*.

115. There will be a separate Hearing scheduled to address the issue of penalty.

DATED at Saskatoon, Saskatchewan this 26th day of November 2018.

THE COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN DISCIPLINE COMMITTEE per:

"*Bruce Gibson*"
Bruce Gibson---Chair of the Discipline Hearing Panel

"Hilary Stevens"
Dr. Hilary Stevens---Chair of the Discipline Committee and Member of Discipline Hearing Panel

“Raj Bhargava”
Dr. Raj Bhargava---Member of Discipline Hearing Panel

“Alan Heinrichs”
Dr. Alan Heinrichs---Member of the Discipline Hearing Panel

“Nancy Croll”
Ms. Nancy Croll---Member of the Discipline Hearing Panel and Lay Member of Council