

DOLDEN

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PROFESSIONAL LIABILITY FOR DENTISTS IN CANADA: MANAGING THE RISK

Eric A. Dolden & Colleen O'Neil

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18th Floor – 609 Granville St.
Vancouver, BC
Canada, V7Y 1G5
Tel: 604.689.3222
Fax: 604.689.3777

308 – 3330 Richter Street
Kelowna, BC
Canada, V1W 4V5
Tel: 1.855.980.5580
Fax: 604.689.3777

850 – 355 4th Avenue SW
Calgary, AB
Canada, T2P 0J1
Tel: 1.587.480.4000
Fax: 1.587.475.2083

500 – 18 King Street East
Toronto, ON
Canada, M5C 1C4
Tel: 1.416.360.8331
Fax: 1.416.360.0146

CONTACT LAWYER

Eric Dolden

604.891.0350
edolden@dolden.com

Colleen O’Neil

604.891.5256
coneill@dolden.com

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I. INTRODUCTION:

Dental services and procedures are often inherently risk and do not always achieve their intended results. Patients scrutinize treatments and procedures based on success and any unintended consequences. At that point in time assessing liability becomes a forensic exercise. In order to manage risk, dental practitioners must keep up to date on the law as it evolves, in order to take the steps and precautions necessary to safeguard their dental practices and minimize their exposure to liability.

This paper examines provincial legislation and regulatory regimes across Canada that establish standards applicable to dental professionals, and the disciplinary bodies responsible for regulating the conduct of dental professionals. The law of professional negligence, including the standard of care required of dental professionals, and the law of informed consent are reviewed, with case examples. Practice management tips are provided to assist in preventing claims against dentists. Finally, the limitation periods for patients to make claims against dental professionals are examined in each province.

II. DENTAL LEGISLATION AND REGULATION ACROSS CANADA:

Each province and territory in Canada regulates dental professionals, including dentists and dental hygienists. The regulation of dental professionals in Canada is not federally-legislated. Although the specific regulations vary between provinces, the management and standard of conduct of dental professionals across Canada is relatively uniform.

This section of the paper lists the legislation applicable in each province and territory and provides detailed examples of the standard of care they establish. It also explains the role self-regulating bodies play in enforcing the dental legislation; and consider whether the findings and investigations made by disciplinary bodies may be used against dental professionals in civil claims.

A. REGULATORY FRAMEWORK:

Dental legislation across Canada governs the following issues:

- entry and registration into the profession;
- instruction and restriction of practice techniques;

- the investigation of complaints; and
- professional misconduct and discipline.

To control the governance of these issues, each province has established a self-regulating body, or a professional body comprised of members of the dental profession who are charged with the discipline and regulation of the subscribing members. The Northwest Territories and Nunavut territorial governments deal with regulation and discipline themselves, and have not established independent regulatory bodies for that purpose.

A summary of the applicable statutes and associated self-regulatory bodies is set out in the following table:

<i>Province</i>	<i>Dentists</i>	<i>Dental Hygienists</i>
Alberta	<i>Health Professions Act, RSA 2000, c.H-7, Schedule 7</i>	<i>Health Professions Act, RSA 2000, c.H-7, Schedule 5</i>
	Alberta Dental Association and College (www.dentalhealthalberta.ca)	College of Registered Dental Hygienists of Alberta (www.crdha.ca)
British Columbia	<i>Health Professions Act, RSBC 1996, c. 183</i>	<i>Health Professions Act, RSBC 1996, c. 183</i>
	College of Dental Surgeons of British Columbia www.cdsbc.org	College of Dental Hygienists of British Columbia www.cdhbc.com
Manitoba	<i>The Dental Association Act, CCSM, c. D30</i>	<i>Dental Health Workers Act, CCSM, c. D31</i> <i>Dental Hygienists Act, CCSM, c. D34</i>
	Manitoba Dental Association (www.manitobadentist.ca)	College of Dental Hygienists of Manitoba (www.cdhm.info)
Newfoundland and Labrador	<i>Dental Act, SNL 2008, c.D-6.1</i>	<i>Dental Act, SNL 2008, c.D-6.1</i>

<i>Province</i>	<i>Dentists</i>	<i>Dental Hygienists</i>
	Newfoundland and Labrador Dental Board (www.nldb.ca)	Newfoundland and Labrador College of Dental Hygienists Inc. (www.nlcdh.com)
New Brunswick	n/a	n/a
	New Brunswick Dental Society (www.nbdental.com)	New Brunswick College of Dental Hygienists (www.nbcdh.ca)
Northwest Territories	<i>Dental Profession Act</i> , RSNWT 1988, c. 33 (Supp)	<i>Dental Auxiliaries Act</i> , RSNWT 1988, c. D-3
	Government of the Northwest Territories, Health and Social Services (www.hss.gov.nt.ca/professional-licensing)	Government of the Northwest Territories, Health and Social Services (www.hss.gov.nt.ca/professional-licensing)
Nova Scotia	<i>Dental Act</i> , SNS 1992, c.3	<i>Dental Hygienists Act</i> , SNS 2007, c. 29
	Provincial Dental Board of Nova Scotia (www.pdbns.ca)	College of Dental Hygienists of Nova Scotia (www.cdhns.ca)
Nunavut	<i>Dental Profession Act</i> , RSNWT (Nu) 1988, c. 33 (Supp)	<i>Dental Auxiliaries Act</i> , RSNWT (Nu) 1988, c.D-3
	Government of Nunavut, Department of Health and Social Services (www.gov.nu.ca)	Government of Nunavut, Department of Health and Social Services (www.gov.nu.ca)
Ontario	<i>Dentistry Act</i> , SO 1991, c.24	<i>Dental Hygiene Act</i> , S.O. 1991, c.22
	<i>Regulated Health Professions Act</i> , 1991, SO 1991, c.18	<i>Regulated Health Professions Act</i> , 1991, SO 1991, c.18
	Royal College of Dental Surgeons of Ontario (www.rcdso.org)	College of Dental Hygienists of Ontario (www.cdho.org)
Prince Edward Island	<i>Dental Profession Act</i> , RSPEI 1988, c. D-6	<i>Dental Profession Act</i> , RSPEI 1988, c. D-6

<i>Province</i>	<i>Dentists</i>	<i>Dental Hygienists</i>
	Dental Association of Prince Edward Island (www.dapei.ca)	Prince Edward Island Dental Hygienists' Association (www.peidha.ca)
Québec	<i>Dental Act</i> , CQLR c. D-3 <i>Professional Code</i> , CQLR. c. C-26	<i>Professional Code</i> , CQLR c. C-26
	Ordre des dentistes du Québec (www.odq.qc.ca)	Ordre des hygiénistes dentaires du Québec (www.ohdq.com)
Saskatchewan	<i>The Dental Disciplines Act</i> , SS 1997, c. D-4.1	<i>The Dental Disciplines Act</i> , SS 1997, c. D-4.1
	College of Dental Surgeons of Saskatchewan (www.saskdentists.com)	Saskatchewan Dental Hygienists Association (www.sdha.ca)
Yukon Territory	<i>Dental Profession Act</i> , RSY 2002, c.53	<i>Dental Profession Act</i> , RSY 2002, c.53
	Government of Yukon, Department of Community Services www.community.gov.yk.ca/consumer/pl.html	Government of Yukon, Department of Community Services www.community.gov.yk.ca/consumer/pl.html

B. DENTAL SELF -REGULATING BODIES AND THE BOARD OF INQUIRY:

The specialized nature of dental medicine has led most provinces and territories to defer interpretation and enforcement of the prescribed standards of conduct to dental self-regulatory bodies.

Dental self-regulatory bodies include the provincial colleges of dental surgeons (the “Provincial Colleges”) and the provincial dental associations (the “Associations”). The Provincial Colleges develop specific practice standards in concert with the applicable legislation when required. The Associations typically promote the interests and educational standards of dental professionals.

Federally, the Canadian Dental Association (“CDA”) has instituted a Code of Ethics. The CDA Code of Ethics is a set of principles of professional conduct to which dentists

must aspire to fulfil their duties to patients, the public, the profession, and their colleagues. Only Nova Scotia has adopted the National Code of Ethics, by regulation.¹

The provincial governments of British Columbia, Prince Edward Island, Alberta, and the Yukon all defer investigation and enforcement of practice standards to the provincial self-regulatory body, permitting those bodies to investigate and penalize members for professional misconduct.

In the Northwest Territories and Nunavut, a “Board of Inquiry” controls the interpretation and enforcement of dental practice standards. Section 49 of the *Dental Profession Act*, RSNWT 1988, c. D-3 provides that the Board of Inquiry is composed of the following:

- at least one licensee nominated by the Northwest Territories Dental Association, a society incorporated under the *Societies Act* (Northwest Territories);
- at least one person entitled to practice dentistry in a province or the Yukon Territory; and
- at least one member of the public.

The maximum number of members to sit on the Board of Inquiry is five.

Self-regulating bodies play an important role in managing the dental professions, as the legislation applicable to the dental profession across Canada does not completely define the applicable practice standards.

For example, British Columbia’s *Health Professions Act*, RSBC 1996, c. 183 provides at s. 33:

- (4) *The inquiry committee may, on its own motion, investigate a registrant regarding any of the following matters:*
- (a) *a contravention of this Act, the regulations or the bylaws;*
 - (a.1) *a conviction for an indictable offence;*
 - (b) *a failure to comply with a standard, limit or condition imposed under this Act;*
 - (c) *professional misconduct or unprofessional conduct;*
 - (d) *competence to practise the designated health profession;*
 - (e) *a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practise the designated health profession.*

¹ *Code of Ethics Regulation (Regulation Number 3)*, N.S. Reg. 165/93.

The definition of “professional misconduct” includes “infamous conduct and conduct unbecoming a member of the health profession”. The *Act* does not define “infamous conduct”, “conduct unbecoming”, or “competence to practice”. The void in the BC *Act* is filled by the statutory power to enact “rules” that are established and enforced by the British Columbia College of Dental Surgeons (the “Rules”). The Rules set out a number of prohibited practices and conduct, as well as a Code of Ethics.

In Saskatchewan the *Dental Disciplines Act*, SS 1997, c. D-41 (The “*Disciplines Act*”) includes general statutory definitions of professional competence and misconduct. Specifically, ss. 26-27 of the *Act* states that professional incompetence is a “*question of fact*”:

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 a member 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 a part of the practice of that member’s profession;*

is professional incompetence within the meaning of this Act.

27 *Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:*

- (a) *it is harmful to the best interests of the public or the members of the association;*
- (b) *it tends to harm the standing of the member’s profession;*
- (c) *it is a breach of this Act or the bylaws of that member’s association; or*
- (d) *it is a failure to comply with an order of the professional conduct committee, discipline committee or council of that member’s association*

The application of those standards contained in the *Disciplines Act* is left to the College of Dental Surgeons of Saskatchewan.

Section 63 of the Northwest Territories’ and Nunavut’s *Dental Profession Acts* (RSNWT 1988, c. D-3; RSNWT (Nu) 1988, c. 33 (Supp)), list criteria constituting “professional misconduct” or “unskilled practice” as conduct that “*is detrimental to the best interest of the public*”; “*contravenes this Act or the regulations*”; “*harms or tends to harm the standing of the profession of dentistry generally*”; or “*displays a lack of knowledge of or lack of skill or judgment in the practice of dentistry.*”

It is the role of the “Board of Inquiry” to interpret and enforce the standards.

Ontario² and Québec³ have both established, by regulation, lengthy codes of ethics and standards of practice. However, while these regulations are detailed, they are also couched in general terms and defer to the standards established by the provincial self-regulatory body.

For example, Ontario’s *Professional Misconduct Regulation* sets out more than 60 examples of professional misconduct, the first of which is to “*contraven[e] a standard of practice or fail to maintain the standards of practice of the profession*”. The standards of practice of the profession are those established by the Royal College of Dental Surgeons of Ontario. Examples of cases in Ontario where dentists have been disciplined as a result of findings of professional misconduct include:

- providing unnecessary dental service
- providing treatment beyond their competence and expertise
- charging excessive or unreasonable fees in relation to the service performed
- delegating procedures to employees not qualified to perform the procedure
- falsifying records
- submitting false or misleading accounts

Examples of cases in Alberta where dentists have been disciplined as a result of being found guilty of unprofessional conduct in accordance with the *Health Professions Act*, include:

- displaying lack of knowledge, skill or judgment
- failing to provide appropriate treatment
- failing to refer to a specialist
- failing to obtain informed consent from the patient
- failing to consider patients health issues in treatment planning
- failing to keep appropriate dental records
- exceeding approved levels of sedation
- prescribing inappropriate prescriptions and dosages

In sum, all of the provinces, but not the territories, have enacted legislation setting out the professional standards of care, to be further developed and enforced by self-regulating bodies and Boards of Inquiry.

² Professional Misconduct Regulation, O. Reg 853/93

³ *Code of Ethics of Dentists*, CQLR c.D-3, r.4.

C. USE OF DISCIPLINARY FINDINGS IN CIVIL CLAIMS:

When a self-regulating body employs its statutory powers to investigate or discipline its members, the question often arises how and to what extent the disciplinary action and records might affect a civil action.

This section of the paper considers first whether the findings of the self-regulatory body or Board of Inquiry are admissible in civil proceedings as evidence of the common law standard of care. Secondly, may a patient rely on a dentist's past misconduct as evidence that the dentist has a propensity towards such misconduct? Finally, may a patient obtain and use evidence collected by the self-regulating body or Board of Inquiry, in order to establish the dentist's negligence?

Generally, the courts will not admit a dentist's disciplinary records as "direct evidence" of misconduct in relation to a single claim. For example, in *Sawchuk v. Lee-Sing*,⁴ the plaintiff sued two dentists for professional negligence. The plaintiff had previously complained about the dentists to the College of Physicians and Surgeons (the "College"). The plaintiff wanted to introduce the College's findings on the prior complaint as evidence in the civil trial to support her claim. The court held that evidence of the prior proceeding was hearsay and refused to admit it in the civil trial.

The trial judge in *Sawchuk, supra*, also refused to admit evidence from the previous disciplinary proceeding on the basis that such evidence could be highly prejudicial, especially to a jury:

... there is a very great danger that such evidence, even if otherwise admissible and capable of being given some weight, would be very prejudicial if given before a jury. The tendency of lay persons to defer to the opinion of a panel of the defendants' peers selected to investigate the defendants' professional conduct would be very great. All the cautions in the world on my part would not likely overcome that danger. The jury's function is to decide the very question the Complaint's Committee apparently decided.

However, there are several exceptions to the general rule. For example, a plaintiff is entitled to allege in his or her pleadings the results of a professional disciplinary committee.⁵ Further, if the findings of the disciplinary committee are in the favour of the medical practitioner, the findings will likely be admissible in a civil trial because any risk of prejudice to the defendant dentist is minimized.⁶ This is an important factor to consider in defending dental malpractice claims.

⁴ (1987), 58 Sask R. 94 (QB).

⁵ *Spataro v. Handler* (1988), 26 CPC (2d) 28 (Ont. Dist. Ct.), followed *Spectra Architectural Group v. St. Michael's Extended Care Centre Society*, 2001 ABQB 887.

⁶ *Etienne v. McKellar General Hospital*, [1994] OJ No. 2602 (QL) (Gen. Div.).

Another significant exception to the general rule against admission of evidence from administrative proceedings is that the court will permit a plaintiff to admit past disciplinary records of his or her dentist in limited circumstances as “similar fact evidence”.

The three-step test to be applied in determining the admissibility of similar fact evidence was explained by the Supreme Court of Canada in *R. v. Handy*:⁷

- (a) assessment of the probative value of the proposed evidence;
- (b) assessment of the potential prejudicial impact; and
- (c) a balancing of the probative and prejudicial effects.

The question of whether the evidence or records sought to be admitted will pass the test in *Handy* is subjective and will depend on the particular circumstances of each case. For example, if a plaintiff accuses a dentist of sexual misconduct, the evidence of a complaint going against the dentist for sexual harassment in the workplace may or may not be excluded depending on the prejudicial effect of the claim. Unlike in criminal civil practice there is no absolute bar to the use of similar fact evidence.

However, the possible inadmissibility of documents for any of the reasons listed in *Handy* above does not relieve the self-regulating body or Board of Inquiry from being required to produce, upon a proper written request, the results of its investigation including witness statements or investigator notes. The standard of document disclosure in Canada is governed by the applicable privacy legislation, and a self-regulating body or Board of Inquiry is not entitled to withhold information based on its own assessment of admissibility. For example, in *El-Bayoumi v. Wade*,⁸ the court ordered the New Brunswick Dental Society to disclose to the plaintiff tape recordings of the disciplinary hearing conducted as a result of the plaintiff’s complaint, even though the court noted that the recordings would not be admissible at trial.

Practically speaking, it is interesting to note that a defendant/accused in a civil or criminal proceeding can apply to the judge in the criminal or civil proceeding to have the disciplinary proceedings delayed pending the outcome of the civil proceedings regardless of the admissibility of the disciplinary proceedings.⁹

⁷ [2002] 2 SCR 98.

⁸ (1989), 41 CPC (2d) 300 (NBQB, Trial Div.).

⁹ *S. (S.J.) v. College of Physicians & Surgeons (Saskatchewan)*, 1998 CarswellSask 410

III. PROFESSIONAL NEGLIGENCE:

Professional negligence is a subset of the general rules of negligence. A claim in professional negligence depends on establishing that the defendant owed a duty of care to the claimant; that the defendant breached that duty; and that the breach caused loss or injury that should be compensated in damages.

A. THE STANDARD OF CARE:

The legal standard of care for dentists, like other professionals, is that they must provide dental services to their patients in a reasonable and prudent manner. Whether the professional has one year's experience or thirty, whether the dentist practices in a rural or urban setting, a dentist will be held to the same standard of care as his or her peers in terms of their diligence, technique, professional education, and judgment. A practitioner who fails to meet the standard of care with respect to any part of a dental treatment and who causes injury as a result can be found liable in negligence.

Consider the case of *Kangas v. Parker*.¹⁰ Mr. Kangas went to his dentist to have eleven teeth removed. The dentist had an anaesthetist put Mr. Kangas under general anaesthetic and proceeded to perform the dental extraction in his office. After ten of Mr. Kangas' teeth were removed, Mr. Kangas choked on his own blood and died. Both the dentist and the anaesthetist were found negligent. The anaesthetist was responsible for keeping Mr. Kangas' air tract open during the extractions, and the dentist for monitoring Mr. Kangas' status through the full view of his mouth. The doctors' collective failure to recognize and correct the escape of blood breached the standard expected of the profession. The breach of the duty of care was found to have caused the death of the patient.

To succeed in a professional negligence suit, the plaintiff will typically need another dentist to provide an expert opinion that the defendant dentist breached the standard of care, and that this breach caused the plaintiff's injuries.¹¹ As succinctly stated in *Drougov v. Apotex Inc.*,¹² if a plaintiff is to succeed in a medical professional negligence action, a plaintiff requires evidence, typically expert evidence, to establish: (1) the standard of care; (2) whether there was a breach of the standard of care; and (3) causation. Expert evidence is required because dentistry is a technical subject outside of judges' ordinary knowledge and expertise.¹³ As a result, judges frequently dismiss cases where the

¹⁰ [1978] 5 WWR 667 (SKCA).

¹¹ *Szubielski v. Price*, 2013 NSCA 151.

¹² *Drougov v. Apotex Inc.*, 2015 ONSC 2896.

¹³ *Claudia and Louis Sytsma v. Dr. Keleshian and others*, 2015 ONSC 138.

plaintiff fails to adduce expert evidence as to standard of care, and how it was breached.¹⁴

B. WHEN THE PROFESSIONAL STANDARD IS UNREASONABLE:

Following standard medical practice does not ‘suit-proof’ a dentist from a claim in negligence if the average practice itself is found to be unreasonable.

In *Rossmann v. Sas*,¹⁵ a patient alleged her dentist had negligently perforated her sinus during dental surgery, causing her chronic sinus infections. Further, Ms. Rossmann claimed that the surgical treatment was done without her informed consent, as she had not been told by her dentist that perforation of her sinus cavity was a material risk. The dentist called evidence at trial that his standard practice complied with the accepted medical standards, but the court concluded that a simple procedure involving blowing air into Ms. Rossmann’s mouth could have easily detected the perforation. Consequently, while the dentist had conformed to the professional standards existing at the time, the standards themselves were unreasonable. The court stated that compliance with existing standards will still be negligent where there are obvious existing alternatives “*which any reasonable person would use to avoid the risk.*”

Read together, *Kangas* and *Rossmann* demonstrate that the courts’ focus in negligence cases is public protection. The courts will not allow a profession to maintain standards that endanger those who use the service. Accordingly, while the legal standard of care for a dentist may be described as that of the ‘average’ practitioner, average dental practice itself will also be scrutinized for its reasonableness whenever an individual dentist’s actions are called into question. This requires the profession as a whole to be self-conscious and self-policing – proactively advancing its professional standards to avoid stagnation of procedure or practice that could jeopardize the public.

With the standard of care constantly evolving, dentists must stay at or near the forefront of developments in their profession and constantly upgrade their professional practices, both to safeguard patients and, in so doing, avoid claims of negligence.

C. TYPICAL DENTAL CLAIMS:

Typical negligence claims made against dentists include the following:

1. **Poor Craftsmanship:** faulty crowns and bridges; cuts to the patient’s lip or tongue; fractured root tips remaining after extraction and root fractures following extraction; and chemical burns.

¹⁴ *Oliver v. Dr. B. Cervienka Inc.* 2011 BCPC 371; *Guerrero v. Trillium Dental Centre*, 2014 ONSC 3871.

¹⁵ [1997] OJ No. 4384 (Gen. Div.).

2. **Inattention to the patient and/or patient records:** extraction of the wrong tooth; failure to diagnose cavities and periodontal disease; problems associated with TMJ (temporomandibular joint) disorder; fractured file or reamers tips left during root canal therapy; paresthesia due to extrusion of endodontic medicaments and sealers; medical complications arising from failure to obtain or update medical history; and problems associated with anaesthesia.
3. **Communication breakdowns between the dentist and the patient:** failure to obtain informed consent to perform a procedure, discussed below; and failure to inform the patient about a problem during a dental procedure or treatment.
4. **Injures consequent to treatment:** infection after tooth removal; and aspiration of foreign objects such as crowns.
5. **General family dentists taking on work that requires a specialist:** failure to refer patients to specialists to obtain second opinions, and performing work outside of the general dentist's expertise.

D. PROBLEMS ASSOCIATED WITH PRESCRIBING MEDICINE:

Dentists may possess, administer, and prescribe drugs in the course of treating patients. Accordingly, dentists must comply with the regulatory regimes and professional standards attaching to this privilege. Legislation monitoring the right to prescribe prescription drugs includes the federal *Narcotic Control Regulations* and *Benzo Diazepines Regulations*.

The applicable legislation provides that a dentist must administer drugs only to his or her patients. All prescriptions must be paired with documented complaints and the prescriptions be compatible with the applicable diagnosis. Further, dentists must only prescribe drugs within the scope of their practice; for example, a dentist could administer Valium to a patient before a dental procedure, but not to treat depression. All prescriptions must contain the patient's name, drug identification, quantity to be provided, and practitioner's authority. Dentists must keep records of narcotics prescribed and make these records available to inspectors on request. Records of prescriptions made must be kept for *at least two years*.

Dentists must only store narcotics and benzo diazepines ("targeted substances") on business premises if access is limited to authorized employees and the dental office is adequately protected from theft. If a "targeted substance" is lost or stolen, the dentist must report the loss to the Federal Minister of Health within ten days.

Dentists must also be diligent when disposing of “targeted substances”. Specifically, provincial environmental regulations provide that another dentist or practitioner must witness the destruction of a “targeted substance” and both must sign and print their names on a joint statement. Failure to adhere to the legislative provisions regarding prescription drugs can result in criminal charges, disciplinary actions by the applicable professional body, or both. Federal regulatory consequences may also ensue, such as loss of the ability to prescribe medications.

If a dentist develops an addiction to a “targeted substance”, he or she must report the addiction to the applicable self-regulating body or Board of Inquiry, which may require the dentist to seek treatment, and ask the Federal Minister of Health to restrict his or her access to prescription drugs.

E. GOOD DENTAL PRACTICE MANAGEMENT:

Dentists should cultivate and maintain an image of professionalism and competence in the dental office. Offering patients a professional atmosphere requires friendly and competent personnel. Attention to every aspect of a professional office is important.

One of the most important aspects of maintaining dental professionalism are the clinical notes. Thorough, detailed clinical notes may help in the defence of malpractice claims. Dentists must obtain a complete medical and dental history of each patient, date it and update the note with every visit, and record progress, symptoms, and changes. Dentists must also examine patients thoroughly, record their findings, and provide a working diagnosis. The clinical notes should contain information that supports or challenges the diagnosis with tests so treatment and technique can be defended later, if necessary. Ethically, dentists must treat each patient with dignity and respect; maintain good rapport; be honest about problems that arise; and refer patients out where necessary. Finally, dentists should always be encouraged to contact their professional liability program (“PLP”) with questions and, of course, notices of claims being advanced.

Conversely, dentists should not exceed their competence by making extravagant promises to patients, or permitting the patient to dictate treatment. Even if a dentist has a strong relationship with a patient they should not talk to patients about confidential information and should avoid criticizing other medical practitioners. If the professional relationship has broken down between the dentist and the patient, the dentist should not continue to treat the patient and should not bill for care or treatment that might reasonably be expected to result in a malpractice suit.

F. REFERRALS:

Dentists must be careful to not exceed their expertise, and should refer patients to specialists when necessary. A frequent source of complaints and lawsuits is that the general dentist failed to refer the patient to a specialist for a second opinion or a specific procedure. Dentists who recognize the limitations of their expertise and refer care when necessary to specialists significantly minimize their liability risks. Reasons for a referral to a specialist may include:¹⁶

- the complexity of the case;
- the treatment plan objectives;
- the patient's medical objectives;
- the referring dentist's skill and comfort levels;
- the patient's medical condition;
- access to specialized equipment and/or tests;
- staff training and skill level; and
- the patient's wishes

All dentists must stay current on advancements in their field in order to provide all treatment options to patients and meet the current accepted standard of practice for the treatment. Given the broad spectrum of knowledge within the field of dentistry, no one dentist could be expected to have knowledge of every procedure. If a dentist cannot keep current in the field of treatment required by a patient, then he or she must refer the patient to another practitioner.¹⁷

G. WHAT TO DO - AND NOT DO - WHEN A PROBLEM ARISES:

It is a fact of any professional practice that some patients will have adverse physical or even emotional reactions to particular treatments; refuse to pay outstanding accounts; or behave in a belligerent, aggressive, or threatening manner toward the treatment provider. When this occurs or when a dental professional is served with notice from a lawyer that a legal action is contemplated or pending, the standard plan to guide a dentist's reaction and decrease the potential impact of the claim should include the following:

Practice Management "Do's":

- Remain calm.

¹⁶ Practice Advisory, June 2012, Royal College of Dental Surgeons of Ontario

¹⁷ New Technologies in Health Care. Part 2: A Legal and Professional Dilemma. JCDA, September 2008, Vol 74, No 7.

- Notify the applicable professional liability program immediately of any legal action or incident that could result in legal action.
- Instruct staff not to speak with anyone about the incident.

Practice Management “Don’ts”:

- Do not panic.
- Do not admit liability for the alleged transgression or error.
- Do not assume the suit or incident will go away if you ignore it.
- Do not contact a patient who has started a lawsuit against you or retained a lawyer.
- Do not talk to the patient’s lawyer. Instead, refer him or her to your insurer.
- Never alter or add any notes to the patient’s record.
- Do not lose patient records.
- Do not treat the patient after the suit begins, except in an emergency.
- Do not make any chart notations about the legal action, your conversations with your insurer or lawyer, or any other matter relating to the legal action. If you wish to make such notes, do so on a separate sheet for your own confidential records.
- Do not write on original court documents. (You may find it helpful to put these into plastic document holders to prevent you from writing on them.)
- Do not seek information about the patient from other practitioners.
- Do not give away original records.

Ultimately the best defence to a claim is a strong offence. Dentists, armed with the proper tools, may not be able to avoid unhappy patients but will be able to

professionally respond to and defend claims against them by employing positive practice management techniques.¹⁸

IV. LIABILITY FOR BREACH OF FIDUCIARY DUTY:

A. FIDUCIARY DUTY OF MEDICAL PROFESSIONAL TO PATIENT:

Like other medical professionals, dentists owe a fiduciary duty to their patients. The concept of fiduciary duty was developed in the seminal case of *Norberg v. Wynrib*.¹⁹

In *Norberg*, the young plaintiff Ms. Norberg suffered from severe headaches and jaw pain. She was prescribed painkillers to reduce her pain while doctors considered a diagnosis. The cause of her pain was eventually determined to be an abscessed tooth. However, by the time the tooth was removed, Ms. Norberg had become addicted to painkillers.

Driven by her addiction, Ms. Norberg obtained painkillers from a medical practitioner, Dr. Wynrib. Realizing that Ms. Norberg was addicted, Dr. Wynrib proposed a “sex-for-drugs” arrangement, to which Ms. Norberg ostensibly “consented”. Eventually, Ms. Norberg underwent treatment for her addiction, and brought an action against Dr. Wynrib for, among other things, breach of fiduciary duty.

At issue in the case was whether Dr. Wynrib owed Ms. Norberg a fiduciary duty. The Supreme Court of Canada described the three characteristics of a fiduciary relationship as follows:

- the fiduciary has scope for the exercise of some discretion or power;
- the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary’s legal or practical interests; and
- the beneficiary is peculiarly vulnerable or at the mercy of the fiduciary holding the discretion or power.²⁰

The Supreme Court of Canada also emphasized that patients are particularly vulnerable, as they are encouraged to trust and confide in doctors. The exchange of confidential information, accordingly, is another mark of the fiduciary relationship. The

¹⁸ Adapted from “Risk Management Guide: a Handbook for Ontario Dentists”, Section 4 “Malpractice - Proofing A Dental Practice” (October 2005).

¹⁹ [1992] 2 SCR 226.

²⁰ [1992] 2 SCR 226

Court ultimately concluded that Dr. Wynrib owed Ms. Norberg a fiduciary duty, arising inherently from the doctor-patient relationship.

The characterization of the doctor-patient relationship as fiduciary in nature has also been extended to apply to dentists. In *R. (J.) v. White*,²¹ the 33-year old plaintiff sought damages from a dentist for sexual assaults that had begun when the plaintiff was only 13 years old. The dentist argued that he did not owe the plaintiff a fiduciary duty, as there was no exchange of confidential information that would give rise to a relationship of trust. The court disagreed, concluding that the fact that the defendant was a dentist and not a doctor did not materially alter any of the considerations established in *Norberg*. The dentist did indeed owe the plaintiff a fiduciary duty.

B. PROTECTION OF PATIENTS' PRIVACY:

Fundamental to the fiduciary obligation owed by a dentist to his or her patient is the protection of doctor-patient confidentiality and the protection of a patient's right to privacy. A patient's right to privacy was confirmed in the Ontario Court of Appeal's decision in *Re Axelrod*.²² Dr. Axelrod was a dentist who had financed his practice through a loan secured by a general security agreement ("GSA") from a company called Medi-Dent. Dr. Axelrod's business failed, and he declared bankruptcy. Medi-Dent sought to enforce the security provided for in the GSA, the most valuable part of which was Dr. Axelrod's patient records and patient list. Among other things, Medi-Dent asked the court for an Order that Dr. Axelrod's patient files and lists be transferred to a qualified dentist. Dr. Axelrod opposed Medi-Dent's request on the basis that his fiduciary obligations to his patients, and specifically his duty of confidentiality, precluded the list and files from being valid security.

In concluding that Medi-Dent *could* transfer Dr. Axelrod's patient files to another dentist, the court made several important comments on the confidentiality aspect of the fiduciary duty. Specifically, the court noted that Dr. Axelrod owed his patients a duty to serve their best interests, and that: "*best interests are not strictly limited to medical needs, but also encompass privacy and confidentiality*". The court further noted that Dr. Axelrod would have had the right to sell his practice to another dentist, and that the right to sell his practice was not intrinsically different from his pledge of the records as security. However, the duty of confidentiality imposed by Ontario's *Professional Conduct Regulation* also required Dr. Axelrod to keep the identity of his patients confidential, which Dr. Axelrod argued led to an inevitable conflict with his contractual obligation to Medi-Dent.

²¹ (2001), 52 OR (3d) 353 (ONSC).

²² (1994), 29 CBR (3d) 74.

The court phrased this apparent conflict as follows:

The appellant's unwillingness to contact his patients in order to assist the respondent in executing on its security creates an additional problem if the duty of confidentiality extends to a duty to keep the patients' identity confidential. In other words, is the dentist duty bound to keep the very existence of the dentist-patient relationship confidential, except with the patients' consent, or except when otherwise compelled by law to disclose the existence of that relationship? ... The language of section 17 of Reg.853/93 appears broad enough to encompass a duty to keep the dentist-patient relationship in confidence, even to another dentist, except with the consent of the patient. Without the appellant's co-operation, it would be impossible in this case to protect that confidence. This is something that the appellant may have to answer for to the appropriate authorities.

Without each patient's consent, Dr. Axelrod's contractual agreement to disclose patient records, breached the fiduciary duty he owed to his patients, and violated the applicable *Professional Conduct Regulations*.

Re Axelrod emphasizes the duty of confidentiality as a fundamental aspect of the fiduciary duty owed by the dentist to his patient. The duty of confidentiality has been recognized by each of the Provincial Colleges and a breach of that duty can result in a finding of professional misconduct. In addition to the professional duty imposed on dentists to keep patient records confidential dentists are also required to comply with provincial privacy legislation, which adds a further layer of complexity.

Some provinces have passed statutes which specifically address the management of health information.²³ Others such as British Columbia, rely on their general provincial privacy legislation for standards for managements of patient information (the "Acts").²⁴ In provinces that have not passed provincial legislation, the federal *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c.5 ("PIPEDA") applies to all "organizations", including dental offices. Between them, *PIPEDA* and the *Acts* regulate across Canada the collection, use, and dissemination of personal information collected in the course of business.

PIPEDA and the *Acts* set out minimum personal information protection measures that organizations, including dental offices, must comply with. Dentists have a statutory duty to protect patients personal information. *PIPEDA* and the *Acts* generally require that personal information be kept confidential and that the patients' consent be sought prior to any disclosure to any third party. Discussions with patients regarding the

²³ Alberta *Health Information Act*, 2000, c.H-5; Ontario *Personal Health Information Protection Act*, 2004, SO 2004, c.3, Sch. A.

²⁴ *Personal Information Protection Act*, SBC 2003, c.63.

disclosure of records should be noted in the patients' charts, and a signed consent form or authorization should be obtained before any personal information is released.

Dental offices must take reasonable steps to safeguard patient records, including all paper, electronic and other forms of patient information and dental records, in order to ensure its protection against theft, loss, unauthorized use, disclosure, copying, modification and disposal.²⁵

In the event of a security breach that poses a real risk of significant harm to the patient, the *Alberta Personal Information Protection Act* requires Alberta dentists to notify affected parties about the security breach.²⁶ In order to determine whether there is a "real risk of significant harm" the sensitivity of the information that has been breached must be considered, as well as the likelihood that the information has been or might be misused. If such a breach occurs the dental office must notify the Alberta Privacy Commissioner as well as the patient. Recent amendments to PIPEDA, not yet in force, will apply similar notification provisions to all Canadian jurisdictions to which that statute applies.²⁷

In the event of breach of patients' privacy, *PIPEDA* and the *Alberta and British Columbia Acts* allow patients to sue organizations, including dental offices, for damages. *PIPEDA* authorizes a complainant to bring an action in court following a report of a Commissioner, and authorizes the court to award damages for breach of privacy. The *Acts* in British Columbia and Alberta create a statutory cause of action for damages resulting from a breach of the Act found by the Commissioner, if an individual has suffered loss or injury as a result of the breach.

The duty of confidentiality of information has become one of the keystones of dental practice. Dentists and other health professionals who have access to confidential information must be sensitive to their duty of confidentiality. The duty of confidentiality is expressed first, by the common law through the doctrine of fiduciary duty; second, by the rules set out by their governing self-regulating body; and third, by the privacy legislation of their province.

²⁵ *Dental Recordkeeping Guidelines*, College of Dental Surgeons of British Columbia, April 2013.

²⁶ SA 2003, c. P-6.5.

²⁷ SC 2015, c. 32, previously Bill S-4.

V. LIABILITY FOR FAILURE TO OBTAIN INFORMED CONSENT:

A. THE EVOLUTION AND DEFINITION OF INFORMED CONSENT:

Prior to 1980, Canadian professional negligence law tended to favour the medical practitioner. Simply, if a patient consented to treatment, no matter how ill-advised, the patient had no action against his or her doctor for resulting personal injury, or “trespass”. However, Canada moved away from the aforementioned paternalistic approach in *Reibl v. Hughes*,²⁸ a Supreme Court of Canada decision involving a surgeon who failed to warn a patient of the risk of paralysis associated with an elective surgery.

The case considered the doctrine of “informed consent”. Informed consent is a process of dialogue involving ongoing, full, and complete discussions between a healthcare practitioner and a patient regarding both disclosure and appreciation of the “material”, “special”, or “unusual” risks associated with a proposed procedure and treatment. Informed consent also entails the opportunity to evaluate knowledgeably the options available and the risks attendant upon each option.

A patient’s consent is only considered “informed” if the patient has been sufficiently educated by his or her medical practitioner to enable him or her to make a reasoned choice whether to proceed with a particular medical procedure or treatment. In order for the patient to make a reasoned choice the dentist should include the prognosis, alternative goals and means of treatment, success and failure rates, benefits and material risks of the treatment, possible alternative treatments and consequences, and the risks of refusing the treatment.²⁹

The obligation to provide treatment options to the patient requires dentists to keep up to date on the latest developments and technologies in their field. While a dentist is not obliged to disclose treatment options that are considered experimental, they should be aware of any significant advances in their field and inform their patient of all options that are considered to be standard practice.³⁰ It is recommended that dentists attend continuing education courses, seminars, study groups and review the updated literature in their field to meet this obligation.

The test of reasoned choice is a “modified objective test”. In other words, the plaintiff’s subjective assertion that he or she did not consent to a procedure is evaluated against

²⁸ [1980] 2 SCR 880.

²⁹ “New Technologies in Health Care. Part 1: A Moral and Ethical Predicament”, JCDA, Sept. 2008, Vol 74:7.

³⁰ “New Technologies in Health Care. Part 2: A Legal and Professional Dilemma”, JCDA, Sept. 2008, Vol. 74:7.

the objective evidence as to what a reasonable person, requiring the same medical treatment, would have done in a similar circumstance.

Evidence that informed consent has been achieved is grounded in the full recording of all discussions between a health care practitioner. The discussion should be recorded in writing, and witnessed in the patient's clinical records.

A medical practitioner is legally and ethically obligated to treat a patient within the limits of the consent provided. A treating medical practitioner may avoid liability and damages for battery if he or she can provide evidence of a valid consent.

B. THE STANDARD OF DISCLOSURE:

To obtain the consent of a patient for the performance upon him or her of a medical procedure, a medical practitioner is required to disclose to his or her patient the "*nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the operation.*"³¹

The standard of disclosure can be broken down into the following three components:

- Was the risk material, unusual or special?
- If so, should the doctor have disclosed that risk?
- If so, did the breach of the duty the cause of the plaintiff's damages?³²

Materially, the focus of the standard of disclosure is not on what a reasonable and prudent practitioner would regard as relevant to disclose, but rather on what a "reasonable person" *in the patient's position* would need to know and understand to provide a valid consent.³³ Accordingly, a medical practitioner must disclose all risks that a patient would likely consider significant in deciding whether to undergo a proposed treatment.

To appreciate what a reasonable person in the patient's position would consider relevant during the course of treatment the onus is on the medical practitioner to keep an updated medical history and engage in ongoing dialogue with his or her patient.³⁴

Consider that one in every 100,000 wisdom tooth extractions results in a jaw fracture; since the risk of a jaw fracture is so low, no warning is typically required.³⁵ A medical

³¹ *Hopp v. Lepp*, [1980] 2 SCR 192; 112 DLR (3d) 67, p.81.

³² *Videto v. Kennedy* (1981), 33 OR (2d) 497 (CA), pp. 501 and 503.

³³ *Reible v. Hughes*, *supra*.

³⁴ *Rawlings v. Lindsay* (1982), 20 CCLT 301 (BCSC), p. 306.

³⁵ *Dickie v. Minnett*, 2012 ONSC 4474

practitioner is not legally obligated to inform the patient of the risk if there is nothing particular to the patient's bone structure to increase the risk of a jaw fracture. The risk is not material.³⁶ Similarly, there is no obligation on the medical practitioner to warn the patient of risk of numbness associated with performing a local anaesthetic and intravenous sedation, as such an injury was so rare.³⁷ However, if the dentist is aware that the patient has severe osteoporosis, or a history of adverse reactions to anaesthetic, then the risks of a fractured jaw or ongoing numbness would be material to *that* patient.

C. IS THE RISK MATERIAL, UNUSUAL OR SPECIAL?:

Material risks are significant risks that pose a real threat to the patients' life, health or comfort. In considering whether the risk is material, one must balance the severity of a potential result with the likelihood of the risk occurring. If there is a small chance of serious injury or death the risk must be considered material. Conversely, if there is a significant chance of a slight injury the risk is material.

Unusual or special risks are rare occurrences that are known to occur occasionally. However, in comparison to a material risk, an unusual or special risk is less dangerous and not frequently encountered.³⁸

Consider the risks associated with a root canal. During a root canal, drill bits sometimes break off and lodge in the root of a tooth. Often the dentist cannot remove the drill bit from the root without permanently damaging the tooth. Is this risk material? Does a dentist need to disclose the risk? It is not the frequency alone that a drill bit could break during a root canal that makes this risk material; materiality also depends upon the consequences of the break. The risk that a drill bit will break during a root canal is not a material risk because the consequence of drill breaking off in the root of a decaying tooth is no greater than the consequence of the tooth decay.³⁹ However, after the drill bit becomes lodged in the root, and it is determined it cannot be removed, a medical practitioner has a duty to disclose information about the options for further treatment.⁴⁰

A treating practitioner that is asked a specific questions about a personal concern is also obligated to answer the patient's specific questions in a reasonable way.⁴¹ In the age of internet research, personal concerns are increasing as patients have greater access to information – and misinformation – about the risks associated with a procedure. When

³⁶ *Carter v. Higashi* (1993), 15 Alta. L.R. (3d) 51 (QB)

³⁷ *Kumar v. Braverman*, 2014 BCPC 304

³⁸ *White v. Turner* (1981), 31 OR (2d) 773.

³⁹ *Curteneau v. Kapusianyk*, 2001 BCSC 1290; *Kuper v. McMullin* 37 CCLT 318, 30 73 NBR (2d) 288.

⁴⁰ *Kuper v. McMullin*, *supra*.

⁴¹ *Hopp v. Lepp*, [1980] 2 SCR 192.

answering a patient's specific questions, a medical practitioner is entitled to filter or generalize the information provided, in consideration for the patient's emotional condition, including any apprehension or reluctance to undergo a procedure or treatment.⁴²

D. THE DUTY TO DISCLOSE THE RISKS:

While expert medical evidence is relevant to the determination of material risks, the scope of the duty of disclosure is not established on the basis of professional medical standards alone. The subjective concerns and unique nature of each individual patient also determines the materiality of a risk. A medical practitioner has the obligation to research the condition of each of his or her patients and disclose information relevant to the individual patient.

If a patient challenges the extent of the disclosure made, the court should consider the following factors:

- inherent risks of treatment;
- whether the ramifications of treatment are serious;
- the frequency of the risk;
- the information normally given to patients undergoing the same procedure;
- the gravity of the patient's condition;
- the importance of the benefit of the treatment;
- any need to encourage the patient to accept treatment;
- the intellectual and emotional capacity of the patient;
- the information the doctor knows or should know that the patient deems relevant to his or her decision to choose a treatment; and
- evidence from the patient, and in some cases from his or her family, as to the information the patient would have wanted to receive before electing to undergo or refuse treatment.⁴³

In addition to the considerations used to evaluate the common law duty to disclose as listed above, most Canadian provinces have passed legislation that outline the requirements of obtaining informed consent.⁴⁴ The common law and applicable medical health statutes underscore the patient's right to make an informed choice.

⁴² *Malette v. Shulman* (1987), 43 CCLT 62; affirmed (1990), 67 DLR (4th) 321 (ONCA).

⁴³ *Rossmann v. Sas*, *supra*, para 83.

⁴⁴ *Health Care Consent Act*, RSO 1996, c. 2; *Health Care (Consent) and Care Facility (Admission) Act*, 1996 RSBC, c. 181; *The Health Care Directives Act*, CCSM c. H-27; *Advance Health Care Directives Act*, SNL 1995, c. A-4.1; *Consent to Treatment Act and Health Care Directive Act*, RSPEI 1988, c. C-17.

Patients' particular medical circumstances can complicate the duty of disclosure. For example, in every wisdom tooth extraction the risk of sinus perforation increases with the proximity of the sinus floor to the root tip. Perforation of the sinus floor can cause chronic sinus infections. A dentist's duty to disclose the risk is dependent upon the distance of the root tip to the sinus floor.⁴⁵

E. DID LACK OF DISCLOSURE CAUSE THE PLAINTIFF'S INJURY?:

If the dentist fails to obtain the patient's informed consent, the patient's claim for damages will only succeed if the failure to disclose the risks would have stopped the patient from selecting the treatment. Consequently, a legal claim against a medical practitioner will fail if court concludes that the plaintiff would have proceeded with the treatment, even if the proper disclosure of all the material risks had been made.

The difficult question the court must answer is whether, on a balance of probability, a "reasonable person" in the plaintiff's position would have proceeded with the treatment anyway, had the dentist had provided full disclosure of the material risks?⁴⁶ The "reasonable person" is taken to possess the patient's reasonable beliefs, fear, desires and expectations. The patient's expectations and concerns will usually be revealed by the questions posed in the clinical setting.⁴⁷

The plaintiff has the onus of establishing that the medical practitioner's failure of make a proper disclosure amounted to negligence.⁴⁸ However the clinical records of the medical practitioner will be a critical tool in defending the claim.

F. INFORMED REFUSAL:

A dentist must comply with the wishes of a patient to refuse treatment, no matter how ill-advised the dentist may believe the instruction to be. Otherwise, the treatment is a battery which attracts liability consequences.⁴⁹

The doctrine of informed consent does not extent to informed refusal. For example, a doctor confronted with an unconscious patient, in a life-threatening situation, who possesses a card refusing a blood transfusion by virtue of a religious belief, commits a battery by administering blood. A battery is committed regardless of the fact that the doctor is unaware of the circumstance prohibiting the blood transfusion. Unlike informed consent, it is not the responsibility of the doctor to verify that the patient's

⁴⁵ *Rossmann v. Sas*, *supra*.

⁴⁶ *De Vos v. Robertson* (2000), 48 CCLT (2d) 172.

⁴⁷ *Smith v. Arndt, et al.* (1997), 148 DLR (4th) 48 (SCC), p. 56.

⁴⁸ *Best v. Hoskins*, 2006 ABQB 58.

⁴⁹ *Malette v. Shulman*, *supra*.

decision to *refuse* blood was an informed choice or that the card represents the current wishes of the patient.⁵⁰

If a patient is conscious and capable, he or she has the right to refuse treatment that does not fit the patient's values, attitudes, and experience, even if such treatment is recommended by the medical practitioner. Whether the medical practitioner is ultimately responsible for the patient's poor medical choice is rooted in the consultation and discussion prior to the treatment, as evidenced by the medical practitioner's clinical notes.

In a situation where a patient has chosen an inappropriate procedure, and blames the dentist for his or her choice, the court will closely consider what the dentist advised in relation to acceptable standard dental practice, and whether the dentist properly explained the risks and viability of alternative treatment options. In other words, was the patient adequately informed of his or her options, and with this information did the patient decide to proceed with an option that they were advised against?⁵¹

The duty to disclose alternative medical treatment is limited to the case where in the opinion of the medical practitioner the alternative procedure offers some advantage and is likely to achieve a beneficial result.

G. EMERGENCY TREATMENT:

When immediate treatment is necessary to save the life or health of a patient who is unable to express consent by reason of lack of consciousness or extreme illness, it is not a battery for a medical practitioner to proceed with a treatment in the absence of the patient's consent. An emergency standard exists on the impossibility of obtaining consent because of the grave condition and the urgent necessity for treatment to protect life and health.

If a doctor or a dentist proceeds without consent the doctor must be able to show in his clinical records the following information:

- the impossibility of obtaining the patient's consent (assuming him to be an adult of sound mind); and
- the procedure was immediately necessary to preserve the health and life of the patient.⁵²

⁵⁰ *Malette v. Shulman, supra.*

⁵¹ *Whissell v. Trus*, 2001 CarswellOnt 44 (SC).

⁵² *Malette v. Shulman, supra.*

The importance of complete and detailed clinical notes cannot be overstated in this situation as the reasonableness of the treatment is delegated to an individual whom the patient has not chosen.

H. THE IMPORTANCE OF COMPLETE CLINICAL NOTES:

To prove informed consent a medical practitioner must document the full and complete disclosure of the risks associated with a procedure and include in his or her clinical notes a notation that the patient understood the nature of the informed communication.⁵³ Informed consent is more than just a signature; a signed consent form is only evidence that the dentist and the patient discussed the issue.

A medical practitioner can delegate to a clinician the responsibility of advising a patient about the material risks of a procedure. However, it is ultimately the practitioner's responsibility to ensure that the clinician is fully informed and capable of communicating the risks to a patient. It is also critical that the clinician appreciates when a patient's particular concern requires an answer directly from the medical practitioner.

All clinical note entries should be made in ink and errors should not be erased or obliterated but crossed out with a single line so that they can still be read. The correction should also be initialled and dated. Any notations in clinical notes that evidence a warning about a treatment should include the date of disclosure to ensure that the warning was given contemporaneously with the notation.⁵⁴ No changes to clinical records should be made after a complaint or the notification of a problem exists. Under the applicable privacy legislation a patient can challenge the accuracy of a clinical record.

Illegible chart entries do not reflect positively on the medical practitioner. Professional, ethical and legal requirements dictate that patient's records must be maintained with care as they are crucial part of the patient's medical history. For example, a full and complete dental record involving a drill bit breaking off in a patient's tooth during a root canal should include:

- the name and date of the dental appointment;
- a notation that the drill bit used for the root canal broke off and lodged in the root canal;

⁵³ Cronk, E.A., "Informed Consent in 2001: "Don't Leave Home Without It'", *Dispatch*, June 2001, Royal College of Dental Surgeons of Ontario (special supplement).

⁵⁴ *Diack v. Bardsley* (1983), 46 BCLR 240, 25 CCLT 159 (SC).

- that, as a result of the lodged drill bit in the root canal, the endodontic treatment could not be completed;
- a referral to an endodontist for the special removal of the drill bit; and
- a list of the additional treatment that might be required as a result of the accident.

A full and complete clinical record entry related to the extraction of a wisdom tooth should include the following information:

- the date and name of the patient;
- the reason why the extraction was necessary;
- a statement involving the patient was warned of the risks and the possible surgical outcome;
- the consequences of not obtaining the treatment were discussed and a consent form was provided;
- a detailed account of the treatment and procedures as discussed;
- the costs of the procedure; and
- the signature of the patient on a consent form.

Progress notes containing full and complete information, as set out above, demonstrates to a trier of fact that the patient was aware of his or her condition and is responsible for the election of the treatment provided.⁵⁵

A full and complete dental record is also invaluable when a dispute arises over the information provided to a patient about a proposed medical treatment. Specifically, when the credibility of two witnesses is otherwise equal, and no surrounding or other circumstances make one version of events more probable than the other, the court will utilize the following theories to determine which information is most reliable:

- Are the medical practitioner's clinical record full and complete? If the medical practitioner's clinical notes should have been capable of supporting the doctor's version of events, but the clinical notes are incomplete, the patient's version of events are preferred.
- Affirmative conflicting evidence is favoured over negative evidence.
- The evidence of the party who has only one transaction to remember is preferred over the evidence of the party who has several similar transactions to recall,

⁵⁵ *A Handbook for Ontario Dentists*, Section 4, "Malpractice-Proofing A Dental Practice".

particularly when the practitioner has no particular reason to remember the transaction in question.⁵⁶

Clearly, the theories utilized by the courts are tilted in favour of the patient. Logically the propensity of the courts to favour the information provided by the patient is balanced against the medical practitioner's right and obligation to detail in writing the full and complete conversation he or she had with the patient.

The first line of defence to a claim for professional negligence is to ensure that the clinical records show that the patient was fully informed of the risks associated with the procedure performed. Also as stated above the quality of the dentist's clinical records are a window into the future risk the dentist may present to an insurer.

I. THE AGE OF CONSENT:

In most Canadian jurisdictions, including Ontario, there is no age of consent. A person under the age of majority can consent to dental or medical treatment provided that the medical practitioner believes that the patient is competent and capable of understanding the risks associated with the proposed treatment.⁵⁷

If a patient is not competent, a legal guardian or other substitute caregiver must consent to the medical procedure on the patient's behalf. A patient may be considered not legally competent if he or she cannot understand the information relevant to making a decision about treatment, or is unable to appreciate the foreseeable risks of a medical decision.

VI. VICARIOUS LIABILITY:

Dentists like other professionals rely upon the services of medically trained staff and technicians to perform important technical services. A dentist can be held vicariously liable for the wrongful acts of his or her employees.

The Supreme Court of Canada delineated the principles of vicarious liability in two cases involving sexual assaults.⁵⁸ Employers will be liable for their employees' and agents' wrongful conduct if the conduct is sufficiently related to the conduct authorized by the employer. Imposition of vicarious liability on employers is a form of strict

⁵⁶ *Diack v. Bardsley*, *supra*, para. 35.

⁵⁷ The age of consent to medical treatment is 18 in Prince Edward Island and Saskatchewan; 16 in New Brunswick and British Columbia, and 14 in Québec. No other jurisdictions have legislated an age of consent.

⁵⁸ *Bazley v. Curry*, [1999] 2 SCR 534; *Jacobi v. Griffiths*, [1999] 2 SCR 570

liability. Consequently, the employer may be without fault or blame for the underlying negligence or intentional misconduct of the tortfeasor. The fact that an employee has his or her own professional liability insurance will not affect such a finding.⁵⁹

An employee's wrongful conduct is said to fall within the course and scope of his or her employment when it consists of either; (1) acts authorized by the employer or (2) unauthorized acts that are so connected with the acts that the employer has authorized that they may be regarded as modes of doing what was authorized.

In *Bazley*, the employer operated a residential care facility for troubled children. An employee of the facility repeatedly abused a child. The Supreme Court of Canada found the employer vicariously liable for the employee's unauthorized and intentional wrong on application of the following three principles:

1. The court should openly confront the question of whether liability should lie against the employer, rather than obscuring the decision beneath semantic discussions of 'scope of employment' and 'mode of conduct'.
2. The court should determine the fundamental question of whether the wrongful act is sufficiently related to conduct authorized by the employer to justify the imposition of vicarious liability. Where there is a significant connection between the creation or enhancement of a risk and the wrong that occurs, vicarious liability will serve the policy considerations for the provision of an adequate and just remedy and of deterrence. Employers should bear the generally foreseeable cost of their business.
3. To determine the sufficiency of the connection, the following factors should be considered:
 - a) the opportunity afforded for the employee to abuse his power;
 - b) the extent to which the act is furthered by the employer's aims;
 - c) the extent to which the act is related to friction, confrontation, or intimacy;
 - d) the extent of the power of the employee over the victim; and,
 - e) the vulnerability of the potential victims.

⁵⁹ *Guerrero v. Trillium Dental Centre*, 2014 ONSC 3871

In short, the test for an employer's vicarious liability for an employee's sexual abuse of a patient should focus on whether the employer's enterprise and its empowerment of the employee materially increased the risk of sexual assault, and hence the harm. The test should not to be applied mechanically but with a view to the policy considerations that justify the imposition of vicarious liability including fair and efficient compensation for committed wrongs, and deterrence.

An example of a medical clinic being held vicariously liable for a sexual assault perpetrated by an employee is *Weingerl v. Seo*.⁶⁰ An ultrasound technician assaulted a female patient during an examination. Presumably for privacy reasons, the clinic protocol called for the technician to be alone in the room with the patient who was partially disrobed. During the ultrasound the technician "tested" for ovarian cysts, rather than testing the upper gastrointestinal tract. The clinic was held vicariously liable for the technician's conduct. The Ontario Court of Appeal, applying the principles set out in the child sexual assault cases set out above, found that the nature of the clinic's services required or permitted the employee to touch the patient in "intimate body zones", and that its policies materially increased the risk of sexual assault.

The court commented on the fact that the nature of the relationship between an employee and an adult patient is materially different from that between a child and a caregiver. Specifically, a competent adult in a health care setting is less vulnerable to a sexual assault; an adult is physically more able to protect himself or herself from a sexual assault; and an employee is more likely to fear reprisal from an adult. However, in *Weingerl* the nature of the touching made it difficult for the patient to appreciate the fact that she was being abused.

In *Weingerl*, the assault might have been prevented if a nurse was required to be in the room with the patient during the ultrasound. Accordingly, the finding of vicarious liability in the *Weingerl* case also followed the policy objectives stated above. An employer who has introduced the "opportunity", or risk of wrong, is fairly and usefully charged with the obligation to manage and minimize the harm.

⁶⁰ (2005), 256 DLR (4th) 1 (ONCA).

VII. COMPLETE DENTAL RECORDS, AN “EVIDENTIARY TOOL” IN DEFENDING AN ACTION:

A. THE PURPOSE OF CLINICAL RECORDS:

Keeping good clinical records is helpful to a dentist’s practice in several ways. Good dental records indicate the scope of services provided, and help avoid errors that engender complaints and malpractice suits. If a patient does complain or file suit, good records can support a defence of no negligence and halt a lawsuit in its tracks. Finally, good record keeping is the law. Provincial legislation applying to dentists makes it clear that failure to keep good dental records is an act of professional misconduct. In short, deficient records put both patients and practitioners at risk.

B. THE CONTENT OF DENTAL RECORDS:

Generally speaking, dental records must be accurate, legible, current, and organized.

Accuracy:

Dental records should contain the following:

- the patient’s name;
- treatment date(s);
- thorough and up-to-date medical and dental history;
- allergies and medications;
- reason for service/complaint(s);
- patient expectations;
- clinical findings and impressions;
- differential diagnosis;
- treatment plan and explanation given to the patient, including discussion of medications that may be required;
- informed consent notes and documents;
- notes regarding explanation of known or suspected complications and side effects from treatment and any medications involved;
- recommendations or referrals;
- treatment performed and followed up;
- consultation with or referral to other practitioners; and
- missed appointments.

Dental records should not contain the professional’s opinion on care given by others or details of communications with the PLP or the patient’s lawyer.

Legibility:

Dental records should be created in the following form:

- ink, not pencil;
- legibly-written or typed;
- records typed from dictation should be checked for accuracy; and
- diagrams where required to illustrate complex conditions, such as the location and presentation of lesions, growths, or abnormalities.

Corrections should be initialled and dated, but no changes may be made after notification of a claim or problem.

Currency:

Dental records should indicate clearly when each record was created, and note the dates on which any record is updated. Practitioners should not rely on memory, but should create clinical notes as soon as possible after the treatment or preferably during the visit

Organization:

In terms of practice management dentist should always read records or letters prior to signing and should review patients' records before visiting with or working on the patient.

C. KEEPING COMPUTER RECORDS:

In a computer age, with more and more offices going "paperless," a dentist's office computer system should employ the following computer practices:

- create login and password to protect against unauthorized access;
- maintain the capacity to retrieve and print stored information;
- keep an audit trail capacity;
- provide links between clinical and financial records;
- be capable of displaying and printing the information for each patient in chronological and entered order;
- prevent entry and alteration of data files from the back-end; and
- back-up files on a removable medium that allows data recovery or provides by other means reasonable protection against loss, damage, and/or inaccessibility of patient information.

D. RECORD DISCLOSURE AND CONFIDENTIALITY:

As discussed above, dentists must maintain patient confidentiality over records. Specifically, physical and electronic records must be secured, and disclosure must occur pursuant to a consistent office policy, communicated to all staff, and only with the patient's consent. A dental record is defined as more than just a written and electronic document. Dental records also include x-rays, casts, and molds made of the patient in the course of treatment.

While dentists own their written records, their patients have a possessory interest in the information contained therein. Accordingly, patients are entitled to review and get a copy of their own records.⁶¹ Be aware that disclosure of dental records also includes amended or deleted records. However, a dentist should not disclose patient records without a patient's written request or consent, a court order, or a written request of their provincial professional licensing body or the Professional Liability Program. In the United States, at least one case has found a dentist breached patient-dentist privilege when he disclosed a patient's records at a trial concerning the patient's fraud in obtaining narcotics prescriptions.⁶²

In extremely limited circumstances, access to a record can be denied even to the patient it concerns – but this is a very unusual situation and the health care provider must show that reasonable grounds exist for denying access. The Canadian Dental Association and the dental associations of the provinces and territories prescribe a code of professional ethics that describes the duty of confidentiality and the disclosure of dental records.

In British Columbia, unlike other provinces, dentists may release patient information to protect the patient or the community and report adverse drug reactions to Health Canada. In other jurisdictions, unless there is an emergency or legislative exception, confidentiality is more absolute and disclosure forbidden unless the dentist suspects child abuse, serious and imminent threat to another, or the patient has contracted one of a number of communicable diseases.

VIII. LIMITATION PERIODS:

The time to pursue an action against a dentist is not indefinite in Canada. Policy reasons dictate that no person should be forced to have a black cloud of potential

⁶¹ Dentists who practice with public bodies such as hospitals or universities must be aware of the provincial privacy legislation affecting the public sector in their jurisdiction. In BC the applicable legislation is the *Freedom of Information and Protection of Privacy Act*. Dentists practicing in their own offices need to be aware of private sector requirements, including – if they disclose the information outside provincial borders for economic or other benefit – the federal *PIPEDA* or equivalent provincial legislation, as discussed above.

⁶² *People v. Sinski*, 669 N.E.2d 809 (N.Y. 1996).

liability hang over them forever. All provinces in Canada have passed legislation that specifically provide time limits by which an action must be brought against another party for damage they have suffered as a result of the offending party's negligence, or otherwise. As will be seen below, some provinces have chosen to establish specific limitation periods as it relates to the dental profession, while others have classified such actions with other tortious claims for bodily injury. This section briefly discusses the various limitation periods for actions against dentists in Canada, as well as providing a synopsis of various issues relating to limitation periods - postponement, discoverability, and the ultimate limitation period.

A. POSTPONEMENT/DISCOVERABILITY:

The issue of postponement relates to when the limitation period commences to run. In essence, does the limitation period begin to run from the date that the negligent dental service was provided? The answer to that question depends in part upon the particular province and whether the province has enacted specific legislation dealing with postponement of the limitation period, or whether common-law 'discoverability' principles govern provincial law. Postponement or discoverability is important in cases of latent injury suffered as a result of negligent dental services. For example, an injured party may not know that they suffered injury or that negligent dental work was performed until several years after the expiration of the applicable limitation period.

Many provinces have enacted specific provisions in the various limitation statutes to deal with this type of situation. In general, these provisions state that the limitation period begins to run from the date at which a person knew, or ought to have known, that: (a) he or she had suffered an injury; (b) that the injury was attributable in whole or in part to the conduct of the proposed defendant; and (c) that the nature of the injury was such that bringing an action to claim damages was an appropriate remedy.⁶³

For those provinces that have not enacted statutory postponement provisions, the common law provides a discoverability principal in order to allay the harshness of a limitation period in situations where the injured party was unaware of their injury. In essence, the limitation period does not begin to run until the injury is 'discovered'; that is, until the plaintiff discovers the injury and knows or ought to know that the injury was attributable to conduct of the proposed defendant. As the Supreme Court of Canada stated in 1992, the discoverability principal essentially states that a limitation period "*does not accrue until the plaintiff is reasonably capable of discovering the wrongful nature of the defendant's acts and the nexus between those acts and her injuries.*"⁶⁴ Put

⁶³ See the below summary of provincial limitation statutes, for example, the Alberta *Limitations Act*. RSA 2000, c. L-12.

⁶⁴ *M. (K.) v. M. (H.)*, [1992] 3 SCR 6.

another way, the Supreme Court has also stated that “a cause of action arises for purposes of a limitation period when the material facts on which it is based have been discovered or ought to have been discovered by the plaintiff by the exercise of reasonable diligence”⁶⁵.

However, judge-made discoverability rules will not apply in cases where the governing limitations legislation sets the limitation period running immediately upon the occurrence of a particular event. So for example, where the limitation provision states that an action must be commenced “within one year from the date when the professional services terminated in respect of the matter”, it will not matter that the injured party did not or could not discover the injury prior to that point. Discoverability will only apply in circumstances where the time runs from “the accrual of the cause of action” or from some other event which can be construed as occurring only when the injured party has knowledge of the injury sustained.⁶⁶

B. ULTIMATE LIMITATION PERIOD:

Regardless of any issues relating to discoverability, many provinces have enacted provisions which state that a claim must be brought within a specific period of time or the cause of action will effectively be extinguished. In other words, regardless of whether or not the injured party is aware, or ought to have been aware, that an injury had been suffered and that the injury was caused by a breach of duty on the part of the dentist, some provinces have dictated that the action must be brought within a period (ranging from 10-30 years by province) or else it will be considered completely time-barred. This final limitation period is often referred to as the “ultimate limitation period”.

C. PARTIES UNDER DISABILITY:

All provinces’ limitation statutes postpone the running of limitation periods relating to minors or persons mentally incapable of managing their affairs. In essence, these provisions state in part that the limitation period does not commence running during the time that the injured party is a minor, and further, the limitation is suspended for any period of time in which the injured party is incapable, by reason of mental infirmity, from managing his or her own affairs.

In the following paragraphs we outline the limitation legislation of several Canadian jurisdictions.

⁶⁵ *Central & Eastern Trust Co. v. Rafuse*, [1986] 2 SCR 147.

⁶⁶ See for example *Langenhahn v. Czyz* 158 DLR (4th) 615, 61 Alta. L.R. (3d) 115 (CA); *Perrie v. Martin*, [1986] 1 SCR 41; *Fehr v. Jacob*, [1993] 5 WWR 1 (MBCA).

D. BRITISH COLUMBIA:

The “old” *Limitation Act* provided that no claim may be brought by a person seeking damages in respect of injury to a person after the expiration of two years after the date on which the right to do arose.⁶⁷ However, some patients whose bridges or crowns failed successfully argued that the six-year limitation period applicable to claims for breach of contract should apply, because the damage was caused by defects in the product itself rather than as a result of the work done by the dentist.⁶⁸ This led to confusion in cases where the service provided by contract resulted in personal injury – such as where a patient purchased dental services – was the limitation period two or six years?

The “new” *Limitation Act*, which came into force June 1, 2013,⁶⁹ has established a basic limitation of two years after the day on which a claim is discovered, whether the claim is brought in tort or contract. Note that the “old” *Act* applies to claims arising from dental services provided before June 1, 2013.

The “old” *Act* provides that the limitation period for personal injury or professional negligence does not begin to run until the plaintiff knows the identity of the defendant, and the plaintiff knows “*those facts ... such that a reasonable person, knowing those facts and having taken the appropriate advice a reasonable person would seek on those facts, would regard those facts as showing that a cause of action would...have a reasonable prospect of success and the person whose means of knowledge is in question ought, in the person’s own interests and taking the person’s circumstances into account, to be able to bring the action.*” The question is when the plaintiff knew that the medical procedure had been unsuccessful,⁷⁰ and “*in light of his or her own particular circumstances and interests, at what point could the plaintiff reasonably have brought an action?*”⁷¹

In the “new” *Act*, the basic underlying principles of discoverability remain intact, but the wording has changed:

A claim is discovered by a person on the first day on which the person knew or reasonably ought to have known all of the following:

(a) *that injury, loss or damage had occurred;*

⁶⁷ RSBC 1996, c. 266.

⁶⁸ *Zurbrugg v. Bowie* (1992), 68 BCLR (2d) 322 (CA).

⁶⁹ SBC 2012, c. 13.

⁷⁰ *Sigurdur v. Fung and Louie*, 2007 BCPC 239.

⁷¹ *Novak v. Bond*, [1999] 1 SCR 808.

- (b) *that the injury, loss or damage was caused by or contributed to by an act or omission;*
- (c) *that the act or omission was that of the person against whom the claim is or may be made;*
- (d) *that, having regard to the nature of the injury, loss or damage, a court proceeding would be an appropriate means to seek to remedy the injury, loss or damage.*

The limitation period is also postponed so long as the plaintiff is under a legal disability. In other words, the running of time with respect to a limitation period will not run so long as the person remains a minor or is incapable of managing his or her own affairs.

In claims where the limitation is subject to a postponement as described above, the “old” Act provides that the ultimate limitation period as against a “*medical practitioner, based on professional negligence or malpractice*” is “*6 years from the date on which the right to do so arose*”. The Act was amended to extend the limitation period for claims against dentists as defined in the *Dental Act* to ten years from the date on which the right to do so arose.

As of June 1, 2013, “new” Act replaced the pre-existing limits with an ultimate limitation period of fifteen years from the date of the occurrence. This new limitation period applies to claims arising from acts that occurred and are discovered, on or after June 1, 2013.

E. ALBERTA:

The Alberta *Limitations Act* provides that a claimant must seek a remedial order (*e.g.*, a judgment) within two years of when the claim arose.⁷² In the dental context, a claim based on a breach of duty would occur when the conduct, act, or omission of the dentist occurs. The two-year limitation would start to run when the claimant first knew, or ought to have known, that an injury had occurred, that the injury was attributable to the conduct of the defendant, and that the injury warranted bringing a proceeding.

The Alberta Court of Appeal has noted that the wording of the statutory discoverability provisions in the Act could permit different ‘discoverability time periods’ for the same negligent act. The Court cited with approval a lower court Chambers ruling which stated, “*the discovery period will commence not at the time of the event, but at the time of*

⁷² *Limitations Act*, RSA 2000, c. L-12.

discovery of the injury. Therefore, it may begin at different times for different injuries for which remedial orders are sought".⁷³

Interestingly, the *Alberta Act* provides that the claimant bears the legal burden of proving that a remedial order was sought within the two-year limitation period. While the *Act* requires that the limitation period be pleaded as an affirmative defence, it provides that the legal burden then shifts to the claimant to show that the action was brought within the limitation period.

The *Alberta Act* suspends the limitation period during any period of time that the claimant is under a legal disability. In Alberta, this applies both to minors, or adults in respect of whom a "*certificate of incapacity*" has been issued under the relevant legislation.

Finally, the *Alberta Act* provides for a ten-year ultimate limitation period, which applies regardless of the *Act's* statutory discoverability provisions.

F. SASKATCHEWAN:

Saskatchewan's *Limitations Act* formerly provided that an action in professional negligence against a dentist was subject to a one-year limitation period. However, under the current statute actions against dentists are subject to the standard two-year limitation period, running "*from the day on which the claim is discovered*".⁷⁴

Saskatchewan's *Limitations Act* provides a statutory discoverability provision; that is, the two-year limitation period does not begin to run until the claimant knew or ought to have known that he or she had been injured, that the injury had been caused by the defendant, and that the injury warranted bring a proceeding.

As with many other provinces, the operation of the limitation periods in Saskatchewan is suspended during any period in which the claimant is a minor or is a person who, by reason of mental disability, is not competent to manage his or her affairs. However, the limitation period will not be suspended if an adult with mental disease is represented by a personal guardian who is aware of the claim and has the legal capacity to commence the proceeding on the person's behalf.

Section 7 of Saskatchewan's *Act* provides that no claim shall be commenced after fifteen years from the day on which the act or omission on which the claim is based took place. Claims for latent injury caused by a dentist must therefore be commenced within fifteen

⁷³ *Sun Gro Horticulture Canada Ltd. v. Abe's Door Service Ltd.*, 2006 CarswellAlta 1067 (CA).

⁷⁴ *Limitations Act*, SS 2004, c. L-16.1.

years of the date on which services were provided, regardless of any postponement provisions.

G. MANITOBA:

The limitation period that applies to dentists in Manitoba is governed by the *Dental Association Act*,⁷⁵ which states in essence that a claim for negligence or malpractice against a dentist must be brought within two years “*from the date when, in the matter complained of, those professional services rendered terminated*”.

The *Limitations of Actions Act* provides that in certain circumstances the limitation period can be extended for actions commenced or continued.⁷⁶ The *Act* provides that the court may grant leave to commence the action if it is satisfied that not more than twelve months have elapsed between when the applicant knew or ought to have *known* “*of all material facts of a decisive character upon which the action is based*”, and the date of the application. In other words, the *Act* provides for a statutory discoverability scheme whereby the limitation period can be extended as long no more than one year has passed since the patient discovered that he or she had been injured and knew or ought to have known that the injury appeared to have been caused by the act or omission of a prospective defendant.

In *Fehr v. Jacob*,⁷⁷ the Manitoba Court of Appeal noted that the judge-made discoverability principles are nothing more than a rule of construction. In other words, as noted above, where the limitation period provides that the clock starts running from a specified event, regardless of the knowledge of the injury, then discoverability principles have no impact. In the context of the *Dental Professions Act*, which provides that the limitation period begins upon the termination of the professional services, this means that no recourse can be made to the common-law discoverability principle; rather, any extension of the limitation period must be found within the context of the *Limitation of Actions Act* itself.

The *Limitation of Actions Act* provides that despite any postponement to a limitation period which occurs as a result of a person being a minor or being mentally incapable of management of his affairs, no action can be brought after thirty years from the date on which negligence or malpractice occurred.

⁷⁵ *Dental Association Act*, CCSM c. D30.

⁷⁶ *The Limitations of Actions Act*, CCSM c. L150.

⁷⁷ 1993 CarswellMAN109 (CA).

H. ONTARIO:

The Ontario *Limitations Act, 2002* establishes a basic two-year limitation period from the date that the “claim was discovered”.⁷⁸ The *Act* specifically applies to all claims of medical malpractice or negligence, and includes claims for dental malpractice or negligence.

Similar to other provinces, the Ontario *Act* provides that a claim is “discovered” on the day that the claimant knew, or ought to have known, that any injury occurred, that the injury was caused by the prospective defendant, and that a proceeding for damages would be an appropriate means of redress. Note that a person is presumed to have discovered the claim at the time in which the incident occurred, unless the contrary is proven by the claimant.

In *Brown v. Wahl*,⁷⁹ the court dismissed the patient’s argument that he did not discover the dentist’s negligence until receiving an expert report. Similarly in *Verombeck v. Jerome*,⁸⁰ the patient was held to have discovered the claim after another dentist performed restorative work on the same tooth that was the subject of the complaint. The relevant date for commencing the limitation period was when the plaintiff knew, or reasonably should have known, that their problems were caused by the defendant dentist. Discoverability is a fact-based analysis. Common examples cited in case law for determining a claim has been ‘discovered’ include, restorative work, complaints to authoritative bodies, retaining a lawyer and sending demand letters.⁸¹

In certain circumstances an expert report may be necessary for a person to discover the claim. As discussed in *Barry v. Pye*,⁸² there are circumstances whereby an expert report, or finding of the regulatory college may bring to light new and necessary facts for the claim to be discovered. For example, this could occur where the report discloses that the medical practitioner used the wrong instrument during a surgery, information that the patient could not have been aware of without an expert opinion. Typically these will be cases that are very complex or unique on its facts.

The limitation period is postponed during any period in which the claimant is a minor *and* not represented by a litigation guardian regarding the claim. The limitation period is also postponed during any period in which the person with the claim “is incapable of commencing a proceeding in respect of the claim because of his or her physical, mental or

⁷⁸ SO 2002, c. 24.

⁷⁹ *Brown v. Wahl*, 2015 ONSC 1328.

⁸⁰ *Verombeck v. Jerome*, 2015 ONSC 2272.

⁸¹ *Conidis v. Tait*, 2015 ONSC 1558.

⁸² *Barry v. Pye*, 2014 ONSC 1937.

psychological condition" (and is not represented by a litigation guardian regarding the claim).

The Ontario *Act* sets a fifteen-year ultimate limitation period for all claims from the date on which the incident giving rise to the claim occurred, regardless of any discoverability provisions.

I. NEW BRUNSWICK:

The governing legislation for limitation periods is found under the New Brunswick's *Limitation of Actions Act*,⁸³ which establishes a basic two-year limitation period from the date a claim is discovered. This *Act* replaces the *Medical Act*, which formerly provided that claims against medical practitioners (including dentists) must be brought within two years from the day in which the medical services terminated, or one year after the person commencing the action knew or ought to have known the facts upon which he alleges negligence or malpractice, whichever period is longer.

The *Act* further provides that in terms of minors or mental incompetents, the limitation period is one year from the date in which the person becomes of full age, or of sound mind, or as the case may be.

The *Limitations of Actions Act* introduced a fifteen-year ultimate limitation period for all claims from the date on which the incident giving rise to the claim occurred.

J. NOVA SCOTIA:

The *Limitations of Actions Act* provides that an action for either negligence or malpractice arising out of professional services rendered by a dentist must be brought within two years of those professional services having terminated.⁸⁴

Common-law discoverability principles do not apply to claims of dental negligence or malpractice, given the specific trigger in the *Act*, *i.e.*, termination of services. In *Smith v. McGillivray*,⁸⁵ the Nova Scotia Supreme Court noted that, consistent with the law of other jurisdictions, the discoverability principle is only relevant where it runs from the accrual of the cause of action and not in circumstances where the statute specifically states the point at which the limitation period begins to run.

However, the Nova Scotia *Act* grants the courts a discretion to extend the limitation period in certain circumstances, up to a maximum of four years after the limitation

⁸³ *Limitation of Actions Act*, SNB 2009 c.L-8.5

⁸⁴ RSNS, c. 258, s. 1.

⁸⁵ 2000 CarswellNS 417.

period had expired. The *Act* specifically lists various factors that a court must consider on such an application, many of which relate to the prejudice potentially incurred by either the plaintiff or the proposed defendant.

As for persons under a legal disability, the *Act* provides that if any person is within the age of nineteen years or a “*person of unsound mind, then such person shall be at liberty to bring the same action, so as such person commences the same within such time after his or her coming to or being of full age or of sound mind*” or “*within five years, whichever is the shorter time*”.

Given the wording of the postponement provisions, it would appear that the ultimate limitation period in Nova Scotia would be six years for a claim of dental malpractice.

K. NEWFOUNDLAND AND LABRADOR:

The basic limitation period for an action in professional negligence against a dentist in Newfoundland and Labrador is two years from the date on which the right to do so arose, which pursuant to the *Limitations Act* is considered to be from the date on which the damage first occurs.⁸⁶

The *Act* contains statutory postponement provisions, similar to other provinces, which provides that the limitation period is postponed in cases of professional negligence does not commence until the patient knows or, considering all circumstances of the matter, ought to know, that he or she has a cause of action.

The *Act* further provides that the applicable limitation period is either postponed or suspended during the period in which a person is under a legal disability, which according to the *Limitations Act* is when the person is either a minor or is “*incapable of the management of his or her affairs because of disease or impairment of his or her physical or mental condition*”.

The *Act* provides for a ten-year ultimate limitation period, notwithstanding any postponement on discoverability or persons under a legal disability.

L. PRINCE EDWARD ISLAND:

The *Dental Professions Act* provides that no civil action may be brought against any dentist for negligence or malpractice unless that claim is brought within six months of when the professional service terminated.⁸⁷

⁸⁶ SNL 1995, c. L-16.1.

⁸⁷ *Dental Profession Act*, RSPEI 1988, c. D-6.

Courts in Prince Edward Island have held that “professional services” as it relates to the above limitation provision are those services set out and defined in the *Dental Profession Act* as constituting professional dental services.

For persons under a legal disability, the *Statute of Limitations* provides that a person has two years in which to commence his or her claim from the date that the legal disability ends.

As there is no statutory provision governing discoverability in Prince Edward Island, the common law discoverability principles set out above apply. Issues of discoverability are not usually determined on a summary basis, but are left to the trial judge.⁸⁸ It should also be noted that given the judicial comments of other provinces, it is uncertain whether the common-law discoverability scheme would apply; that is, the *Dental Professions Act* specifies a particular time from which the limitation period begins and thus there may be no place for the discoverability principles as a “rule of construction”.

While there is no ultimate limitation period provided by the Prince Edward Island *Statute of Limitations*, if there is no discoverability scheme to the limitation period set out in the *Dental Profession Act*, then arguably the ultimate limitation period would of necessity be six months.

⁸⁸ See for example *Oliver v. Severance*, 2005 CarswellPEI 13.