



# PROFESSIONAL LIABILITY FOR DENTISTS IN CANADA: MANAGING THE RISK

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## **I INTRODUCTION**

Practising dentists, like other medical practitioners, are open to scrutiny as a result of treatment provided or withheld. Managing the risk of professional liability for dentists in Canada requires an understanding of the laws applicable to dentists, identifying good practice management protocol and proactively recognizing typical dental claims to avoid loss.

This paper describes the legislative regimes applicable to dental professionals across Canada; outlines the standard of dental professional negligence; and finally, offers practice management tips to assist in developing strategies to employ in the defence of claims against dentists.

## **II. DENTAL LEGISLATION AND REGULATION ACROSS CANADA**

Each province and territory in Canada regulates dental professionals, including dental hygienists. The regulation of dental professionals in Canada is not federally-legislated. Notwithstanding the fact that dental regulation varies from province to province the management and standard of conduct of dental professionals across Canada is relatively uniform.

This section of the paper will list the legislation applicable in each province and territory and provide detailed examples of the standard of care enunciated therein. This section of the paper will also explain 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:

1. entry and registration into the profession;
2. instruction and restriction of practice techniques;
3. the investigation of complaints; and
4. 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 directly.

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

Province	Dentists	Dental Hygienists
Alberta	<i>Health Professions Act</i> , R.S.A. 2000, c.H-7, Schedule 7	<i>Health Professions Act</i> , R.S.A. 2000, c.H-7, Schedule 5
	Alberta Dental Association and College, <a href="http://www.abda.ab.ca">www.abda.ab.ca</a>	College of Registered Dental Hygienists of Alberta, <a href="http://www.askadentalhygienist.com">www.askadentalhygienist.com</a>
British Columbia	<i>Dentists Act</i> , R.S.B.C. 1996, c.9	<i>Health Professions Act</i> , R.S.B.C. 1996, c. 183
	College of Dental Surgeons of British Columbia: <a href="http://www.cdsbc.org">www.cdsbc.org</a>	College of Dental Hygienists of British Columbia: <a href="http://www.cdhbc.com">www.cdhbc.com</a>



Manitoba	<i>Dental Association Act</i> , R.S.M. 1987, c. D30	<i>Dental Health Workers Act</i> , R.S.M. 1987, c.D31 <i>Dental Hygienists Act</i> , R.S.M. 2005, c.51
	Manitoba Dental Association: <a href="http://www.manitobadentist.com">www.manitobadentist.com</a>	Manitoba Dental Association: <a href="http://www.manitobadentist.com">www.manitobadentist.com</a>
Newfoundland and Labrador	<i>Dental Act</i> , R.S.N. 1990, c.D-6	<i>Dental Act</i> , R.S.N. 1990, c.D-6
	Newfoundland and Labrador Dental Board: <a href="http://www.nlda.net">www.nlda.net</a>	Newfoundland and Labrador Dental Board: <a href="http://www.nlda.net">www.nlda.net</a>
New Brunswick		
	New Brunswick Dental Society, <a href="http://www.nbdental.com">www.nbdental.com</a>	New Brunswick Dental Society, <a href="http://www.nbdental.com">www.nbdental.com</a>
Northwest Territories and Nunavut	<i>Dental Profession Act</i> , R.S.N.W.T. 1988, c. D-3	<i>Dental Auxiliaries Act</i> , R.S.N.W.T. 1988, c.D-3
	Government of the Northwest Territories, Review Officer	Government of the Northwest Territories, Provincial Licensing Registrar
Nova Scotia	<i>Dental Act</i> , S.N.S. 1992, c.3	<i>Dental Act</i> , S.N.S. 1992, c.3
	Provincial Dental Board of Nova Scotia, <a href="http://www.pdbns.ca">www.pdbns.ca</a>	Provincial Dental Board of Nova Scotia, <a href="http://www.pdbns.ca">www.pdbns.ca</a>
Ontario	<i>Dentistry Act</i> , S.O. 1991, c.24, and <i>Regulated Health Professions Act</i> , 1991, S.O. 1991, c.18	<i>Dental Hygiene Act</i> , S.O. 1991, c.22, and <i>Regulated Health Professions Act</i> , 1991, S.O. 1991, c.18
	Royal College of Dental Surgeons of Ontario, <a href="http://www.rcdso.org">www.rcdso.org</a>	College of Dental Hygienists of Ontario, <a href="http://www.cdho.org">www.cdho.org</a>
Prince Edward Island	<i>Dental Profession Act</i> , R.S.P.E.I. 1988, c. D-6	<i>Dental Profession Act</i> , R.S.P.E.I. 1988, c. D-6
	Dental Association of Prince Edward Island	Dental Council of Prince Edward Island



Quebec	<i>Dental Act</i> , R.S.Q. c. D-3, <i>Professional Code</i> , R.S.Q. c. C-26	<i>Professional Code</i> , R.S.Q. c. C-26
	Ordre des dentistes du Quebec, <a href="http://www.ordredesdentistesduquebec.qc.ca">www.ordredesdentistesdu quebec.qc.ca</a>	Ordre des hygiénistes dentaire du Québec <a href="http://www.odhg.com">www.odhg.com</a>
Saskatchewan	<i>Dental Disciplines Act</i> , S.S. 1997, c. D-41	<i>Dental Disciplines Act</i> , S.S. 1997, c. D-41
	College of Dental Surgeons of Saskatchewan, <a href="http://www.saskdentists.com">www.saskdentists.com</a>	Saskatchewan Dental Hygienists Association
Yukon Territory	<i>Dental Profession Act</i> , R.S.Y. 2002, c.53	<i>Dental Profession Act</i> , R.S.Y. 2002, c.53
	Government of Yukon, Department of Community Services	Government of Yukon, Department of Community Services

## B. Dental Self -Regulating Bodies and the Board of Inquiry

The specialization of dental medicine naturally requires 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. Nova Scotia is the only province that has chosen to adopt the National Code of Ethics by regulation.<sup>1</sup>

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.

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

- (a) at least one licensee nominated by the Northwest Territories Dental Association, a society incorporated under the *Societies Act* (Northwest Territories);
- (b) at least one person who is entitled to practice dentistry in a province or the Yukon Territory; and
- (c) 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: Section 43 of the *Dentists Act*, R.S.B.C. 1996, c. 94 (the “BC Act”) provides:

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<sup>1</sup> Code of Ethics Regulation (Regulation Number 3) N.S. Reg. 165/93



- (1) *The council may, after giving a current or former registrant an opportunity to be heard, determine if the current or former registrant*
  - (a) *has contravened this Act or a rule made under it,*
  - (b) *has failed to comply with a limitation, term or condition imposed under this Act or the rules,*
  - (c) *has been convicted in Canada or elsewhere of any offence that, if committed by a registrant would constitute conduct unbecoming a registrant or unprofessional conduct,*
  - (d) *has **incompetently practiced** dentistry or carried out the duties and procedures delegated to him or her as a registrant,*
  - (e) *has engaged in **conduct unbecoming a registrant**,*
  - (f) *has engaged in **unprofessional conduct**,*
  - (g) *has failed to comply with an agreement that binds him or her under section 8 (2), or*
  - (h) *is suffering from a physical ailment, emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practice dentistry or carry out the duties and procedures delegated to him or her.*

The Act does not define “conduct unbecoming a registrant”, “incompetent practice”, or “unprofessional conduct.” 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, which provide specific rules and guidelines for dentists.

In Saskatchewan the *Dental Disciplines Act*, S.S. 1997, c. D-41 (The “Disciplines Act”) includes general statutory definitions of professional competence and misconduct. Specifically, s. 26 of the *Dental Disciplines Act* provides that professional incompetence is a “*question of fact*”, but goes on to clarify that the question of whether a dentist has been incompetent will include:



*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...*

The *Disciplines Act* also provides that “professional misconduct” is a “question of fact”:

*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 *Dental Profession Act*, R.S.N.W.T. 1988, c. D-3 lists criteria constituting “professional misconduct” or “unskilled practice” as:

*The Board of Inquiry may find that any conduct of a licensee or professional corporation constitutes either **unskilled practice** of dentistry or **professional misconduct** where, in the opinion of the Board, the conduct*

- (a) *is detrimental to the best interest of the public;*
- (b) *contravenes this Act or the regulations;*
- (c) *harms or tends to harm the standing of the profession of dentistry generally; or*
- (d) *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.

Ontario<sup>2</sup> and Quebec<sup>3</sup> 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 over 61 instances of professional misconduct, the first of which is that it is professional misconduct for a dentist 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.

In sum, all of the provinces, excepting the territories, have enacted legislation setting out the professional standards of care, it is the role of the self-regulating bodies and Board of Inquiry to flesh out and enforce the legislation.

### **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 will consider first whether the findings of the self-regulatory body or Board of Inquiry “facts” are admissible in a civil proceeding in negligence as evidence of the common law standard of care. Secondly, can a patient rely on a dentist’s past misconduct as evidence that the dentist has a propensity to act in a certain

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<sup>2</sup> *Professional Misconduct Regulation*, O. Reg 853/93

<sup>3</sup> *Code of Ethics of Dentists*, R.Q. c.D-3, r..4.



way? Finally, can a patient access the evidence collected by the self-regulating body or Board of Inquiry to establish the dentist's professional negligence?

Generally, the courts will not allow the admission of a dentist's disciplinary records to be used as "direct evidence" of misconduct in relation to a single claim. For example, in *Sawchuk v. Lee-Sing*,<sup>4</sup> 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 the evidence of the prior complaint proceedings 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.<sup>5</sup> 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

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<sup>4</sup> (1987), 58 Sask R. 94 (Q.B.).

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



risk of prejudice to the defendant dentist is minimized.<sup>6</sup> This is an important factor to consider in defending dental malpractice claims.

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*:<sup>7</sup>

*(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 *R. v. 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 *R. v. 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 acts, and it is clear that

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<sup>6</sup> *Etienne v. McKellar General Hospital*, [1994] O.J. No. 2602 (Q.L.)(Gen. Div.).



regardless of admissibility, 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*,<sup>8</sup> 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.<sup>9</sup>

### **III. PROFESSIONAL NEGLIGENCE**

Professional negligence is a subset of the general rules of negligence. A claim in professional negligence depends on establishing first, that a duty of care is owed by the defendant to the claimant, second, that the defendant is in breach of that duty, and most importantly, that the loss claimed was a consequence of the breach. The standard test of a breach of professional negligence is the failure to exercise the degree of care that a careful or prudent dental practitioner would have exercised under like circumstances. This section of the paper will consider the standard of care expected of dental professionals, how the standard of care evolves, and a list of typical claims in dental negligence.

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<sup>7</sup> [2002] 2 S.C.R. 98.

<sup>8</sup> (1989), 41 C.P.C. (2d) 300 (N.B.Q.B., Trial Div.).

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



### **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 an average, 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. Every allegation that a dentist has breached the standard of care expected from him or her is determined on the particular facts of the claim.

Consider the case of *Kangas v. Parker*, [1978] 5 W.W.R. 667 (Sask. C.A.). Mr. Kangas a healthy 28-year old man went to his dentist to have 11 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, the dentist noticed Mr. Kangas had choked and died on his own blood during the procedure. Both the dentist and the anaesthetist were found negligent. The finding of negligence against the dentist and the anaesthetist was based on the overall responsibility of the anaesthetist to keep Mr. Kangas' air tract open during the extractions and the dentist to monitor Mr. Kangas' status through the full view of his mouth. As a team, the doctors failed to recognize and correct the escape of blood, which the court said, was below the standard expected of the profession. The breach of the duty of care was found to have caused the death of the patient.

### **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*, [1997] O.J. No. 4384 (Gen. Div.), a patient sued her dentist for negligence, alleging he perforated her sinus during dental surgery. Ms. Rossmann claimed the surgery opened a fistula between her mouth and sinus causing a chronic sinus infection. 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 to substantiate that his standard practice complied with the acceptable medical standards usual to the surgical procedure, but the dentist's conformity did not insulate him from negligence. In evaluating the standard medical practice it was the opinion of the court that a simple procedure involving blowing air into Ms. Rossmann's mouth could have easily detected the perforation.

Consequently, while the dentist conformed to the professional standards existing at the time of the treatment, the standard itself was negligent. It was the opinion of the court that, *"a finding of negligent standards can be made in situations where there are "obvious existing alternatives which, if not so complex, highly technical or dependant on scientific testing so as to go beyond the comprehension of a judge or jury and is an alternative which any reasonable person would use to avoid the risk."*

Read together, *Kangas v. Parker* and *Rossmann v. Sas* 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 being effectively a moving goal, 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.
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.

### **D. Problems Associated with Prescribing Medicine**

Dentists can possess, administer, and prescribe drugs in the course of their practice to effect a treatment. Accordingly, it is important that dentist be aware of and 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 the *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 can only prescribe drugs within the scope of their practice. In other words, a dentist could administer Valium to a patient before a dental procedure, but a dentist must not administer Valium to treat depression. All Prescriptions must contain the patient's name, drug identification, quantity to be provided, and practitioner's authority. Dentists must also keep records of prescriptions issued for narcotics and to make these available to inspectors on request. Records of prescriptions made must be kept for **at least two years.**

Dentists must also 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 break and entry. If a "targeted substance" is lost or stolen, it is the responsibility of the dentist to report the loss to the Federal Minister of Health within no more than ten days.

Dentists must also be diligent in the manner that they destroy "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. There can also be federal regulatory consequences, such as loss of the ability to prescribe medications.



If a dentist develops an addiction to a “targeted substance” the dentist is required to report the addiction to either the applicable self-regulating body or Board of Inquiry. If addicted, a dentist may be required by the applicable self-regulating body to seek treatment, and ask the Federal Minister of Health to restrict him or her from access to prescription drugs.

#### **E. Good Dental Practice Management**

In practice, 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 the detail of every aspect of a professional office is important.

One of the most important aspects of maintaining dental professionalism are the clinical notes. Complete detailed clinical notes help defend malpractice claims. Dentists must take a thorough medical and dental history of each patient, date it, and update the note with every visit, record progress, symptoms, and changes. Dentist must also provide patients with a thorough examination, record their findings and provide a working diagnosis. The clinical notes should also 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.

#### **F. Inferior Dental Practice Management**

In contrast to positive practice management, dentists should not exceed their competence by making extravagant promises to patients, or permitting the patient to



dictate treatment. 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 causing or resulting in malpractice.

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.

Dentists should also be careful not to speak with a patient's lawyer unless instructed to do so by the Professional Liability Program ("PLP"), most importantly, a dentist or dental assistant should never erase notes or alter records after notification of a claim or a serious injury. While it is human nature to want to hide mistakes, dentists should notify the PLP of every claim and should not accept any financial obligation without first notifying PLP of the problem.

#### **G. What to Do - and What Not to 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:

##### **(i) Practice Management Do's**

1. Remain calm.
2. Notify the applicable professional liability program immediately of any legal action or incident that could result in legal action.



3. Advise staff not to speak with anyone about the incident.

*(ii) Practice Management Don'ts*

1. Do not panic.
2. Do not admit liability for the alleged transgression or error.
3. Do not assume the suit or incident will go away if you ignore it.
4. Do not contact a patient who has started a lawsuit against you or retained a lawyer.
5. Do not talk to the patient's lawyer. Instead, refer him or her to your insurer.
6. Do not alter or add any notes to the patient's record.
7. Do not lose patient records.
8. Do not treat the patient after the suit begins, except in an emergency.
9. Do not make any chart notations about the legal action, your conversations with your insurer, or any other matter relating to the legal action. If you do wish to make these notes, do so on a separate sheet for your own confidential records.
10. 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.)



11. Do not seek information about the patient from other practitioners.
12. 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<sup>10</sup>.

#### **IV. LIABILITY FOR BREACH OF FIDUCIARY DUTY**

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*.<sup>11</sup> This section of the paper will discuss *Norberg v. Wynrib* and the fiduciary duty of dentists including the importance of the protection of privacy.

As you may be aware, in *Norberg v. Wynrib* the young plaintiff, Ms. Norberg, suffered from severe headaches and jaw pain. Ms. Norberg was prescribed painkillers to reduce her pain while doctors considered a diagnosis. The cause of Ms. Norberg's pain was eventually determined to be an abscessed tooth. However, by the time the tooth was removed, Ms. Norberg was addicted to painkillers. Driven by addiction, Ms. Norberg obtained Fiorinal, a painkiller from a medical practitioner, Dr. Wynrib. Realizing Ms. Norberg's addiction, Dr. Wynrib proposed a "sex-for-drugs" arrangement, which Ms. Norberg "consented" to. Eventually, Ms. Norberg underwent treatment for her addiction, and brought an action against Dr. Wynrib for, among other things, breach of fiduciary duty.

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<sup>10</sup> Risk Management Guide a Handbook for Ontario Dentists, Section 4 Malpractice – Proofing A Dental Practice – October 2005

<sup>11</sup> [1992] 2 S.C.R. 226.



At issue in the *Norberg* case was the test to establish a fiduciary relationship. In enunciating the three characteristics of a fiduciary relationship, the Supreme Court of Canada stated:

1. *the fiduciary has scope for the exercise of some discretion or power;*
2. *the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; and*
3. *the beneficiary is peculiarly vulnerable or at the mercy of the fiduciary holding the discretion or power.*<sup>12</sup>

The Supreme Court of Canada also emphasized that patients are both particularly vulnerable to and encouraged to trust and confide in doctors. The exchange of confidential information, accordingly, is also a hallmark of the fiduciary relationship. After considering all of the above facts the Supreme Court of Canada concluded that Dr. Wynrib did owe Ms. Norberg a fiduciary duty, and noted that that duty was inherent in the doctor-patient relationship.

The *Norberg* decision has had a widespread effect on the consideration of how the decisions and acts of medical professionals will be scrutinized in claims of professional negligence. The characterization of the doctor-patient relationship as fiduciary in nature has also been extended to apply to dentists. In *R. (J.) v. White*,<sup>13</sup> a 33 year old plaintiff sought damages from a dentist for sexual assaults that began at the age of thirteen. The defendant doctor 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, however, disagreed, concluding that the fact that the defendant was a dentist and not a doctor did not materially alter any of the

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<sup>12</sup> [1992] 2.S.C.R. 226 at p.

<sup>13</sup> (2001), 52 O.R. (3d) 353 (S.C.J.).



considerations established in *Norberg*. The defendant dentist did indeed owe the plaintiff a fiduciary duty.

### A. The Protection of 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*.<sup>14</sup> In *Re Axelrod*, 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 was, however, to be permitted access to the patient list and files if any disciplinary matter arose). Dr. Axelrod sought to oppose Medi-Dent's request on the basis that his fiduciary obligations to his patients, and specifically, the 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

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<sup>14</sup> (1994), 29 C.B.R. (3d) 74.



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.

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 cooperation, 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, such as Alberta<sup>15</sup> and Ontario,<sup>16</sup> have passed statutes which specifically address the management of health information. Others, such as British Columbia, rely on their general provincial *Privacy Acts* for standards for management of patient information (the “Acts”).<sup>17</sup> The Acts regulate the collection, use, dissemination, and access to personal information collected in the course of business. The standards set out in the Acts varies by province, but generally requires that personal information be kept confidential and that the consent of the patient must be sought prior to any disclosure.

The duty of confidentiality of information has become one of the keystones of dental practice. Dentists and dental health professionals, who have access to confidential information, must be sensitive to the duty of confidentiality imposed upon them. 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.

## **V. LIABILITY FOR FAILURE TO OBTAIN INFORMED CONSENT**

### **A. The Evolution and Definition of Informed Consent**

Prior to 1980, the law in Canada with respect to medical professional negligence was tipped in favour of the medial practitioner. Simply, if a patient consented to treatment, no matter how ill-advised, the patient had no action against his or her doctor for “trespass”. Canada moved away from the aforementioned paternalistic approach in

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<sup>15</sup> *Health Information Act*, 2001, c.H-5.

<sup>16</sup> *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sched. A.

<sup>17</sup> *Personal Information Protection Act*, R.S.B.C. 1996, c.165.



*Reibl v. Hughes*, [1980] 2 S.C.R. 880, a decision of the Supreme Court of Canada involving an action against a surgeon for failing 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 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.

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 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.*”<sup>18</sup>

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

- (a) Is the risk material, unusual or special?
- (b) If yes, is there a duty of disclosure upon the doctor to disclose the risks?
- (c) If so, did the breach of the duty the cause of the plaintiff’s damages?<sup>19</sup>

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.<sup>20</sup>

Accordingly, a medical practitioner is obligated to disclose all risks that a patient would likely attach significance to 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.<sup>21</sup>

Consider that one in every 100,000 wisdom tooth extractions results in a jaw fracture. A medical practitioner is not legally obligated to inform the patient of the risk if there is

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<sup>18</sup> *Hopp v. Lepp*, [1980] 2 S.C.R. 192; 112 D.L.R. (3d) 67, p.81.

<sup>19</sup> *Videto v. Kennedy* (1981), 33 O.R. (2d) 497 (Ont. C.A.), p. 501 and p. 503.

<sup>20</sup> *Reible v. Hughes*



nothing particular to the patient's bone structure to increase the risk of a jaw fracture. The risk is not material.<sup>22</sup> However, if the dentist is aware that the patient has severe osteoporosis the risk of a fractured jaw is a material risk to the 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.<sup>23</sup>

Consider the risks associated with a root canal. During a root canal, drill bits have been known to break off and lodge in the root of a tooth. Often it is not possible for the dentist to 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.<sup>24</sup> However, after the drill bit becomes lodged in the root, and it is

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<sup>21</sup> *Rawlings v. Lindsay* (1982), 20 C.C.L.T. 301 (B.C.S.C.), p. 306.

<sup>22</sup> *Carter v. Higashi* (1993), 15 Alta. L.R. (3d) 51 (Q.B.)

<sup>23</sup> *White v. Turner* (1981), 31 O.R. (2d) 773.

<sup>24</sup> *Curteneau v. Kapusianyk*, 2001 BCSC 1290; *Kuper v. McMullin* 37 C.C.L.T. 318, 30 73 N.B.R. (2d) 288.



determined it cannot be removed, a medical practitioner has a duty to disclose information about the options for further treatment.<sup>25</sup>

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.<sup>26</sup> Personal concerns, in the age of internet research are increasing as patients have greater access to information about the risks associated with a procedure. However, when answering a patient's specific questions a medical practitioner is entitled to consider the emotional condition of the patient and the patient's apprehension or reluctance to undergo a procedure or treatment in filtering or generalizing the information provided.<sup>27</sup>

#### **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, it is incumbent on the court to consider the following factors:

- (a) inherent risks of treatment;
- (b) whether the ramifications of treatment are serious;
- (c) the frequency of the risk;

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<sup>25</sup> *Kuper v. McMullin*, 37 C.C.L.T. 318, 30 73 N.B.R. (2d) 288.

<sup>26</sup> *Hopp v. Lepp*, [1980] 2 S.C.R. 192.

<sup>27</sup> *Malette v. Shulman* (1987), 43 C.C.L.T. 62; affirmed (1990), 67 D.L.R. (4<sup>th</sup>) 321 (Ont. C.A.).



- (d) the information normally given to patient's undergoing the same procedure;
- (e) the gravity of the patient's condition;
- (f) the importance of the benefit of the treatment;
- (g) any need to encourage the patient to accept treatment;
- (h) the intellectual and emotional capacity of the patient;
- (i) the information the doctor knows or should know that the patient deems relevant to the patient's decision to choose a treatment; and
- (j) evidence from the patient, and his/her family, as to the information the patient would have wanted to be provided with prior to the election or refusal of treatment.<sup>28</sup>

In addition to the considerations used to evaluate the common law duty to disclose as listed above, a majority of Canadian provinces have passed legislation that outline the requirements of obtaining informed consent.<sup>29</sup> Accordingly, the common law and applicable medical health statues underscore the patient's right to make an informed choice.

What can complicate the duty of disclosure are the variations in anatomical factors between patients. For example, in every wisdom tooth extraction the extent of the proximity of the sinus floor to the root tip increases the risk of the perforation of the sinus. The perforation of the sinus floor can cause chronic sinus infections. A dentist

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<sup>28</sup> *Rossmann v. Sas*, 1997 CarswellOnt 4274 (Gen.Div.), para 83

<sup>29</sup> *Health Care Consent Act*, R.S.O. 1996 c. 2; *Health Care (Consent) and Care Facility (Admission) Act*, 1996 R.S.B.C. c. 181; *The Health Care Directives Act*, C.C.S.M. c. H-27; *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1; *Consent to Treatment Act and Health Care Directive Act*, R.S.P.E.I. 1988, c. C-17.



duty to disclose the risk is dependent upon the distance of the root tip to the sinus floor.<sup>30</sup>

#### **E. Was the Breach of the Duty to Disclose the Cause of the plaintiff's Damage?**

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 can not succeed if it can be established 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, would a "reasonable person" in the plaintiff's position, on a balance of the probabilities, have opted against the treatment if the dentist had provided full disclosure of the material risks?<sup>31</sup>

The "reasonable person" who sets the standard for the objective test must be 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.<sup>32</sup>

The plaintiff has the onus of establishing that the medical practitioner's failure of make a proper disclosure amounted to negligence.<sup>33</sup> However the clinical records of the medical practitioner will be a critical tool in defending the claim.

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<sup>30</sup> *Rossmann v. Sas*, 1997 WL 1926929 (Ont. Gen Div.), 1997 CarswellOnt 4274

<sup>31</sup> *De Vos v. Robertson* (2000), 48 C.C.L.T. (2d) 172

<sup>32</sup> *Smith v. Arndt, et al.* (1997), 148 D.L.R. (4<sup>th</sup>) 48 (S.C.C.), p. 56

<sup>33</sup> 1991 WL 1140278 (Ont. Gen Div.)



## 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.<sup>34</sup>

It may surprise you that the doctrine of informed consent does not extend 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 decision to refuse blood was an informed choice or that the card represents the current wishes of the patient.<sup>35</sup>

If a patient is conscious and capable, what complicates the right to refuse treatment is the freedom of choice to elect a treatment that may fit the patient's values, attitudes, and experience but does not fit with the preferred recommended treatment. Whether the medical practitioner is ultimately responsible for the patient's poor medical choice, is rooted in the consultation and discussion making process prior to the treatment and evidenced by the medical practitioner's clinical notes.

In the situation where a patient has chosen an inappropriate procedure, and blamed the dentist for his or her choice, the court will closely consider what the dentist advised in relation to acceptable standard dental practice. The court will consider whether, on the balance of the probabilities, the defendant was negligent in explaining to the patient the risks and viability of alternative treatment options. In other words was the patient

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<sup>34</sup> *Malette v. Shulman* (1987), 48 C.C.L.T. 62; affirmed (1990), 67 D.L.R. (4<sup>th</sup>) 321 (Ont. C.A.).

<sup>35</sup> *Malette v. Shulman* (1987), 48 C.C.L.T. 62; affirmed (1990), 67 D.L.R. (4<sup>th</sup>) 321 (Ont. C.A.).



adequately informed of their options and with this information did the patient decided to proceed with an option that they were advised against.<sup>36</sup>

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:

- (a) the impossibility of obtaining the patient's consent (assuming him to be an adult of sound mind); and
- (b) the procedure was immediately necessary to preserve the health and life of the patient.<sup>37</sup>

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.

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<sup>36</sup> *Whissell v. Trus*, 2001 CarswellOnt 44 (S.C.J.).

<sup>37</sup> *Malette v. Shulman* (1987), 43 C.C.L.T. 62; affirmed (1990), 67 D.L.R. (4<sup>th</sup>) 321 (Ont. C.A.).



## 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.<sup>38</sup> 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.<sup>39</sup>

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.

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<sup>38</sup> Informed Consent in 2001: "Don't Leave Home Without It" Eleanore A. Cronk June 2001 Royal College of Dental Surgeons of Ontario as a special supplement to the June 2001 issue of *Dispatch*

<sup>39</sup> *Diack v. Bardsley* (1983), 46 B.C.L.R. 240, 25 C.C.L.T. 159 (S.C.).



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:

- (a) the name and date of the dental appointment;
- (b) a notation that the drill bit used for the root canal broke off and lodged in the root canal;
- (c) as a result of the lodged drill bit in the root canal the endodontic treatment could not be completed;
- (d) referral to an endodontist for the special removal of the drill bit;  
and
- (e) 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:

- (a) the date and name of the patient;
- (b) the reason for why the extraction was necessary;
- (c) a statement involving the patient was warned of the risks and the possible surgical outcome;
- (d) the consequences of not obtaining the treatment were discussed and a consent form was provided;



- (e) a detailed account of the treatment and procedures as discussed;
- (f) the costs of the procedure; and
- (g) 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.<sup>40</sup>

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 there are no surrounding or other circumstance making one version of events more probable than the other, the court will utilize the following theories to determine which information is most reliable:

- (a) 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;
- (b) affirmative conflicting evidence is favored over negative evidence; and
- (c) 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, particularly when the

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<sup>40</sup> *A Handbook for Ontario Dentists*, Section 4, "Malpractice-Proofing A Dental Practice"



practitioner has no particular reason to remember the transaction in question.<sup>41</sup>

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 provinces, 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.<sup>42</sup>

If a patient is not competent a legal guardian or other substitute caregiver must consent to the medical procedure on behalf of the incompetent patient or child. A patient is not legally competent if the patient is not capable of understanding the information that is relevant to making a decision about treatment; or unable to appreciate the foreseeable risks of a medical decision.

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<sup>41</sup> *Diack v. Bardsley* (1983) 46 B.C.L.R. 240 (S.C.), para. 35.

<sup>42</sup> The age of consent to medical treatment is 18 years of age in Prince Edward Island and Saskatchewan. The age of consent to medical treatment in New Brunswick and British Columbia is 16 years old. In Quebec the age of consent to medical treatment is 14 years old. In all other provinces there is no legislative age of consent.



## 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. This section of the paper will consider the application of the doctrine of vicarious liability in the context of sexual assaults perpetrated at medical and dental clinics.

The Supreme Court of Canada, considering two child sexual assault cases, *Bazley v. Curry* [1999] 2 S.C.R. 534 and *Jacobi v. Griffiths* [1999] 2 S.C.R. 570 (S.C.C.) has delineated the principles of the doctrine of vicarious liability. Specifically, the doctrine of vicarious liability imposes liability on employers for the wrongful conduct of their employees and agents, provided that the conduct is sufficiently related to the conduct authorized by the employer. Imposition of vicarious liability on employers is a form of strict liability. Consequently, the employer may be without fault or blame for the underlying negligence or intentional misconduct of the tortfeasor.<sup>43</sup>

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.<sup>44</sup>

In *Bazley*, the employer operated a residential care facility for troubled children. An employee of the facility repetitively 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*

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<sup>43</sup> *Bazley v. Curry*, [1999] 2 S.C.R. 534 and *Jacobi v. Griffiths*, [1999] 2 S.C.R. 570 (S.C.C.)

<sup>44</sup> *Bazley v. Curry* [1999] 2 S.C.R. 534 and *Jacobi v. Griffiths* [1999] 2 S.C.R. 570 (S.C.C.)



*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.*

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.

The most recent example of a medical clinic being held vicariously liable for a sexual assault perpetrated by an employee is *Weingerl v. Seo* (2005), 256 D.L.R. (4<sup>th</sup>) 1 (Ont. C.A.) In *Weingerl*, an ultrasound technician assaulted a female patient during an ultrasound. 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 the clinic’s enterprise and empowerment of the ultrasound technician materially increased the risk of sexual assault. The risk of sexual touching was increased by the fact that the ultrasound testing required or permitted the employee to touch the patient in “intimate body zones”.

It is important to note that the Ontario Court of Appeal 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 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.

## **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.

### **(i) Accuracy**

The content of a dental record 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.

**(ii) 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;
- lesions, growths, or abnormalities should be documented with diagrams for clarity; and
- corrections should be initialled and dated, but no changes may be made after notification of a claim or problem.



**(iii) Currency**

Dental records should be composed as follows:

- dates entered as they are created (including x-rays and electronic records);
- dates updated with subsequent visits; and
- practitioners should not rely on memory, but create clinical notes as soon as possible after the treatment or preferably during the visit.

**(iv) Organization**

In terms of practice management dentist should always:

- read records or letters prior to signing; and
- read their 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**

Importantly, dentists must also 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 pursuant to Freedom of Information and Protection of Privacy law<sup>45</sup>. 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

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<sup>45</sup> 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 *Personal Information Protection and Electronic Documents Act*.



provincial professional licensing body or the Professional Liability Program. In the U.S., 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: *People v. Sinski*, 669 N.E.2d 809 (N.Y. 1996).

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.

In addition to Freedom of Information and Protection of Privacy Law, 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.

Also be advised that 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, POSTPONEMENT OF LIMITATION PERIODS AND THE ULTIMATE LIMITATION PERIOD**

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 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 paper 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’ principals 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 the plaintiff knew, or ought to have known, that: (a) they 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.<sup>46</sup>

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<sup>46</sup> See the below summary of provincial limitation statutes, for example, the *Alberta Limitations Act*. R.S.A. 2000, c. L-12



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.*"<sup>47</sup> Put 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*"<sup>48</sup>.

Caution is urged however, when considering whether or not the discoverability rule will apply. There is case law to suggest that the judge-made discoverability rule will not apply in cases where the governing limitations legislation provides clearly that the limitation period starts running from the occurrence of a particular event. So for example, where the limitation provision states that the action must be commenced "within one year from the date when the professional services terminated in respect of the matter", then it will not matter that 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.<sup>49</sup>

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<sup>47</sup> *M. (K.) v. M. (H.)*, [1992] 3 S.C.R. 6

<sup>48</sup> *Central & Eastern Trust Co. v. Rafuse*, [1986] 2 S.C.R. 147

<sup>49</sup> See for example the following cases: *Langenhahn v. Czyz* 158 D.L.R. (4th) 615, 61 Alta. L.R. (3d) 115 (ABCA); *Perrie v. Martin*, [1986] 1 S.C.R. 41 (S.C.C.); *Fehr v. Jacob*, [1993] 5 W.W.R. 1 (Man. C.A.).



## **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 have provisions that deal with the running of the limitation period as it relates to minors or those 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.

## **D. British Columbia**

### ***(i) Basic Limitation Period***

The *Limitation Act*<sup>50</sup> provides that no claim may be brought by a person seeking damages in respect of injury to a person, whether based on contract, tort or statutory duty, after the expiration of 2 years after the date on which the right to do arose. This



establishes, in essence, the basic 2 year period in which a claim for dental injury must be brought by a claimant, subject to a postponement of the limitation period or on the basis that the plaintiff is under a legal disability as described below.

**(ii) Postponement**

The Limitation Act provides that the running of time with respect to the limitation period for personal injury or professional negligence does not begin to run against the plaintiff until the identity of the Defendant is known to the plaintiff and *“those facts within the plaintiff’s means of knowledge are 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.”* As discussed above, this represents an example of a statutory postponement provision that provides in essence that the limitation period will not start to run until the plaintiff knows, or ought to know, that a breach of duty caused injury to the plaintiff. The case law suggests that a proper interpretation of this ‘obscure’ provision, is to ask the following question: *“in light of his or her own particular circumstances and interests, at what point could the plaintiff reasonably have brought an action?”*<sup>51</sup>

In British Columbia, 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.

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<sup>50</sup> *Limitation Act*, R.S.B.C. 1996, c.266

<sup>51</sup> *Novak v. Bond*, [1999] 1 S.C.R. 808



**(iii) *Ultimate Limitation Period***

In claims where the limitation is subject to a postponement as described above, the *Limitation 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”. Interestingly, a dentist in British Columbia is not statutorily defined as a ‘medical practitioner’. However, an amendment to the *Limitation Act*, has been passed to extend the expiration of the limitation period for claims against dentists as defined in the *Dental Act* to 10 years from the date on which the right to do so arose.

**E. Alberta**

**(i) *Basic Limitation Period***

Alberta has enacted a relatively new *Limitations Act*<sup>52</sup>, which effectively brings the various limitation periods found in multiple statutes into one essential Limitations Act. The Alberta *Limitations Act* provides that a claimant must seek a remedial order (a judgement for example) within 2 years of when the claim arose. In the dental context, a claim based on a breach of duty would occur when the conduct, act, or omission of the dentist occurs.

**(ii) *Postponement***

The Alberta *Limitations Act* provides that a remedial order must be sought within 2 years after the date on which the claimant first knew, or ought to have known, that an

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<sup>52</sup> *Limitations Act*, R.S.A. 2000, c. L-12



injury had occurred, that the injury was attributable to the conduct of the Defendant, and that the injury warrants bringing a proceeding.

The Alberta Court of Appeal has noted that based on the wording of the statutory discoverability provisions in the Limitations Act, it is possible to have 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 discovery of the injury. Therefore, it may begin at different times for different injuries for which remedial orders are sought*”<sup>53</sup>

Interestingly, the *Limitations Act* provides that the claimant bears the legal burden of proving that a remedial order was sought within the 2-year limitation period. While the *Act* requires that the limitation period be plead 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 *Limitations Act* provides that the limitation period is suspended 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.

### ***(iii) Ultimate Limitation Period***

The *Limitations Act* provides for a 10-year ultimate limitation period, by which a claim must be brought. The 10-year ultimate limitation period applies regardless of the statutory discoverability provisions found in the context of the 2 year limitation period.

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<sup>53</sup> *Sun Gro Horticulture Canada Ltd. v. Abe's Door Service Ltd.*, 2006 CarswellAlta 1067 (ABCA)



## F. Saskatchewan

### (i) *Basic Limitation Period*

Saskatchewan has recently enacted a new *Limitations Act*<sup>54</sup>, which has rationalized the various limitation periods found in other statutes. In particular, it was once provided that an action in professional negligence against a dentist was subject to a one-year limitation period. Actions against dentists are now subject to the standard limitation period set out in the *Limitations Act*, which is a 2-year period “from the day on which the claim is discovered”.

### (ii) *Discoverability/Postponement*

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.

The new *Limitations Act* has not yet received much judicial comment, particularly as it relates to the interpretation of the statutory discoverability provisions.

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. As pertains to the latter, the *Limitations Act* provides that 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 behalf of that person.

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<sup>54</sup> *Limitations Act*, S.S. 2004, c. L-16.1



**(iii) *Ultimate Limitation Period***

Section 7 of the *Limitations Act* provides that no claim shall be commenced after 15 years from day on which the act or omission on which the claim is based took place. As such, claims for latent injury caused by a dentist must be commenced before the expiration of the 15 year ultimate limitation period.

**G. Manitoba**

**(i) *Basic Limitation Period***

The limitation period that applies to dentists in Manitoba is governed by the *Dental Association Act*,<sup>55</sup> which states in essence that a claim for negligence or malpractice against a dentist must be brought within 2 years “from the date when, in the matter complained of, those professional services rendered terminated”.

**(ii) *Postponement/Discoverability***

The *Limitations of Actions Act* provides that in certain circumstances the limitation period can be extended for actions commenced or continued. The *Act* provides that the court may grant leave to commence the action if it is satisfied that not more than 12 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 as more than 12 months have not passed since the date on which the plaintiff ‘discovered’ that he or she was injured and that he knew or ought to have known that the injury appeared to have been caused by the act or omission of a prospective defendant.

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<sup>55</sup> *Dental Association Act*, C.C.S.M. c. D30



The case law in Manitoba suggests that the appropriate approach to interpretation the postponement provisions of the *Limitations of Actions Act* is similar to the approach taken by the Supreme Court of Canada in interpreting the provisions of the British Columbia *Limitations Act*. Further, the Manitoba Court of Appeal has noted that for all intents and purposes, “the applicable principles for both the common law rule and the legislative scheme remain the same for all practical purposes”.<sup>56</sup>

In *Fehr v. Jacob*,<sup>57</sup> the Manitoba Court of Appeal noted that the judge-made discoverability principals 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 principal; rather, any extension of the limitation period must be found within the context of the *Limitation of Actions Act* itself.

### **(iii) Ultimate Limitation Period**

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 30 years from the date on which negligence or malpractice occurred. The 30 year ultimate limitation period further applies to any potential extension of the limitation period as provided above.

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<sup>56</sup> See *Johnson v. Johnson*, 2001 CarswellMan 610 (Man CA)

<sup>57</sup> 1993 CarswellMAN109



## H. Ontario

### (i) *Basic Limitation Period*

The Ontario *Limitations Act, 2002*,<sup>58</sup> establishes a basic 2 year limitation period from the date that the ‘*claim was discovered*’. The *Act* replaces many of the special limitations periods that had applied to various groups of medical practitioners. The *Act* now specifically applies to all claims of medical malpractice or negligence, and includes claims for dental malpractice or negligence.

### (ii) *Discoverability/Postponement*

Similar to other provinces, the Ontario *Limitations Act, 2002* 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.

The limitation period is postponed during any period in which the claimant is a minor (and is 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 psychological condition” (and is not represented by a litigation guardian regarding the claim).

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<sup>58</sup> S.O. 2002, chapter 24



**(iii) *Ultimate Limitation Period***

The *Limitations Act, 2002* provides a 15 year ultimate limitation period for all claims from the date on which the incident giving rise to the claim occurred. In other words, the claim is barred after 15 years from the date of the incident regardless of the discoverability provisions.

**I. *New Brunswick***

**(i) *Basic Limitation Period/Discoverability/Postponement***

The governing legislation for limitation periods is found under the New Brunswick *Medical Act*, which provides that an action for negligence or malpractice against any medical practitioner (which includes a dentist) 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.

This particular provision of the *Medical Act* thus introduces a statutory discoverability scheme whereby the limitation period will essentially not commence until the injured party is aware of the ‘facts’ which underlay the claim for negligence against the dentist. There does not appear to be any case law which discusses the interpretation of what the ‘facts’ would have to consist of, but given the interpretation of similar worded provisions in other jurisdictions, one would assume that the facts would include the knowledge of the offending party, the breach of a duty owed to the injured party, and knowledge of a resulting injury.



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.

## J. Nova Scotia

### (i) *Basic Limitation Period*

The *Limitations of Actions Act*<sup>59</sup> 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.

### (ii) *Postponement*

There is caselaw in Nova Scotia to suggest that the common-law discoverability principals have no application to claims brought pursuant to dental negligence or malpractice. The reasons relate to the specificity of the limitation provision found in the *Limitations of Actions Act*. The provision is clear that the time begins to run from the date that the professional services terminated. In *Smith v. McGillivray*<sup>60</sup>, the Nova Scotia Supreme Court noted that, consistent with the law of other jurisdictions, the discoverability principal 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.

However, the *Limitation of Actions Act* extends the limitation period in certain circumstances. In essence, there is discretion granted to the court to extend the limitation period, but the limitation period cannot be extended where the action is commenced more than 4 years after the limitation period had expired. The *Act*

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<sup>59</sup> R.S., c. 258, s. 1



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*”.

### ***(iii) Ultimate Limitation Period***

Given the wording of the postponement provisions, it would appear that the ultimate limitation period in Nova Scotia would be 6 years for a claim of dental malpractice.

## **K. Newfoundland and Labrador**

### ***(i) Basic Limitation Period***

The basic limitation period for an action in professional negligence against a dentist in Newfoundland and Labrador is 2 years after the date on which the right to do so arose, which pursuant to the *Limitations Act*<sup>61</sup> is considered to be from the date on which the damage first occurs.

### ***(ii) Postponement***

The *Limitations Act* contains statutory postponement provisions, similar to other provinces, which provides that the limitation period is postponed in cases of

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<sup>60</sup> 2000 CarswellNS 417

<sup>61</sup> S.N.L. 1995, c. L-16.1



professional negligence does not commence until he or she 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”

**(iii) *Ultimate Limitation Period***

The *Limitations Act* provides for a 10-year ultimate limitation period, notwithstanding any postponement on discoverability or persons under a legal disability.

**L. Prince Edward Island**

**(i) *Basic Limitation Period***

The *Dental Professions Act*<sup>62</sup> provides that no civil action may be brought against any dentist regarding negligence or malpractice as it relates to professional services rendered unless that claim is brought within 6 months of when the professional service terminated.

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.

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<sup>62</sup> *Dental Profession Act*, R.S.P.E.I. 1988, c. D-6



**(ii) Postponement**

For persons under a legal disability, the *Statute of Limitations* provides that a person has 2 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 enunciated above apply in the context of determining whether a plaintiff's claim is barred by the passage of time. It should be noted that cases in Prince Edward Island suggest that issues of discoverability are not usually to be determined on a summary basis and are best left to the trial judge.<sup>63</sup> 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'.

**(iii) Ultimate Limitation Period**

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 by 6 months.

Province	Basic Limitation Period	Ultimate Limitation Period
British Columbia	2 years after the date on which the right to do so arose	6 years with an amendment yet to come into force extending the limitation period to 10 years

<sup>63</sup> See for example *Oliver v. Severance*, 2005 CarswellPEI 13



Alberta	Within 2 years of when the claim arose	10 years
Saskatchewan	2 years from the day on which the claim is discovered	15 years
Manitoba	2 years from the date when the professional services terminated	30 years
Ontario	2 years from the day on which the claim is discovered	15 years
New Brunswick	2 years from the date when the professional services terminated	
Nova Scotia	2 years from the date when the professional services terminated	6 years
Prince Edward Island	6 months from the date when the professional services terminated	6 months
Newfoundland and Labrador	2 years after the date on which the right to do so arose	10 years

## IX. CONCLUSION

Knowledge of dental legislation, the standard of care, and of the typical negligence claims encountered by dentists is critical to identifying and employing strategies to manage professional liability risks. We hope that this paper has conferred a solid understanding of the many factors that must be considered in assessing dental professional liability claims. However, as the law related to dental professional liability is constantly evolving, we invite you to contact our offices to discuss the application of the law to the facts and circumstances of your claim.