DISCIPLINE COMMITTEE OF THE COLLEGE OF DENTURISTS OF ONTARIO

PANEL:	Barry Solway	Chairperson
	Barbara Smith	Public Member
	Robert Velensky, DD	Professional Member

BETWEEN:

COLLEGE OF DENTURISTS OF ONTARIO	)	BERNARD LEBLANC for College of Denturists of Ontario
- and -	)	
ADRIAN HAIGH	)	VALERIE WISE for Adrian Haigh
	)	Heard: May 2, 2013

DECISION AND REASONS

This matter came on for a hearing before a panel of the Discipline Committee on May 2, 2013 at Victory Verbatim Court Reporters in Toronto, Ontario.

The Allegations

At the commencement of the hearing, College counsel advised the panel that the College was requesting leave to withdraw a number of allegations set out in the Notice of Hearing, dated September 9, 2010 and marked as Exhibit 1. The panel granted this request. The remaining allegations as set out in the Notice of Hearing are as follows.

1. Adrian Haigh was at all material times a denturist, registered to practice denturism in the Province of Ontario.

2. (Amended) In respect of the following patients, Mr. Haigh withdrawn failed to document for the purpose for extended treatments:

   (a) Mr. Haigh relined Mr. RS's complete upper denture two weeks after he inserted new dentures.

   (b) Withdrawn.

   (c) Withdrawn.

   (d) Mr. Haigh rebased TR's precision dentures eight months after insertion.

   (e) Withdrawn.

   (f) Mr. Haigh rebased DT's full lower denture three weeks after insertion. No explanation was provided. Additionally, Mr. Haigh relined DT's complete upper denture six months after insertion, without providing any reason for the procedure in his records.

   (g) Mr. Haigh fabricated precision dentures for KF. Subsequently Mr. Haigh had to do a complete denture reline, then an upper and lower denture remake, another upper denture reline, and then an upper denture rebase.

   (h) The dentures that Mr. Haigh fabricated for ME began to fall out of her mouth approximately one year after insertion. Mr. Haigh also rebased ME's complete upper denture and relined it twice.

   (i) Mr. Haigh relined NA's dentures four months after insertion as they did not fit well despite making adjustments, and he needed to repair the bottom denture when a wire broke.

   (j) Mr. Haigh did a reline for Anne A, even though they were precision dentures.

   (k) Mr. Haigh remade Claire C's partial upper denture.

   (l) Withdrawn.

(m) Withdrawn.

3. (Amended) Mr. Haigh thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) withdrawn of section 1 of Ontario regulation 854/93 under the Denturism Act, 1991.

4. Withdrawn.

5. Withdrawn.

6. Withdrawn.

7. Withdrawn.

8. (Amended) Mr. Haigh failed to keep proper records in respect of the following patients:

   a. Anne A: (Amended) The treatment plan at the initial December consult indicated precision dentures plus bleaching, yet there were no subsequent references to patient education regarding bleaching, the shade used, or an indication that bleaching was completed. Also the records did not indicate why these precision dentures required a reline.

   b. MA: (Amended) Mr. Haigh billed MA for bleaching although the records contained no information with regards to shade use, insert of bleaching tray, or patient education regarding bleaching.

   c. Withdrawn.

   d. Mr. Haigh's patient records contained no treatment plan, medical history or oral assessment. Nor did the records describe the condition of the patient's ridges.

   e. Withdrawn.

   f. Claire C: (Amended) Mr. Haigh's billing records indicated a cast partial upper denture plus bleaching tray costs of $1400.00 yet his patient records did not indicate that a bleaching tray was inserted, the particular shade used, or that the patient was education regarding bleaching. Further, the records contained no indication of the teeth used for the cast partial upper design.

   g. P de J: (Amended) Mr. Haigh's patient records did not indicate that he performed an oral assessment, nor did they contain a treatment plan. The records also failed to indicate why the patient's dentures were rebased and not relined.

   h. Withdrawn.

   i. Withdrawn.

   j. Withdrawn.

k. KF: (Amended) Mr. Haigh's records contained no oral assessment or patient history.

l. RS: Mr. Haigh's records contained no information indicating that he provided patient education regarding bleaching or whether bleaching was completed.

m. Withdrawn.

n. DR: The records contained no oral assessment.

o. Withdrawn.

p. Withdrawn.

q. Withdrawn.

r. Withdrawn.

9. (Amended) Mr. Haigh thereby engaged in professional misconduct within the meaning of paragraphs 2 (failing to maintain the standards of practice of the profession) of section 1 of Ontario regulation 854/93 under the *Denturism Act, 1991*.

10. With respect to his patients Alvera A, AW, KF, DR, JV, DT, MS, and VB, Mr. Haigh used an incorrect breakdown did of billing codes for injection processes acrylic procedures for his patients.

11. (Amended) Mr. Haigh thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of Ontario regulation 854/93 under the Denturism Act, 1991.

12. Withdrawn.

13. Withdrawn.

14. Withdrawn.

15. Withdrawn.

16. Withdrawn.

17. Withdrawn.

18. Withdrawn.

19. Withdrawn.

20. (Amended) With respect to Mr. Haigh's patient Marjorie A, the records indicated that the member billed the patient's insurance company on June 29, 2006, the same day he took first impressions. Payment was received July 27, 2006 whereas the records indicated that the insertion date was September 6, 2006. Mr. Haigh failed to maintain proper records.

21. Withdrawn.

22. Withdrawn.

23. (Amended) With respect to Mr. Haigh's patients HP and BP, Mr. Haigh fabricated precision dentures, but the records contained no information with respect to a facebow transfer, final impressions, or teeth used, necessary procedures in the fabrication of precision dentures. Mr. Haigh failed to maintain appropriate records.

24. (Amended) With respect to Mr. Haigh's patient TR, Mr. Haigh fabricated precision dentures, but the records contained no information with respect to facebow transfer, final impression, or teeth used, procedures required in the fabrication of precision dentures. Mr. Haigh failed to maintain proper records.

25. Withdrawn.

26. Withdrawn.

27. (Amended) Mr. Haigh engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of Ontario regulation 854/93 under the Denturism Act, 1991.

Member's Plea

As set out in the Agreed Statement of Facts, described below, the Member admitted that he engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of Ontario regulation 854/93 under the Denturism Act, 1991. The panel was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel of the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts (marked as Exhibit #2) which provided as follows:

1. The Complainant, C.C., was a former employee of Mr. Haigh's who initiated her complaint in January 2007, after leaving the Member's employ. No patient complaints formed the basis of the referral of any allegations of professional misconduct to the Discipline Committee. The College appointed an investigator in July 2007, and allegations of professional misconduct against Mr. Haigh were referred to the Discipline Committee on November 12, 2009.

2. Mr. Haigh admitted to the College investigator on February 29, 2008 that his record-keeping could use improvement. While his hearing was pending, Mr. Haigh voluntarily completed a course in record-keeping through the Ontario Dental Hygenists Association.

3. Mr. Haigh admits that, in respect of the following patients, he failed to document the purpose for the following extended treatments, which were done at no additional charge to the patients:

   (a) Mr. Haigh relined Mr. RS's complete upper denture two weeks after he inserted new dentures.

   (b) Mr. Haigh rebased TR's precision dentures eight months after insertion.

   (c) Mr. Haigh rebased DT's full lower denture three weeks after insertion. No explanation was provided. Additionally, Mr. Haigh relined DT's complete upper denture six months after insertion, without providing any reason for the procedure in his records.

   (d) Mr. Haigh fabricated precision dentures for KF. Subsequently Mr. Haigh had to do a complete denture reline, then an upper and lower denture remake, another upper denture reline, and then an upper denture rebase.

   (e) The dentures that Mr. Haigh fabricated for ME began to fall out of her mouth approximately one year after insertion. Mr. Haigh also rebased ME's complete upper denture and relined it twice.

   (f) Mr. Haigh relined NA's dentures four months after insertion as they did not fit well despite making adjustments, and he needed to repair the bottom denture when a wire broke.

   (g) Mr. Haigh did a reline for Anne A, even though they were precision dentures.

   (h) Mr. Haigh remade Claire C's partial upper denture.

4. Mr. Haigh admits that he thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of the Ontario Regulation 854/93 under the Denturism Act, 1991.

5. Mr. Haigh admits that he failed to keep proper records in respect of the following patients:

   (a) Anne A: The treatment plan at the initial December consult indicated precision dentures plus bleaching, yet there were no subsequent references to patient education regarding bleaching, the shade used, or any indication that bleaching was completed. Also, the records did not indicate why these precision dentures required a reline.

   (b) MA: Mr. Haigh billed MA for bleaching although the records contained no information with regards to shade used, insert of bleaching tray, or patient education regarding bleaching.

(c) NB: Mr. Haigh's patient records contained no treatment plan, medical history or oral assessment. Nor did the records describe the condition of the patient's ridges.

(d) Claire C: Mr. Haigh's billing records indicated a case partial upper denture plus bleaching tray yet his patient records did not indicate that a bleaching tray was inserted, the particular shade used, or that the patient was educated regarding bleaching. Further, the records contained no indication of the teeth used for the cast partial upper design.

(e) P de J: Mr. Haigh's patient records did not indicate he performed an oral assessment, nor did they contain a treatment plan. The records also failed to indicate why the patient's dentures were rebased and not relined.

(f) KF: Mr. Haigh's records contained no oral assessment or patient history.

(g) RS: Mr. Haigh's records contained no information indicating that he provided patient education regarding bleaching or whether bleaching was completed.

(h) DR: the records contained no oral assessment.

6. Mr. Haigh admits that he thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of the Ontario regulation 854/93 under the Denturism Act, 1991.

7. With respect to the patients Alvera, A, AW, KF, DR, JV, DT, MS, and VB, the complainant C.C. used an incorrect breakdown of billing codes for injection processed acrylic procedures when entering the charges into the computer. If Mr. Haigh had testified, he would have explained that he sent Ms. C.C. for a 2-day training program on his software, at his expense (in terms of her registration fee and her time). However, Mr. Haigh admits that he himself did not detect the errors and recognizes the general principle that he is responsible for the operations of his office.

8. Mr. Haigh admits that he thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of the Ontario Regulation 854/93 under the Denturism Act, 1991.

9. With respect to Mr. Haigh's patient Marjorie A, the records indicate that the claim form was sent to the patient's insurance company on June 29, 2006, the same day that the member took first impressions, indicating that service was completed on June 29, 2006. The records indicate that the insertion date was September 6, 2006. The claim form bore the office stamp of the member. Had he testified, the member would have said that his office policy was not to issue claim forms until service was completed and the balance owing paid by the patient. Had he testified, the member would have denied any knowledge of this claim form having been sent, and would have testified that this was sent by the complainant C.C. However, the

member recognizes the general principle that he is responsible for the operations of his office.

10. With respect to Mr. Haigh's patients HP and BP, Mr. Haigh fabricated precision dentures, but the records contained no information with respect to facebow transfer, final impressions, or teeth used, necessary procedures in the fabrication of precision dentures. Mr. Haigh admits that he failed to maintain appropriate records.

11. With respect to Mr. Haigh's patient TR, Mr. Haigh fabricated precision dentures, but the records maintained no information with respect to facebow transfer, final impression, or teeth used, procedures required in the fabrication of precision dentures. Mr. Haigh admits that he failed to maintain proper records.

12. For each of these reasons, Mr. Haigh admits that he thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of the Ontario Regulation 854/93 under the Denturism Act, 1991.

13. The parties hereto agree that these facts are substantially accurate.

Decision

Based on the Agreed Statement of Facts and the Member's plea, the panel finds that Mr. Haigh engaged in professional misconduct within the meaning of paragraph 2 (failing to maintain the standards of practice of the profession) of section 1 of Ontario regulation 854/93 under the *Denturism Act, 1991*.

Reason for Decision

The panel was satisfied by the admissions and evidence set out in the Agreed Statement of Facts that the Member's record keeping in certain instances had fallen below a standard that would be reasonably expected of denturists.

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty (Exhibit #3) had been agreed upon. The Joint Submission as to Penalty provides as follows:

1. The member shall appear before the Panel of the Discipline Committee to be reprimanded, the fact of which shall be recorded on the public register of the College.

2. Directing the Registrar to suspend the member's certificate of registration for a period of one (1) month, such suspension itself to be suspended in the event that the member provides evidence satisfactory to the College that he has complied with paragraph 3, below. In the

event that the member fails to comply with paragraph 3, the members' certificate of registration shall be suspended on September 1, 2013 and the matter shall be reported to the Registrar.

3. Directing the Registrar to impose a specified term, condition and limitation on the member's certificate of registration requiring that the member complete a record keeping course satisfactory to the Registrar by no later than August 31, 2013, at the member's own expense.

4. There shall be no order as to costs.

5. The member acknowledges that this Joint Submission as to Penalty and Costs is not binding upon the Discipline Committee.

6. The member acknowledges that he has had the opportunity to receive, and has in fact received, independent legal advice.

Penalty Submissions

Counsel for the College and the Member jointed submitted that the proposed penalty was reasonable in the circumstances. This matter has had a lengthy and tortuous history. A penalty that focuses on rehabilitation – rather than denunciation is appropriate for this Member in this case.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and accordingly orders:

1. The member shall appear before the Panel of the Discipline Committee to be reprimanded, the fact of which shall be recorded on the public register of the College.

2. Directing the Registrar to suspend the member's certificate of registration for a period of one (1) month, such suspension itself to be suspended in the event that the member provides evidence satisfactory to the College that he has complied with paragraph 3, below. In the event that the member fails to comply with paragraph 3, the members' certificate of registration shall be suspended on September 1, 2013 and the matter shall be reported to the Registrar.

3. Directing the Registrar to impose a specified term, condition and limitation on the member's certificate of registration requiring that the member complete a record keeping course satisfactory to the Registrar by no later than August 31, 2013, at the member's own expense.

The panel makes no order as to costs.

Reasons for Penalty Decision

The panel agreed that a reprimand and remedial work is appropriate in this situation. The panel appreciated that the Member's admission saved the College significant costs that would have been incurred if a contested hearing had been required. Furthermore, the Member will incur costs associated with taking the educational course on record keeping.

The panel also recognizes that the Member incurred considerable costs with respect to his failed application for judicial review in this matter. While the Member was unsuccessful in that application, it was not without merit. In the circumstances, the panel is satisfied that this is not an appropriate case for costs.

I, Barry Solway, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

Chairperson

May 23/13
Date

Barry Solway
Barbara Smith
Robert Velensky, DD