DISCIPLINE SUMMARIES

DECISION 4

Dr. Jordan Lottman NO CURRENT PRACTICE ADDRESS

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Notice of Hearing #1:

- Failed to abide by a written undertaking given to the College (para. 54).
- Contravened a term, condition and limitation on his certificate of registration (para. 2).
- Disgraceful, dishonourable, unprofessional, unethical conduct (para. 59).

Notice of Hearing #2:

- Failed to maintain the standards of practice of the profession (para. 1).
- Charged an excessive or unreasonable fee (para. 31).
- Submitted an account or charge for dental services that he knew or ought to have known was false or misleading (para. 33).
- Disgraceful, dishonourable, unprofessional, unethical conduct (para. 59).

Notice of Hearing #3:

- Failed to maintain the standards of practice of the profession (para. 1).
- Treated without consent (para. 7).
- Charged an excessive or unreasonable fee (para. 31).
- Submitted an account or charge for dental services that he knew or ought to have known was false or misleading (para. 33).

Notice of Hearing #4:

• Failed to maintain the standards of practice of the profession (para. 1).

BRIEF SYNOPSIS OF FACTS

- This hearing included allegations arising from four Notices of Hearing, one that originated from a Registrar's investigation and three from complaints.
- One day after signing an undertaking with the College agreeing not to initiate or perform any endodontic treatment, Dr. Lottman performed and billed for endodontic treatment. Investigation revealed that he continued to provide endodontic treatment for 12 more patients over a period of four months, in breach of the undertaking.
- With respect to one patient, the member's diagnosis, treatment plan, case work up, in relation to extensive implant treatment was inadequate and ultimately the implants were poorly placed, and one implant protruded into the patient's maxillary sinus, which caused the patient ongoing pain and problems.
- With respect to the same patient, the member provided substandard and incomplete endodontic treatment which failed to properly obturate the canal and left an apparent void of 2mm in the middle of the canal. Dr. Lottman failed to advise the patient that the treatment was not successful or complete and failed to refer the patient to an endodontist to complete the treatment due to the calcified canal and billed the patient as if the treatment had been successfully completed.
- With respect to another patient, the member inserted an unconventional bridge, which was an inappropriate treatment option for which he did not obtain the patient's consent.

- With respect to the same patient, the member charged a fee for the complicated extraction of a tooth where the fee was not justified. In addition, a significant portion of the root of the tooth was not removed which would have been readily apparent. The patient was not informed and treatment options including referral to a specialist were not provided to the patient.
- With respect to another patient,
 Dr. Lottman failed to maintain the
 standard of practice by failing to obtain
 intra-procedural radiographs with a
 radio-opaque marker to check the
 insertion path of the drill when
 preparing an implant site.
 Consequently, he placed the implant
 very close to the apical area of another
 tooth which damaged the periapical
 nerve and blood supply to the other
 tooth, resulting in the development of
 an endodontic lesion.

DISCIPLINE SUMMARIES

DECISION

1. Finding

 The member pleaded guilty and was found guilty with respect to the above allegations.

2. Penalty

- · Reprimand.
- Suspension of certificate of registration for 6 months (March 28, 2013 – September 27, 2013).
- Restricted from performing surgical placement of implants until completion of a technical competency assessment and retention of a mentor.
- Mentoring program in the area of surgical implant treatment.
- Practice to be monitored for 36 months following completion of mentoring program.

3. Costs/Publication

- Costs awarded to the College in the amount of \$5,000.
- Member to pay monitoring costs.
- Pursuant to the legislation, publication of this matter includes the member's name and address.

4. Panel's Reasoning

- The penalty was a joint submission reached following a pre-hearing conference.
- The penalty was reasonable and met the objectives of protecting the public, serving as a specific deterrent to the member and a general deterrent for the profession, rehabilitating the member and maintaining public confidence in the profession.

- The panel considered the following aggravating circumstances:
 - The member had previously been found guilty of professional misconduct by the Discipline Committee in 2011.
 - The member disregarded the conditions of a written Undertaking given to the College on multiple occasions, including the very next day after signing the undertaking.
 - The member caused unnecessary pain and suffering to the three patients who filed complaints with the College.
 - The member charged excessive fees for substandard treatment in respect of one of those patients.
- The panel also considered mitigating factors which included:
 - The member's cooperation with the College in this matter.
 - The member's admission of guilt and the joint submission on penalty, which indicated his acceptance of responsibility and his remorse.
 - The restrictions placed on the member with respect to surgical implant placement will ensure that the public is not placed at risk and provides for the remediation of the member.
 - The length of the suspension and the length of the practice monitoring are reasonable and appropriate given the member's discipline history and his disregard for the undertaking that he gave to the College.