THE DISCIPLINE COMMITTEE OF THE
ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. KAREN LOGAN**, of the City of London, in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation").

AND IN THE MATTER OF the *Statutory Powers Procedure Act*, Revised Statutes of Ontario, 1990, Chapter S.22, as amended; 1993, Chapter 27; 1994, Chapter 27.

Members in Attendance: Dr. Richard Hunter (Chair)
Dr. William Coyne
Dr. Nancy Di Santo
Mr. Manohar Kanagamany
Mr. Gregory Larsen

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Megan Shortreed
	)	For the Royal College of Dental Surgeons of Ontario
- and -	)	
DR. KAREN DONNA LOGAN	)	Dr. Gary Srebrolow
	)	For Dr. Karen Logan
	)	Ms. Julie Maciura
	)	Independent Counsel for the Discipline Committee of the Royal College of Dental Surgeons of Ontario

Hearing held on August 30, 2016.

DECISION AND REASONS FOR DECISION

This matter arose by way of two Notices of Hearing, one dated August 15, 2013 (File H130010) and one dated January 22, 2015 (File H150001), both of which were served on the Dr. Karen Logan (or the "Member"). The hearing into both sets of allegations was set for and held on August 30, 2016.

The Member was present and was represented by Dr. Gary Srebrolow.

PUBLICATION BAN

The panel of the Discipline Committee made an Order that there shall be a ban on the publication or broadcasting of the identity of any patients of the Member, or any information that could disclose the identity of any patients that are named in the Notice of Hearing and/or the Agreed Statement of Facts and/or any of the exhibits in this matter.

ALLEGATIONS

The Notice of Hearing dated August 15, 2013 (H130010) alleged as follows:

1. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010, 2011 and 2012, you recommended and/or provided an unnecessary dental service relative to the following patients, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., I.	2011
F., Z.	2011
F.-G., M.	2012
L., H.	2010
M., K.	2011
S., M.	2011

Particulars:

- You placed restorations on the proximal surfaces of teeth that did not require restorations (A., I. tooth 15 D; F., Z. tooth 26 D; F.-G., M. teeth 18 D and 28 D; L., H. tooth 36 M (as per the records tooth 36; however the tooth appears to be tooth 37); M., K. teeth 47 M and D, and 46 M and D; and S., M. tooth 17 M), which was unnecessary treatment, for the above-listed patients.

2. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010, 2011 and 2012, you charged a fee that was excessive or unreasonable in relation to the service performed relative to the following patients, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., I.	2011
F., Z.	2011
F.-G., M.	2012
L., H.	2010
M., K.	2011
S., M.	2011

Particulars:

- You billed for the restoration of proximal surfaces of teeth that did not require restorations (A., I. tooth 15 D; F., Z. tooth 26 D; F.-G., M. teeth 18 D and 28 D; L., H. tooth 36 M (as per the records tooth 36; however the tooth appears to be tooth 37); M., K. teeth 47 M and D, and 46 M and D; and S., M. tooth 17 M), and therefore the fees were excessive or unreasonable.
- You billed for complete examinations without completing all the required documentation, that being extra-oral findings, intra-oral findings and odontograms (F., D. – Jan. 10/11 and F., Z. – Jan. 10/11), and therefore the fees were excessive or unreasonable.

3. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2008 and 2011, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to the following patients, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., R.	2011
D., R.	2011
G., J.	2011
L., H.	2011
R., M.	2008

Particulars:

- You did not provide the option of full metal and/or porcelain fused to metal crowns/bridge (A., R. tooth 47 crown; D., R. teeth 14-17 bridge; G., J. tooth 25 crown; L., H. tooth 15 crown and R., M. tooth 15 implant crown), to the above listed patients, therefore you could not have obtained the informed consent from these patients prior to providing those services.

4. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010 and 2011, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to the following patients, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., I.	2011
D., R.	2010
E., H.	2010
L., H.	2011
M., K.	2011
S., M.	2011

Particulars:

- You placed Zinc Oxide Eugenol (S., M. – tooth 46) and composite resin restorations (A., I. – tooth 16; D., R. – tooth 47; E., H. – tooth 47; M., K. – tooth 47; S., M. – teeth 47, 17, 16, 14, 27 & 26) in deep tooth preparations without using liners.
- You failed to take a post-operative endodontic periapical x-ray (L., H. tooth 15).

5. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010, 2011 and 2012, you delegated an act as set out in Section 4 of the *Act* except as permitted by the Regulations, relative to the following patients, contrary to paragraphs 3 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., R.	2010
B., F.	2011
C., T.	2011

D., S.	2011
E., E.	2011
F., D.	2011
F., Z.	2011
G., M.	2011
G., L.	2011
L., H.	2011
P., D.	2011
P., P.	2011
S., T.	2011
S., K.	2011
S., J.	2011, 2012
Z., D.	2011

Particulars:

- You allowed your office manager, L., M., an unregulated person, to instruct your dental hygienist (J., B.) to take x-rays for 2 patients (C., T. – Sep. 06/11 and P., D. – Oct. 04/11), which she did.
- You allowed your dental hygienist(s) to perform recall examinations on the following patients: A., R. – Apr. 01/10; B., F. – Feb. 10/11; D., S. – Aug. 22/11; G., L. – Jan. 13/11 and Aug. 18/11; L., H. – Jan. 26/11; S., T. – Mar. 22/11; S., K. – Feb. 16/11; S., J. – May 09/11 and Feb. 27/12 and Z., D. – Feb. 10/11. There is no indication that you performed the examinations and/or communicated the diagnoses to the patients.
- You permitted your dental hygienist (J., B.), who was not registered at the CDHO in the specialty category for restorative procedures, to use a high-speed hand piece on your patient's teeth (E., H. – May 04/11).
- You permitted your dental hygienists to perform procedures that are not listed in the Standards of Practice of the Profession Relating to the Performance of Orthodontic Procedures by Third Parties as follows: fitted and dispensed active removable orthodontic appliances (E., H. – Mar. 21/11; P., P. – Aug. 09/11, Oct. 19/11 and Dec. 01/11) fitted, placed and cemented an active fixed expansion appliance (P., P. – Mar. 22/11) and placed/cemented "attachments" for aligners (P., P. – Sep. 08/11).

  You permitted your dental hygienists to perform orthodontic procedures for your patients when you were not in the office (G., M. – Sep. 21/11 and P., P. – Sep. 08/11).
- You permitted your dental hygienists to perform orthodontic procedures for your patients without documentation of an order from you to do so in your records (E., H. – Mar. 21/11 and May 04/11; F., D. – Jul. 19/11; F., Z. – Jul. 19/11; G., M. – Sep. 21/11 and Nov. 17/11; P., P. – Mar. 22/11, Aug. 09/11, Sep. 08/11, Oct. 19/11 and Dec. 01/11).

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2011, you failed to keep records as required by the Regulations relative to the following patients, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
F., D.	2011
F., Z.	2011
J., C.	2011

Particulars:

- You failed to document an emergency examination (J., C. – Apr. 04/11).
- You failed to chart extra-oral findings, intra-oral findings and odontograms as part of your complete examinations (F., D. – Jan. 10/11 and F., Z. – Jan. 10/11).

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative one or more of the following patients, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., R.	2010
B., F.	2011
C., T.	2011
D., S.	2011
E., E.	2011
F., D.	2011
F., Z.	2011
G., M.	2011
G., L.	2011
L., H.	2011
P., D.	2011
P., P.	2011
S., T.	2011
S., K.	2011

S., J.	2011, 2012
Z., D.	2011

Particulars:

- You knew or ought to have known that your dental hygienist (J., B.) took x-rays for 2 patients (C., T. – Sep. 06/11 and P., D. – Oct. 04/11), based on instructions from your Office Manager, L., M., an unregulated person.

- You allowed your dental hygienist(s) to perform recall examinations on the following patients: A., R. – Apr. 01/10; B., F. – Feb. 10/11; D., S. – Aug. 22/11; G., L. – Jan. 13/11 and Aug. 18/11; L., H. – Jan. 26/11; S., T. – Mar. 22/11; S., K. – Feb. 16/11; S., J. – May 09/11 and Feb. 27/12 and Z., D. – Feb. 10/11. There is no indication that you performed the examinations and/or communicated the diagnoses to the patients.
- You permitted your dental hygienist (J., B.), who was not registered at the CDHO in the specialty category for restorative procedures, to use a high-speed hand piece on your patient's teeth (E., H. – May 04/11).
- You permitted your dental hygienists to perform procedures that are not listed in the Standards of Practice of the Profession Relating to the Performance of Orthodontic Procedures by Third Parties as follows: fitted and dispensed active removable orthodontic appliances (E., H. – Mar. 21/11; P., P. – Aug. 09/11, Oct. 19/11 and Dec. 01/11) fitted, placed and cemented an active fixed expansion appliance (P., P. – Mar. 22/11) and placed/cemented "attachments" for aligners (P., P. – Sep. 08/11).
- You permitted your dental hygienists to perform orthodontic procedures for your patients when you were not in the office (G., M. – Sep. 21/11 and P., P. – Sep. 08/11).
- You permitted your dental hygienists to perform orthodontic procedures for your patients without documentation of an order from you to do so in your records (E., H. – Mar. 21/11 and May 04/11; F., D. – Jul. 19/11; F., Z. – Jul. 19/11; G., M. – Sep. 21/11 and Nov. 17/11; P., P. – Mar. 22/11, Aug. 09/11, Sep. 08/11, Oct. 19/11 and Dec. 01/11).

The Notice of Hearing dated January 22, 2015 (H150001) alleged as follows:

1. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you charged a fee that was excessive or unreasonable in relation to the service performed relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., I.	2011
A., R.	2010, 2011
A., L.	2011, 2012
A., L.-L.	2012
B., F.	2010, 2011
B., R.	2011, 2012
C., T.	2010, 2011
C., B.	2011
D., K.	2011
D., R.	2010, 2011, 2012
D., S.	2011
F.-G., M.	2012
G., J.	2011
G., J.	2012
G., L.	2010
J., F.	2011
J., C.	2011
K., R.	2010, 2011
L., H.	2010, 2011
M., V.	2011
M., J.	2010, 2011
M., S.	2010, 2011
M., D.	2011
M., D.	2011, 2012
M., K.	2011
M., K.	2010, 2011
M., G.	2011, 2012
R., M. A.	2010, 2011, 2012
S., M.	2011
S., T.	2010
S., P.	2010, 2011
S., J.	2010, 2012
Z., S.	2011
Z., D.	2010

Particulars:

- You inappropriately used procedure code 41211 from the Ontario Dental Association Suggested Fee Guide for General Practitioners (Oral Disease Management Of Oral Manifestations, Oral Mucosal Disorders Mucocutaneous disorders and diseases of localized mucosal conditions…), for oral cancer screening; specifically, having a dental hygienist use

ViziLite on twenty-four (24) occasions. Oral cancer screening is considered part of the examination and diagnosis procedure performed by the dentist, and is not a separate billable procedure (B., F., B., R., C., B., D., K., D., S., J., F., J., C., K., R., L., H., M., V., M., J., M., S., M., D., M., K., M., K., R., M. A., P.S., S., J.).

- You billed/claimed a fee twice for a cephalometric x-ray image in respect of one patient, even though only one cephalometric x-ray image was taken (A., L.).
- You billed/claimed a fee for various x-ray images in respect of two (2) patients, but no x-ray images were provided to the College (I.A., C., T.).
- You inappropriately used procedure code 49101 from the ODA Suggested Fee Guide for General Practitioners, (Periodontal Re-evaluation/ Evaluation), for charting of periodontal probing depths by a dental hygienist and/or in conjunction with another examination procedure code in respect of twelve (12) patients. Charting of periodontal probing depths is not a separate billable procedure and code 49101 should not be used in combination with another examination procedure code (A., R., C., T., D., R., G., L., K., R., L., H., M., J., M., S., R., M., S., T., S., J., Z., D.).
- You inappropriately used procedure codes 92101 and 92102 from the ODA Suggested Fee Guide for General Practitioners, (local anaesthesia), in respect of one patient who only received scaling, and one patient who only received in-office bleaching, when the use of local anaesthetic for those dental procedures/services should not be charged (D., R., F.-G., M.).
- You billed/claimed a fee for an additional surface on dental restorations for four (4) patients, whereas post-operative x-ray images do not support that the surface in question was actually restored (L., H., M., K., S., M., Z., S.).
- You inappropriately used procedure code 71201 from the ODA Suggested Fee Guide for General Practitioners, (Removals, Erupted Teeth, Complicated), in respect of one patient, but the corresponding chart entry does not support that the extraction was complicated and required a surgical flap or sectioning of the tooth as this procedure code describes (J., C.).
- You inappropriately used procedure code 42311 from the ODA Suggested Fee Guide for General Practitioners (Periodontal Surgery, Gingivectomy), for four (4) patients when only laser treatment was provided by a dental hygienist. In addition to the 4 patients, there was one patient for whom no periodontal treatment, including laser treatment, was provided. Surgical procedures, such as gingivectomies, can only be performed by dentists (A., R., D., R., G., J., K., R., M., J.).
- You inappropriately used procedure code 42811 from the ODA Suggested Fee Guide for General Practitioners, (Periodontal Surgery, Proximal Wedge Procedure with Flap Curettage, per site), for one patient, but such procedure was not performed (M., G.).

- You inappropriately used procedure codes 16511 - 16514 from the ODA Suggested Fee Guide for General Practitioners, (Occlusal Adjustment/ Equilibration 1-4 units), in the following cases:
    - On eleven (11) occasions when no such treatment was provided and when TENS and/or EMGs and/or scans were performed instead; in addition, on three (3) occasions, no chart entries were available from the date in question (A., L., L.L.A, M., D., M., G., R., M.).
    - For one patient, when you cemented twelve crowns on August 15, 2011, and billed for occlusal adjustments on September 1 and 6, 2011, and January 16, 2012, when occlusal adjustment fee codes may only be employed in conjunction with basic restorative treatment when the adjustment is not required as a result of that restoration (M., G.).
- You charged a laboratory fee that was more than the commercial laboratory cost actually incurred in respect of three (3) patients (A., R., G., J., M., J.).

2. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 28 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., I.	2011
A., R.	2010, 2011
A., L.	2011, 2012
A., L.-L.	2012
B., F.	2010, 2011
B., R.	2011, 2012
C., T.	2010, 2011
C., B.	2011
D., K.	2011
D., R.	2010, 2011, 2012
D., S.	2011
E., H.	2010
F.-G., M.	2012
G., J.	2011
G., J.	2012
G., L.	2010
J., F.	2011
J., C.	2011

K., R.	2010, 2011
L., H.	2010, 2011
M., V.	2011
M., J.	2010, 2011
M., S.	2010, 2011
M., D.	2011
M., D.	2011, 2012
M., K.	2011
M., K.	2010, 2011
M., G.	2011, 2012
R., M. A.	2010, 2011, 2012
S., M.	2011
S., T.	2010
S., P.	2010, 2011
S., J.	2010, 2012
W., T.	2012
Z., S.	2011
Z., D.	2010

Particulars:

- You inappropriately used procedure code 41211 from the Ontario Dental Association Suggested Fee Guide for General Practitioners (Oral Disease Management Of Oral Manifestations, Oral Mucosal Disorders Mucocutaneous disorders and diseases of localized mucosal conditions…), for oral cancer screening; specifically, having a dental hygienist use ViziLite on twenty-four (24) occasions. Oral cancer screening is considered part of the examination and diagnosis procedure performed by the dentist, and is not a separate billable procedure (B., F., B., R., C., B., D., K., D., S., J., F., J., C., K., R., L., H., M., V., M., J., M., S., M., D., M., K., M., K., R., M. A., P.S., S., J.).
- You billed/claimed a fee twice for a cephalometric x-ray image in respect of one patient, even though only one cephalometric x-ray image was taken (A., L.).
- You billed/claimed a fee for various x-ray images in respect of two (2) patients, but no x-ray images were provided to the College (I.A., C., T.).
- You inappropriately used procedure code 49101 from the ODA Suggested Fee Guide for General Practitioners, (Periodontal Re-evaluation/ Evaluation), for charting of periodontal probing depths by a dental hygienist and/or in conjunction with another examination procedure code in respect of twelve (12) patients. Charting of periodontal probing depths is not a separate billable procedure and code 49101 should not be used in

combination with another examination procedure code (A., R., C., T., D., R., G., L., K., R., L., H., M., J., M., S., R., M., S., T., S., J., Z., D.).

- You inappropriately used procedure codes 92101 and 92102 from the ODA Suggested Fee Guide for General Practitioners, (local anaesthesia), in respect of one patient who only received scaling, and one patient who only received in-office bleaching, when the use of local anaesthetic for those dental procedures/services should not be charged (D., R., F.-G., M.).
- You billed/claimed a fee for an additional surface on dental restorations for four (4) patients, whereas post-operative x-ray images do not support that the surface in question was actually restored (L., H., M., K., S., M., Z., S.).
- You inappropriately used procedure code 71201 from the ODA Suggested Fee Guide for General Practitioners, (Removals, Erupted Teeth, Complicated), in respect of one patient, but the corresponding chart entry does not support that the extraction was complicated and required a surgical flap or sectioning of the tooth as this procedure code describes (J., C.).
- You inappropriately used procedure code 42311 from the ODA Suggested Fee Guide for General Practitioners (Periodontal Surgery, Gingivectomy), for four (4) patients when only laser treatment was provided by a dental hygienist. In addition to the 4 patients, there was one patient for whom no periodontal treatment, including laser treatment, was provided. Surgical procedures, such as gingivectomies, can only be performed by dentists (A., R., D., R., G., J., K., R., M., J.).
- You inappropriately used procedure code 42811 from the ODA Suggested Fee Guide for General Practitioners, (Periodontal Surgery, Proximal Wedge Procedure with Flap Curettage, per site), for one patient, but such procedure was not performed (M., G.).
- You inappropriately used procedure codes 16511 - 16514 from the ODA Suggested Fee Guide for General Practitioners, (Occlusal Adjustment/ Equilibration 1-4 units), in the following cases:
    - On eleven (11) occasions when no such treatment was provided and when TENS and/or EMGs and/or scans were performed instead; in addition, on three (3) occasions, no chart entries were available from the date in question (A., L., L.L.A, M., D., M., G., R., M.).
    - For one patient, when you cemented twelve crowns on August 15, 2011, and billed for occlusal adjustments on September 1 and 6, 2011, and January 16, 2012, when occlusal adjustment fee codes may only be employed in conjunction with basic restorative treatment when the adjustment is not required as a result of that restoration (M., G.).
- You charged a laboratory fee that was more than the commercial laboratory cost actually incurred in respect of three (3) patients (A., R., G., J., M., J.).

3. you committed an act or acts of professional misconduct as provided by s.51(1)(c)

of the *Code*, in that you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 33 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., I.	2011
A., R.	2010, 2011
A., L.	2011, 2012
A., L.-L.	2012
B., F.	2010, 2011
B., R.	2011, 2012
C., T.	2010, 2011
C., B.	2011
D., K.	2011
D., R.	2010, 2011, 2012
D., S.	2011
E., H.	2010
F.-G., M.	2012
G., J.	2011
G., J.	2012
G., L.	2010
J., F.	2011
J., C.	2011
K., R.	2010, 2011
L., H.	2010, 2011
M., V.	2011
M., J.	2010, 2011
M., S.	2010, 2011
M., D.	2011
M., D.	2011, 2012
M., K.	2011
M., K.	2010, 2011
M., G.	2011, 2012
R., M. A.	2010, 2011, 2012
S., M.	2011
S., T.	2010
S., P.	2010, 2011
S., J.	2010, 2012
W., T.	2012
Z., S.	2011
Z., D.	2010

Particulars:

- You inappropriately used procedure code 41211 from the Ontario Dental Association Suggested Fee Guide for General Practitioners (Oral Disease Management Of Oral Manifestations, Oral Mucosal Disorders Mucocutaneous disorders and diseases of localized mucosal conditions…), for oral cancer screening; specifically, having a dental hygienist use ViziLite on twenty-four (24) occasions. Oral cancer screening is considered part of the examination and diagnosis procedure performed by the dentist, and is not a separate billable procedure (B., F., B., R., C., B., D., K., D., S., J., F., J., C., K., R., L., H., M., V., M., J., M., S., M., D., M., K., M., K., R., M. A., P.S., S., J.).
- You billed/claimed a fee twice for a cephalometric x-ray image in respect of one patient, even though only one cephalometric x-ray image was taken (A., L.).
- You billed/claimed a fee for various x-ray images in respect of two (2) patients, but no x-ray images were provided to the College (I.A., C., T.).
- You inappropriately used procedure code 49101 from the ODA Suggested Fee Guide for General Practitioners, (Periodontal Re-evaluation/ Evaluation), for charting of periodontal probing depths by a dental hygienist and/or in conjunction with another examination procedure code in respect of twelve (12) patients. Charting of periodontal probing depths is not a separate billable procedure and code 49101 should not be used in combination with another examination procedure code (A., R., C., T., D., R., G., L., K., R., L., H., M., J., M., S., R., M., S., T., S., J., Z., D.).
- You inappropriately used procedure codes 92101 and 92102 from the ODA Suggested Fee Guide for General Practitioners, (local anaesthesia), in respect of one patient who only received scaling, and one patient who only received in-office bleaching, when the use of local anaesthetic for those dental procedures/services should not be charged (D., R., F.-G., M.).
- You billed/claimed a fee for an additional surface on dental restorations for four (4) patients, whereas post-operative x-ray images do not support that the surface in question was actually restored (L., H., M., K., S., M., Z., S.).
- You inappropriately used procedure code 71201 from the ODA Suggested Fee Guide for General Practitioners, (Removals, Erupted Teeth, Complicated), in respect of one patient, but the corresponding chart entry does not support that the extraction was complicated and required a surgical flap or sectioning of the tooth as this procedure code describes (J., C.).
- You inappropriately used procedure code 42311 from the ODA Suggested Fee Guide for General Practitioners (Periodontal Surgery, Gingivectomy), for four (4) patients when only laser treatment was provided by a dental hygienist. In addition to the 4 patients, there was one patient for whom no

periodontal treatment, including laser treatment, was provided. Surgical procedures, such as gingivectomies, can only be performed by dentists (A., R., D., R., G., J., K., R., M., J.).

- You inappropriately used procedure code 42811 from the ODA Suggested Fee Guide for General Practitioners, (Periodontal Surgery, Proximal Wedge Procedure with Flap Curettage, per site), for one patient, but such procedure was not performed (M., G.).
- You inappropriately used procedure codes 16511 - 16514 from the ODA Suggested Fee Guide for General Practitioners, (Occlusal Adjustment/ Equilibration 1-4 units), in the following cases:
    - On eleven (11) occasions when no such treatment was provided and when TENS and/or EMGs and/or scans were performed instead; in addition, on three (3) occasions, no chart entries were available from the date in question (A., L., L.L.A, M., D., M., G., R., M.).
    - For one patient, when you cemented twelve crowns on August 15, 2011, and billed for occlusal adjustments on September 1 and 6, 2011, and January 16, 2012, when occlusal adjustment fee codes may only be employed in conjunction with basic restorative treatment when the adjustment is not required as a result of that restoration (M., G.).
- You charged a laboratory fee that was more than the commercial laboratory cost actually incurred in respect of three (3) patients (A., R., G., J., M., J.).

4. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, you charged a laboratory fee for a dental appliance or device that was more than the commercial laboratory cost actually incurred by you relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 35 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., R.	2011
G., J.	2011
M., J.	2011

Particulars:

- You charged a laboratory fee that was more than the commercial laboratory cost actually incurred in respect of three (3) patients.

5. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010 and/or 2011 and/or 2012 and/or 2013, and/or 2014, you published, displayed, distributed, or used or

caused or permitted, directly or indirectly, the publication, display, distribution or use of any advertisement, announcement or information related to your practice, contrary to paragraph 60 of Section 2 of the Dentistry Act Regulation.

Particulars:

- Your website claims you have "Neuromuscular expertise."
- You referred to yourself as a "Holistic dentist" on your business cards.
- You included testimonials on your website.
- You refer to your continuing education, including LVIM, and LVI courses from "a world-class post-graduate dental training centre."
- You describe yourself as an "LVI fellow."
- Your description of your oral cancer screening (using ViziLite) may reasonably be regarded as suggestive of uniqueness or superiority over another member or practice.

6. you committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical during the year(s) 2010 and/or 2011 and/or 2012 and/or 2013, and/or 2014, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Particulars:

- Despite having signed an Undertaking/Agreement dated May 14, 2009 (which has by now expired) regarding your advertisements, you have continued to use promotional material (2010 - 2014) which the College alleges is inappropriate, including your reference to your "Neuromuscular expertise" and your certification in "neuromuscular dentistry."
- You refer to yourself as a "Holistic dentist" on your business cards.
- You refer to your continuing education, including LVIM, and LVI courses from "a world-class post-graduate dental training centre."
- You describe yourself as an "LVI fellow."

MEMBER'S PLEA

Prior to taking the Member's plea, College counsel advised the Panel that the parties were proceeding on the basis of an Agreed Statement of Facts.

The Member pled guilty to the allegations as set out in the Agreed Statement of Facts.

THE EVIDENCE

The Agreed Statement of Facts, which was made an exhibit in the hearing, is set out below:

Background

1. Dr. Karen Logan (or the "Member") has been registered with the Royal College of Dental Surgeons of Ontario (the "College") as a general dentist since 2002.

2. At the relevant times, she worked as a dentist at in her own practice called Surrideo Dental, in various locations in London, Ontario. She practices though Logan Dentistry Professional Corporation, which received a Certificate of Authorization from the College on January 13, 2004.

The Notices of Hearing

3. The allegations of professional misconduct against the Member are set out in two Notices of Hearing, as follows:

   a. H130010: Notice of Hearing dated August 15, 2013 (attached at Tab A);

   b. H150001: Notice of Hearing dated January 22, 2015 (attached at Tab B).

4. The College and the Member have agreed to resolve the allegations on the basis of the facts and admissions set out below.

Withdrawals and Pleas

5. The College is not proceeding with respect to Allegations 2 and 5 in Notice of Hearing H130010, and Allegations 1, 2, and 4 in Notice of Hearing H150001.

6. Accordingly, with leave of the Discipline Committee, the College withdraws these Allegations.

7. Further, Dr. Logan only pleads to the remaining particulars of the allegations as detailed below.

Facts and Admissions

i. H130010

8. The facts giving rise to the allegations in H130010 came to the attention of the

College through a report by Dr. G. A. a member of the College who practised as a locum dentist at Surrideo Dental between September 6 and October 6, 2011, while Dr. Logan was in Costa Rica on maternity leave.

9. In particular, Dr. A. raised concerns about clients who had not given informed consent because they had not been told about metal and porcelain-fused to metal (PFM) options for fillings and crowns, treatment plans for restorations where there was no clinical evidence of decay radiographically or intra-orally, and delegation of duties to hygienists that they were not qualified to perform by Dr. Logan or her office manager L., M. without Dr. A.'s knowledge.

10. The College's investigator, Dr. Chris Swayze, attended at Dr. Logan's dental office on March 6, 2012. During his visit, Dr. Swayze obtained patient charts for 13 patients identified by Dr. A, as well as for other randomly selected patients, for a total of 30 charts. Dr. Swayze also obtained radiographs and financial records for all 30 patients.

A. Allegation 1 – Unnecessary Dental Service in Relation to the Placement of Interproximal Restorations without Justification

11. The College's investigation identified several instances in which Dr. Logan completed and billed for restorations, without bitewing radiographic evidence of a carious lesion penetration beyond the dentino-enamel junction. While radiographs were available for these patients, some were panoramic xrays only, and did not show evidence of decay. There was also a lack of justification for the restorations in the patients' records.

12. Specifically, Dr. Logan admits that she performed unnecessary dental services by restoring 9 surfaces of teeth without justification, with respect to the following patients:

a. Patient: F., Z.
Tooth in question: 26
Surface in question: D
Date of Restoration: Jan 19, 2011
Examination of the digital panoramic radiographic image produced on January 10th, 2011 by the College's expert did not reveal the presence of caries on the distal aspect of tooth # 26. Further, per the College's expert, proper diagnosis of proximal caries is ideally based on examination of images of bitewing radiographs and not on panoramic images. Without having bitewing radiographs, Dr. Logan would not be able to determine the exact extent of the carious lesion with a high level of precision and if a restoration was warranted or not.

b. Patient: F.-G., M.
Tooth in question: 18
Surface in question: D
Date of Restoration: Feb 27, 2012
Examination of the digital panoramic radiographic image produced on July 19th, 2011 by the College's expert did not reveal the presence of caries on the distal aspect of tooth # 18. Further, per the College's expert, the right side bitewing radiograph that was made on the same day does not show the distal surface of tooth 18. Without having bitewing radiographs, Dr. Logan would not be able to determine the exact extent of the carious lesion with a high level of precision and if a restoration was warranted or not.

c. Patient: F.-G., M.
Tooth in question: 28
Surface in question: D
Date of Restoration: Feb 27, 2012
Examination of the digital panoramic radiographic image produced on July 19th, 2011 by the College's expert did not reveal the presence of caries on the distal aspect of tooth # 28. There is, however, per the College's expert, a radiolucent artifact in the image that coincided with the typical location of proximal caries on the distal surface on both enamel and dentin. This might have caused some confusion to Dr. Logan when she assessed the image and made her believe that a carious lesion existed at this location. Further, the left side bitewing radiograph that was made on the same day does not show the distal surface of tooth 28. Without having bitewing radiographs, Dr. Logan would not be able to determine the exact extent of the carious lesion with a high level of precision and if a restoration was warranted or not.

d. Patient: L., H.
Tooth in question: 37
Surface in question: M
Date of Restoration: March 19, 2010
Examination of the digital left posterior bitewing radiographic image produced on March 2nd, 2010 by the College's expert revealed the presence of an occlusal amalgam restoration, a carious lesion on the distal aspect of the tooth which appears to have penetrated enamel and progressed through the dentino-enamel junction into the outer half of dentin. However, per the College's expert, no caries was detected on the mesial aspect of the tooth, only a speck of calculus (hard plaque that can be removed by cleaning) attached to it. Therefore, placement of a restoration on the mesial aspect of the tooth was not justified.

e. Patient: M., K.
Tooth in question: 47
Surfaces in question: M & D
Date of Restoration: Aug 31, 2011
Examination of the digital right posterior bitewing radiographic image produced on August 15th, 2011 by the College's expert revealed overlap of some enamel of the mesial surface of tooth 47 with that of tooth 46. However, per the College's expert, the image did not reveal the presence of caries on the mesial surface of tooth 47. Further, per the College's expert, with regards to the distal surface of tooth 47, the image provided did not capture this surface in full and, therefore, no diagnosis was possible for this surface. Therefore, placement of a restoration on the mesial and distal aspects of tooth 47 was not justified.

f. Patient: M., K.
Tooth in question: 46
Surfaces in question: M & D
Date of Restoration: Aug 31, 2011
Examination of the digital right posterior bitewing radiographic image produced on August 15th, 2011 by the College's expert revealed that there is some enamel overlap on both mesial and distal surfaces of tooth 46 with those of the adjacent teeth. Further, per the College's expert, there was no evidence of caries on the mesial surface of tooth 46. On the distal surface there appears to be a radiolucent shadow that is most likely an artifact limited to the enamel surface; however, there is no strong evidence of it being true demineralization. Therefore, placement of a restoration on the mesial and distal aspects of tooth 46 was not justified.

g. Patient: S., M.
Tooth in question: 17
Surface in question: M
Date of Restoration: May 16, 2011
Examination of the digital right posterior bitewing radiographic image produced on April 11th, 2011 by the College's expert revealed the presence of an occlusal restoration on the tooth. The mesial surface appears to have an early carious lesion limited to the outer ½ of enamel. Further, per the College's expert, such enamel lesions are referred to as incipient carious lesions and are typically treated following a non-invasive preventative approach through fluoride application and enhancing the patient's oral hygiene habits. Therefore, the placement of a restoration was not justified in this case.

13. Further, Dr. Logan admits that in those instances where she took only panoramic

xrays, those images were not sufficient to properly diagnose caries.

14. Dr. Logan originally took the position in her response to the College that she diagnosed the caries through visual examination, and stated that she detected decay clinically by examining these teeth and proceeded to restore the teeth on this basis. She now acknowledges that visual examination alone of proximal surfaces of a posterior tooth when it has adjacent teeth on both sides does not allow the dentist to determine the presence of caries, and therefore, given that the radiographs did not reveal decay, the restorations were unnecessary.

15. Therefore, Dr. Logan admits that she recommended and/or provided an unnecessary dental service, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

16. The College leads no evidence about patient I.A., and Dr. Logan makes no admission in respect of that patient.

B. Allegation 3 – Treating Patients without Informed Consent

17. Dr. Logan ran a "metal free" office, and only advised her patients of ceramic crowns and bridges as the only option available.

18. Dr. Logan cemented 4 patients (A., R., G., J., L., H., and R., M.) with ceramic crowns (made from E-Max, Zirconia, PFM or Opalite) on posterior teeth, without any apparent or documented discussion about options for different crown materials.

19. A fifth patient (R.D) received a bridge on his posterior teeth made of Opalite Zirconia, with only a documented discussion about Opalite versus E-Max, but without any apparent or documented discussion about options for different bridge materials.

20. Dr. Logan's records do not contain any notation of specific informed consent associated with the material of choice for the crown and bridge therapy she provided the patients in question. In particular:

a. Patient A., R.'s chart notes that his mandibular right second molar was prepared for an E-Max crown and temporized on August 22, 2011. There is no evidence that alternative materials were discussed. This crown was cemented on September 15, 2011, following a failed attempt on September 6, 2011;

b. Patient G., J.' chart notes that her maxillary left second molar was prepared

for an E-Max crown and temporized on August 23, 2011. There is no evidence that alternative materials were discussed. This crown was cemented on September 13, 2011;

c. Patient L., H.'s chart notes that she had an E-Max crown cemented on her upper right second bicuspid on March 21, 2011. There is no evidence that alternate materials were discussed pre-treatment;

d. Patient R., M. had her maxillary right implant in the position of her second premolar restored five times over the course of three years. Each time, the crown's buccal cusp fractured in the same place. Zirconia and Opalite Zirconia materials were used at various times to reduce the potential for fracture; however, there is no evidence in the chart that speaks to the patient regarding the best choice of material for the crown. The entry on May 19, 2011, notes that the last crown was "100% Zirconium, therefore the breakage possibility is nil"; and

e. Patient D., R. had a Opalite Zirconium bridge encompassing his maxillary right first premolar to his maxillary right second molar prepared on January 18, 2011 and cemented on February 10, 2011. There are notes in the chart that detail the options given to this patient regarding the restoration of this edentulous space. Dr. Logan made it clear that she did not recommend this bridge option, that it was a costly option and that she did not expect this bridge to last due to the poor condition of the abutment teeth and the surrounding structures. The patient accepted these risks and opted to proceed. There is a notation in the chart dated January 18, 2011, regarding a decision to be made about whether the bridge should be Opalite Zirconia or E-Max, but there is no evidence that a discussion took place with the patient regarding this decision.

21. In her response to the Investigator's Report, Dr. Logan stated that all of these patients were aware that her practice was metal-free and therefore, she did not believe that these patients needed to be specifically advised of metal crown options. She now admits that this is still required.

22. Subsections 11(2) and (3) of Ontario's Health Care Consent Act state that in addition to all of a patient's questions being answered, patients are entitled to be informed about the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, the alternative courses of action and the likely consequences of not having treatment.

23. The College's Practice Advisory on Informed Consent Issues provides that:

> Dentists are advised that the more complicated or risky the treatment is, the more specific and detailed the consent and its documentation should be.
>
> …The dentist is well-advised to ensure that his or her notes of conversations regarding the nature and scope of the informed consent discussions are fully documented in the patient's chart.

24. Dr. Logan admits that she had an obligation to discuss full metal and partial metal restorative options with her patients even though she didn't provide this service, in order for her patients to ask the appropriate questions so that they were able to make the best choice for them.

25. Dr. Logan acknowledges that documentation is an essential part of obtaining informed consent. She failed to obtain informed consent insofar as she failed to document informed consent in relation to the patients set out above.

26. Therefore, Dr. Logan admits that she treated patients for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without documenting such a consent, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

C. Allegation 4 – Contravening the Standards of Practice

27. On February 10, 2011, Dr. Logan performed a root canal on tooth 15 for patient L., H., and failed to take post-operative endodontic periapical radiographs.

28. Following completion of an endodontic procedure, a periapical radiographic image of the treated tooth is typically necessary in order to assess if the root canal(s) was filled to an optimum level or if it was under- or over-filled.

29. Dr. Logan indicated in her written response to the College that she used an electronic apex locater while performing the endodontic procedure to determine the working length of the two canals that she found in this premolar tooth. While such device will provide a fairly accurate estimation of the canal length, errors may occur during subsequent obturation of the root canals with gutta percha (a special plastic filling material used for root canal obturation). Taking a radiographic image of the tooth with the gutta percha in place, whether before or after cementation of the gutta percha, is important in order to enable verification of optimal fill of the root canal and is considered to be a standard of practice.

30. In addition, Dr. Logan indicated in her response to the College that due to the advanced age of the patient (80-year-old) she decided not to proceed with taking

the post-operative radiograph of the tooth that received the endodontic treatment in order to minimize patient's stress. The radiographic image can be made at a later date when the patient is more relaxed; however, no other dental work should have been performed on the treated tooth until such periapical radiograph was made available. Review of the patient's chart revealed that Dr. Logan proceeded on the same day with placement of post, core and crown without producing a post-endodontic treatment radiograph.

31. Therefore, Dr. Logan acknowledges that she failed to maintain the standard of practice of the profession as she did not ensure that a post-endodontic treatment periapical radiograph was made available for her to examine before she proceeded to placement of post, core and crown on the tooth. This was contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 of the Notice of Hearing.

32. The College leads no evidence with respect to the first particular in Allegation 4 of the Notice of Hearing respecting the placement of Zinc Oxide Eugenol without liners, and Dr. Logan makes no admission in respect of those particulars.

D. Allegation 6 – Failure to Keep Records as Required

33. Dr. Logan charged patients F., D. and F., Z. for complete examinations on January 10, 2011, but no extra-oral findings, intra-oral findings, or odontograms were recorded in their charts. Dr. Logan has stated that the green orthodontic forms in the patients' records substituted for her charting in lieu of the odontograms.

34. A new patient examination is a comprehensive examination that encompasses a detailed review of a patient's medical and dental history and a thorough extra- and intra- oral examination. The extra-oral examination ought to include an assessment of the soft tissues, palpation of the musculature and an assessment of the submandibular and surrounding lymph nodes. The intra-oral examination ought to include a thorough assessment of the hard and soft tissues. The hard tissue assessment includes full charting of the dentition and completion of an odontogram. An assessment of any radiographs must be included as part of the hard tissue examination. The soft tissue assessment includes an assessment of periodontal status of the patient and, at minimum, periodontal screening of the supporting structures where applicable.

35. Dr. Logan coded for new patient examinations for F., D. and F., Z. on January 10, 2011. There are no entries in either of the patients' charts that indicate that any aspects of the aforementioned components of a new patient examination did in fact take place.

36. Dr. Logan has claimed that the information that she obtained as part of her new patient examination was entered into a specific orthodontic examination form. This explanation would constitute appropriate record keeping only if the dates of the examinations coincided and if a single charge was made for the two examinations. In both F., D. and F., Z.'s charts, the dates of the two examinations do not coincide. The new patient examinations took place on January 10, 2011 and the orthodontic examinations took place on February 2, 2011. There is no evidence in the written record that the new patient examination ever took place, even though there were two charges for two examinations.

37. Therefore, Dr. Logan acknowledges that with respect to these two patients and entries in their dental charts, her record keeping was not in accordance with the standards of practice of the profession.

38. Dr. Logan charged patient J., C. for an emergency examination on April 4, 2011, but there is no documentation in the patient file with respect to the emergency examination.

39. When a patient presents for an emergency examination, all basic aspects and general principles of recording keeping as set out in the College's Guideline on Dental Recordkeeping apply. The dental record must include the nature of the complaint, a review of the medical and dental history, an appropriate extra-oral examination, and an appropriate intra-oral examination. If radiographs are required, then a report on the radiographs is also required. The emergency record should then contain a differential or a definitive diagnosis and treatment plan. Any treatment rendered must be accompanied by appropriate informed consent, providing the conditions of the emergency support obtainment of consent.

40. J., C. attended Dr. Logan's office and was charged for an emergency examination on April 4, 2011. There is no entry in the dental record that identifies or describes this appointment. By not properly entering the details of this emergency appointment, Dr. Logan, by her own admission, did not meet the requirements for record keeping as set forth by the profession.

41. Dr. Logan acknowledges that she breached her professional, ethical and legal responsibilities that required her to maintain a complete record documenting all aspects of each patient's dental care, per the College's Dental Recordkeeping Guideline, and s. 38 of Regulation 547.

42. Therefore, Dr. Logan admits that she failed to keep records as required by the Regulations relative to the patients listed, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 6 of the Notice of Hearing.

E. Allegation 7 – Disgraceful, Dishonourable, Unprofessional or Unethical Conduct

(a) Failure to Properly Document Orders for Xrays

43. At the material time, Dr. Logan's office was managed by her husband, L., M., who is not a registered dentist or dental hygienist. Dr. Logan also employs dental hygienists registered with the College of Dental Hygienists of Ontario (CDHO).

44. While Dr. Logan was on maternity leave, she employed an associate dentist, Dr. B. During this time (from September 6 to October 6, 2011), a hygienist reported to Dr. B. that L., M. instructed her to take panoramic x-rays of 2 patients (C., T. and P., D.) even though the digital Panorex computer was not functioning properly as there was a problem retrieving the images. Dr. B. who was the only dentist present in the office at the time, denies ordering the x-rays. She says, and the charts confirm, that the xrays were already noted by the hygienist as "pan taken" when Dr. B. first saw the patients.

45. The hygienist who took the xrays, J., B., did not record in the charts for these patients who ordered the panoramic xrays. The hygienist states that Dr. Logan usually gave verbal instructions regarding taking x-rays. Dr. Logan never asked the hygienists to record her prescription or order for xrays in the patient charts. While the hygienist did not recall anything specifically regarding xrays taken while the Member was in Costa Rica, she indicates that both the Member and L., M. called the office while they were in Costa Rica. She says it was possible that either of them may have made an order for xrays over the phone, although she does not specifically remember this happening.

46. The Healing Arts Protection Act states that no person shall operate an xray machine for the irradiation of a human being unless the irradiation has been prescribed by… a member of the Royal College of Dental Surgeons of Ontario, among other licensed medical practitioners. Members of the CDHO are not permitted to prescribe xrays.

47. The Canadian Dental Association position paper on the Control of x-Radiation in Dentistry (2005) clearly states that the prescription of any dental radiograph must be made by a licensed dentist following an examination of the patient for purposes of diagnosis when the information required for diagnosis cannot be obtained from other sources. The purpose is to ensure that patients under a dentist's care receive the lowest dosage of radiation possible.

48. At the time these xrays were taken by the hygienist, the panoramic radiography

system was not operational such that the images made were non-retrievable. Dr. Logan's charts reveal that images were never retrieved for these patients.

49. Further, in patient C.'s case, a panoramic xray was taken less than 12 months prior and the associated fee for this second film was rejected by the patient's insurance company. The fee paid by the patient was refunded to the patient's account. There are no notations in the patient's chart that an updated film was necessary.

50. Therefore, Dr. Logan admits that she failed to ensure that she or her staff properly documented prescriptions for xrays. In this regard, she admits that she engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 7 of the Notice of Hearing.

(b) Failure to Properly Document Delegation of Recall Examinations

51. The recall examination chart entries for 9 patients (A., R., B., F., D., S., G., L., L., H., S., T., S., K., S., J. and Z., D.) appear to have been written by a dental hygienist and were not initialed, signed or otherwise attributable to Dr. Logan. Accordingly, there is no indication in the records that Dr. Logan performed the exams or communicated the diagnoses to the patients.

52. According to the College's Guideline on Dental Recordkeeping, "all entries should be signed, initialed or otherwise attributable to the treating clinician".

53. In all of the cases named above, the dental hygienist recorded finding or notations respecting a medical history update, radiographic images, soft tissue examination, hard tissue examination, "ViziLite" oral cancer scan, scaling, root planing and polishing teeth, and then set a subsequent recall date.

54. Dr. Logan's response to the College was that she did in fact attend these patients and did provide the diagnoses but was unable to initial the dental charts prior to filing. The hygienists have stated that the recall exams were in fact performed by Dr. Logan. Dr. Logan now acknowledges that the attending dentist is responsible for maintaining her records to an acceptable standard. If an office system was identified that did not support the dentist obtaining this standard, the dentist is required to ensure that the system is modified so that incomplete records cannot be filed prior to completion. Dr. Logan also failed to instruct her dental hygienists to name the dentist who attended the recall and provided the diagnosis for that particular patient in the dental record.

55. Therefore, Dr. Logan admits that she failed to ensure that she or her staff properly

documented recall examinations for these 9 patients on the dates noted in the Notice of Hearing. In this regard, she admits that she engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 7 of the Notice of Hearing.

(c) Failure to Properly Document Delegation of Orthodontic Procedures

56. Dr. Logan permitted her dental hygienists to perform orthodontic procedures on 3 patients (F., D., F., Z. and E., H.) without any documentation of a client-specific order in the patient records. The hygienists initialed all identified procedures in the patient charts.

57. Section 4(8) of the Dentistry Act, lists orthodontic treatment as a controlled act. Section 4 of the Dental Hygiene Act, permits dental hygienists to perform orthodontic and restorative procedures only if the procedure is ordered by a member of the RCDSO.

58. Comparable to a recall examination in general dentistry, in the practice of orthodontics, the dentist or the orthodontist should play an identifiable role and be easily identifiable as the responsible party when delegating procedures to auxiliary staff.

59. Dr. Logan's records do not identify her as the person responsible for making treatment decisions.

60. For the two F. patients, the records indicate that impressions were taken by the hygienist on July 19, 2011, without any apparent order or treatment plan recorded from Dr. Logan.

61. In patient E., H.'s record, on February 22, 2011, Dr. Logan noted that she delivered Invisalign aligners 16, 17 and 18. An assessment of the case was made and the chart was initialed by Dr. Logan. However, on March 21, 2011, aligners 20, 21 and 22 were delivered and decisions regarding the completion of the case were made by the dental hygienist. There is no initial in the record by Dr. Logan indicating that she made the decisions. The record also indicates that aligner 19 was bypassed but no reason was given for this. On May 4, 2011, E., H.'s case was completed by the dental hygienist and advice was given by her regarding her retention protocol. Again, there is no indication that Dr. Logan directed her dental hygienist in the management of E., H.'s orthodontic treatment.

62. Dr. Logan has stated that she has instructed her staff that her initials are required

on all chart entries of this nature, but that, in the past, charts have been filed away prior to her review and despite her instructions. Dr. Logan now acknowledges that she had the responsibility to put into place systems that would maintain a level of quality assurance dictated by the profession.

63. Therefore, Dr. Logan admits that she failed to ensure that she or her staff properly documented delegation of orthodontic procedures for these 3 patients on the dates noted in the Notice of Hearing. In this regard, she admits that she engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 7 of the Notice of Hearing.

64. The College leads no evidence with respect to the remaining particulars and patients in Allegation 7 of the Notice of Hearing, and Dr. Logan makes no admission in respect of those particulars or patients.

ii. H150001

65. During the course of Dr. Swayze's investigation, issues respecting billing and advertising came to his attention and were reported to the Registrar. Therefore, on May 30, 2013, the Registrar appointed Dr. Fred Eckhaus as investigator to inquire into those matters.

66. Dr. Eckhaus attended the Member's practice on March 4, 2014, and obtained at random the records of a further 25 patients, as well as advertising information displayed in Dr. Logan's office. He also preserved a copy of her website.

A. Allegation 3 – Submitting False or Misleading Accounts

67. The ODA Suggested Fee Guide is published annually for the benefit of the members of the Ontario Dental Association. The Fee Guide is distributed to all member dentists of the ODA, of which the vast majority are general dentists.

68. The guide is a comprehensive listing of titled procedure codes, associated with brief description as to what the code represents. Each code also has an associated fee. The fee is based on a system of relative value units or RVUs. The fee that is suggested for each code is determined by a committee of experts that assesses the complexity of the procedure relative to the time spent to complete the procedure. Each unit of time is 15 minutes.

69. Practitioners need not follow the guide to the letter, but patients and insurers rely on the code used to determine the dental work that is done.

(a) Code 49101

70. Dr. Logan charged a fee between $28.23 and $75.45 and used procedure code 49101 in respect of the following 12 patients for charting of periodontal probing depths by a dental hygienist and/or in conjunction with another examination procedure code:

Patient	**Date**	**Fee**	**Periodontal probing billed/claimed where indicated, in conjunction with another examination**
A., R.	Apr. 01/10	$75.45	and recall exam - $27.46
C., T.	Jan. 07/10	$30.00	
D., R.	May 05/10	$30.00	and recall exam - $27.46
G., L.	Mar. 01/10	$30.00	
K., R.	Feb. 03/10	$30.00	
L., H.	Apr. 14/10	$30.00	
M., J.	Mar. 22/10*	$30.00	and recall exam - $27.46
	Jun. 23/10	$30.00	
M., S.	Jan. 04/11	$30.00	and recall exam - $27.46
R., M.	Nov. 11/10	$30.00	
S., T.	Sep. 21/10	$30.00	and recall exam - $27.46
S., J.	Nov. 25/10	$30.00	
Z., D.	May 27/10	$30.00	

71. Dr. Logan stated that she believed code 49101 was the most appropriate code to use to account for sulcular measurements.

72. Code 49101 is a code that represents one unit of time as a follow-up service for the evaluation of ongoing periodontal treatment of to a post-surgical re-evaluation performed more than one month after surgery. The majority of practitioners would use this code to represent the time spent with a patient to assess the response to a specific periodontal procedure (such as pocket reduction surgery) above basic scaling and root planing, Unless a general dentist is performing a significant number of periodontal surgical procedures, the majority of the profession would anticipate that this code would be use most of the time by periodontal specialists. The majority of dental professionals would not use this code in conjunction with a general recall exam code as the reassessment of periodontal pocket depths following non-surgical sanative therapy would be part of the recall examination.

73. Dr. Logan did not perform any specific periodontal surgical procedures for any of the patients named above that warranted a follow-up appointment represented by code 49101. The patients were all on a periodontal maintenance program as part of their regular recall schedule. In 5 cases, she charged for a recall exam on the same visit.

(b) Billing for Restorations not Completed

74. Dr. Logan charged a fee for restoration of an additional surface in respect of the following 4 patients where post-operative x-ray images do not demonstrate the surfaces in question were restored in a conventional manner:

Patient	**Date**	**Tooth & Restoration**	**Surface**	**Post-operative X-ray Images**
L., H.	Mar. 19/10	36 MOD (tipped #37)	M	Jan. 26/11 BW
M., K.	Aug. 31/11	46 MODV	D	Sep. 14/11 PAs (2)
S., M.	May 16/11	17 MO	M	Feb. 27/12 BW
		16 MODL	D	Feb. 27/12 BW
Z., S.	Aug. 29/11	15 MOD	D	Dec. 12/12 BW

75. Examination of the digital radiographic images for each of these patients revealed that the subject surface was not included in the restoration performed. However, Dr. Logan billed for the additional surface in each case. In responding to the Investigation Report, Dr. Logan stated that she used minimally invasive restorative techniques and this is why that in some cases, the restorations were not visible on

post-treatment xrays as being conventional restorations.

(c) Code 71201

76. Dr. Logan used procedure code 71201 in respect of patient J., C. on April 21, 2011, when the corresponding chart entry with respect to the two teeth at issue (#18 and #28) did not support that the extraction was complicated and required a surgical flap or sectioning of the tooth as this procedure code describes.

77. Code 71201 represents a surgical approach to a complicated extraction where a tissue flap is raised, bone is removed, sutures are required, follow-up is involved and/or a tooth must be sectioned in order for the extraction to be completed. If none of these conditions are met, then the extraction must be coded as simple (71101).

78. Dr. Logan has stated that the extraction of teeth #18 and #28 were difficult due to access and, therefore, were justified to be billed under the heading of "complicated"; however, she now acknowledges that her use of the code was not justified.

(d) Code 42311

79. Dr. Logan used procedure code 42311 for 4 patients when only laser treatment was provided by a dental hygienist, as follows:

Patient	**Date**	**Fees**	**Dental Hygienist's Chart Notes**
A., R.	Jul. 06/10	$120.00 $120.00	"Perio laser 0.6 watts @ 37D & 47"
D., R.	Jul. 14/10	$120.00	"Perio laser to entire sextant @ 0.6 watts."
K., R.	Jan. 06/10	$120.00	"Perio laser Sext 3, 4, 6 @0.6 watts."
	Jan. 20/10	$120.00	"Perio laser @ 0.6 watts in Sext 1&3." (local anaesthetic administered to quadrant 2)
M., J.	May 04/10	$120.00 $120.00	"Perio laser @ sext 1&2 @ 0.6 watts."
	May 11/10	$120.00	"Perio laser @ 0.6 watts @ sext 3 (including 23D) re-laser of Q1."

80. Code 42311 represents a periodontal surgical code for an uncomplicated gingivectomy. Traditionally, this procedure involved the administration of local

anesthetic, removal of a band of tissue with a scalpel, possible sutures and/or packing of the surgical site. More recently, gingivectomies are being performed with either lasers alone or in combination with scalpels to achieve superior results. Whichever modality is utilized, the removal of tissue must be the desired outcome. In addition, the procedure must be accompanied by a one-month follow up appointment as part of the code.

81. Dr. Logan never performed a periodontal surgery procedure in any of the patients named above. The laser in these cases was used to activate a chlorohexidine gel to enhance the sanative effects of her scaling in an effort to reduce periodontal pocketing. No tissue was removed.

82. Dr. Logan did follow up with these patients but in the case of patients A., R., D., R., K., R., and M., J., she incorrectly coded and charged for a follow-up that should have been previously accounted for in the gingivectomy code.

83. Dr. Logan also used this same procedure code on October 9, 2012, in respect of a fifth patient, G., J., for whom no periodontal treatment, including laser treatment, was provided. There is no evidence in the record that this procedure ever took place.

(e) Code 42811

84. Dr. Logan used procedure code 42811 for patient M., G. on July 7, 2011, when the patient record did not indicate that such a procedure was performed.

85. Her chart notes only that “Ging v haemorrhagic and inflammed” and “Used laser to settle ging”.

86. Code 42811 is a periodontal surgery code known as the proximal wedge procedure involving tissue removal and curettage of the raised flap to surgically reduce the depth of a periodontal pocket.

87. Dr. Logan has stated that the code was entered incorrectly and that it should have entered 42311. Even if this code had been entered, it would have been inappropriate as the “use of a laser to settle gingiva” as part of a prosthetic procedure does not equate to a surgical gingivectomy and all that it entails.

88. In responding to the Investigation Report, Dr. Logan stated that the fees charged were reasonable in relation to the services provided. With respect to all of the billing outlined in paras. (a) through (e) above, Dr. Logan now admits that she submitted an account or charge for dental services that she knew or ought to have known was false or misleading, contrary to paragraph 33 of Section 2 of the

Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

89. The College leads no evidence with respect to the remaining particulars and patients in Allegation 3 of the Notice of Hearing, and Dr. Logan makes no admission in respect of those particulars or patients.

B. Allegation 5 and 6 – Misleading Advertising and Breach of an Undertaking

90. The Professional Misconduct regulation includes the following as an act of professional misconduct for the purposes of s. 51(1)(c) of the Code:

> 60. Publishing, displaying, distributing, or using or causing or permitting, directly or indirectly, the publication, display, distribution or use of any advertisement, announcement or information related to a member's practice, which,
>
> i. as a result of its content or method or frequency of dissemination, may be reasonably regarded by members as likely to demean the integrity or dignity of the profession or bring the profession into disrepute,
>
> ii. includes information that,
>
> A. is false, misleading, fraudulent, deceptive, ambiguous or confusing or likely to mislead or deceive the public because, in context, it makes only partial disclosure of relevant facts,
>
> B. is not relevant to the public's ability to make an informed choice, or
>
> C. is not verifiable by facts or can only be verified by a person's personal feelings, beliefs, opinions or interpretations,
>
> iii. makes comparisons with another practice or member or would be reasonably regarded as suggestive of uniqueness or superiority over another practice or member, or
>
> iv. is likely to create expectations of favourable results or to appeal to the public's fears.

91. The College's investigator, Dr. Chris Swayze, attended at Dr. Logan's dental office on March 6, 2012. He obtained from her office a business card which identified her as "Neuromuscular Dentist".

92. Dr. Fred Eckhaus attended the Member's practice on May 30, 2013, and obtained a business card which identified her as "Holistic Dentist".

93. In addition, Dr. Logan's website at that time contained the following statements:

a. it claimed she had "Neuromuscular expertise" and referred to herself as "an LVI trained Neuromuscular Dentist";

b. it included testimonials from patients;

c. it referred to her continuing education, including her attendance at the "Las Vegas Institute for Advanced Dental Studies (LVI)", and it indicated that she has completed "the seven core courses in pursuit of a Mastership of Aesthetics and Neuromuscular Dentistry designation (LVIM)", and other LVI courses;

d. it described her as an "LVI fellow".

94. In 2009, Dr. Logan entered into an Undertaking/Agreement with the College. At that time, the College had conducted an investigation with respect to an advertisement for Dr. Logan's office which contravened the regulations and guidelines of the College in that it implied that Dr. Logan was superior to other dentists and included a reference to a designation from a non-accredited university program. In particular, it made reference to receiving a "Fellow Designation from LVI" and undergoing "elective continuous training at LVI ... to maintain the best clinical ability in order to offer a high level of Aesthetic Neuromuscular Dentistry".

95. To resolve the matter without a referral to discipline, Dr. Logan entered into a voluntary Undertaking/Agreement with the following terms:

a. to immediately cease such advertisements;

b. to permit the College to publish a signed letter of apology in Dispatch; and

c. to have the College review all future promotional materials for approval prior to their publication and dissemination to the public for a period of 2 years.

96. In the letter of apology, Dr. Logan stated:

> I acknowledge that all designations obtained from completion of courses at LVI are not recognized in Ontario. I am also aware that neuromuscular dentistry is not a recognized specialty. Furthermore, as all dentists are required to take continuous education courses, I know it is considered inappropriate to include such references in my advertisements. ...
>
> I do accept and I will comply with the existing regulations, and will ensure that all my promotional material, including advertisements and websites, are in compliance with these regulations.

97. Dr. Logan admits that her business cards and website were contrary to paragraph 60 of section 2 in the following ways:

a. Despite the 2009 Undertaking and statements made in the Letter of Apology, Dr. Logan continued to describe herself in advertising using the title “Neuromuscular Dentist”, and as having “neuromuscular expertise”.

b. The testimonials on her website are not verifiable by facts, and/or can only be verified by a person’s personal feelings beliefs, opinions or interpretations; and

c. Despite the 2009 Undertaking and statements made in the Letter of Apology, Dr. Logan continued to refer to her LVI designations and courses on her website. LVI courses are not recognized in Ontario.

98. Further, Dr. Logan required patients to fill out an Oral Screening Consent Form, on which patients indicated whether they would like to have the ViziLite Plus exam performed (for an extra fee). The following excerpts from the consent form convey superiority/uniqueness or make claims that may be false, confusing or misleading:

> Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.
>
> We have incorporated the Vizilite Plus exam into our oral screening standard of care. We find that using Vizilite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages.
>
> Vizilite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear and PSA.
>
> Vizilite Plus is a simple and painless examination that gives the best chance to find oral abnormalities at the earliest possible stage.

99. Dr. Logan acknowledges that providing this information to the public without noting that this is a pre-diagnostic test and that a biopsy would be required to ascertain whether this is in fact cancerous tissue should an optical fluorescence device indicate a change in the tissues, was incomplete and/or misleading.

100. Therefore, Dr. Logan admits that she published, displayed, distributed, or used or caused or permitted, directly or indirectly, the publication, display, distribution or

use of advertisements, announcements or information related to her practice that were contrary to paragraph 60 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 5 of the Notice of Hearing.

101. In addition, Dr. Logan admits that she engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in that she breached her Undertaking/Agreement to the College and advertised in an unprofessional manner, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 6 of the Notice of Hearing.

Past History

102. Dr. Logan has been specifically warned by the ICRC and its predecessor committees about some of the very conduct she is now alleged to have engaged in. The decisions and the Undertaking are attached at Tab C.

103. In particular, in 2008, Dr. Logan was orally cautioned by the Complaints Committee about its concern that there was a lack of informed consent prior to treatment of a patient, and the need to fully document such discussions in the clinical record.

104. Further, in 2011, Dr. Logan was orally cautioned by the ICRC due to serious concerns about her clinical evaluation, record keeping, failure to consult, and lack of informed consent in the treatment of a patient. The Committee also required Dr. Logan to undertake a significant education and remediation program including courses, monitoring and mentoring.

105. There was also the report before the ICRC in 2009 respecting Dr. Logan's advertising (resulting in the above-noted Undertaking and apology).

106. The parties agree that the facts in relation to this history are relevant to the issues of remediation and sanction.

General

107. Dr. Logan admits that the acts described above constitute professional misconduct and she now accepts responsibility for her actions and the resulting consequences.

108. Dr. Logan has had the opportunity to take independent legal advice with respect to her admissions.

FINDING

The Member pled guilty and was found guilty with respect to the following specified allegations of professional misconduct as set out in the two Notices of Hearing:

Notice of Hearing #1 dated August 15, 2013 (File No. H130010)

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010, 2011 and 2012, you recommended and/or provided an unnecessary dental service relative to the following patients, contrary to paragraph 6 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., I.	2011[1]
F., Z.	2011
F.-G., M.	2012
L., H.	2010
M., K.	2011
S., M.	2011

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2008 and 2011, you treated patients for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without documenting such a consent relative to the following patients, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., R.	2011
D., R.	2011
G., J.	2011
L., H.	2011
R., M.	2008

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010 and 2011, you failed to maintain the standard of practice of the profession relative to the following patients, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

[1] The College did not proceed in relation to these patient particulars insofar as it alleged that the Member provided unnecessary dental service; consequently the Member's plea of guilty and the Panel's finding of professional misconduct is limited to the remaining patient particulars.

Patients:	Year(s):
A., I.	2011[2]
D., R.	2010[3]
E., H.	2010[4]
L., H.	2011
M., K.	2011[5]
S., M.	2011[6]

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year 2011, you failed to keep records as required by the Regulations relative to the following patients, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
F., D.	2011
F., Z.	2011
J., C.	2011

7. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional relative one or more of the following patients, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., R.	2010
B., F.	2011
C., T.	2011
D., S.	2011
E., E.	2011
F., D.	2011
F., Z.	2011
G., M.	2011[7]

[2] The College did not proceed in relation to these patient particulars in Allegation 4 of the Notice of Hearing insofar as it is alleged that the Member contravened the standards of practice regarding the placement of Zinc Oxide Eugenol without liners; consequently, the Member's plea of guilty and the Panel's finding of professional misconduct is limited to the remaining patient particulars.
[3] ibid
[4] ibid
[5] ibid
[6] ibid
[7] The College did not proceed in relation to these patient particulars in Allegation 7 of the Notice of Hearing insofar as it is alleged that the Member engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by Members as unprofessional; consequently, the

G., L.	2011
L., H.	2011
P., D.	2011
P., P.	2011[8]
S., T.	2011
S., K.	2011
S., J.	2011, 2012
Z., D.	2011

Notice of Hearing #2 dated January 22, 2015 (File No. H150001)

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you submitted an account or charge for dental services that you knew or ought to have known was false or misleading relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 33 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., I.	2011[9]
A., R.	2010, 2011
A., L.	2011, 2012[10]
A., L.-L.	2012[11]
B., F.	2010, 2011[12]
B., R.	2011, 2012[13]
C., T.	2010, 2011
C., B.	2011[14]
D., K.	2011[15]
D., R.	2010, 2011, 2012
D., S.	2011[16]
E., H.	2010[17]

Member's plea of guilty and the Panel's finding of professional misconduct is limited to the remaining patient particulars.

[8] ibid

[9] The College did not proceed in relation to these patient particulars in Allegation 3 of the Notice of Hearing insofar as it is alleged that the Member submitting false or misleading accounts; consequently, the Member's plea of guilty and the Panel's finding of professional misconduct is limited to the remaining patient particulars.

[10] ibid

[11] ibid

[12] ibid

[13] ibid

[14] ibid

[15] ibid

[16] ibid

[17] ibid

F.-G., M.	2012[18]
G., J.	2011[19]
G., J.	2012
G., L.	2010
J., F.	2011[20]
J., C.	2011
K., R.	2010, 2011
L., H.	2010, 2011
M., V.	2011[21]
M., J.	2010, 2011
M., S.	2010, 2011
M., D.	2011[22]
M., D.	2011, 2012[23]
M., K.	2011[24]
M., K.	2010, 2011
M., G.	2011, 2012
R., M. A.	2010, 2011, 2012
S., M.	2011
S., T.	2010
S., P.	2010, 2011[25]
S., J.	2010, 2012
W., T.	2012[26]
Z., S.	2011
Z., D.	2010

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010 and/or 2011 and/or 2012 and/or 2013, and/or 2014, you published, displayed, distributed, or used or caused or permitted, directly or indirectly, the publication, display, distribution or use of advertisements, announcements or information related to your practice that were contrary to paragraph 60 of Section 2 of the Dentistry Act Regulation.

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Code, in that you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as

[18] ibid
[19] ibid
[20] ibid
[21] ibid
[22] ibid
[23] ibid
[24] ibid
[25] ibid
[26] ibid

unprofessional during the year(s) 2010 and/or 2011 and/or 2012 and/or 2013, and/or 2014, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation.

The following specified allegations of professional misconduct were **withdrawn**:

Notice of Hearing #1 dated August 15, 2013 (File No. H130010)

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010, 2011 and 2012, you charged a fee that was excessive or unreasonable in relation to the service performed relative to the following patients, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., I.	2011
F., Z.	2011
F.-G., M.	2012
L., H.	2010
M., K.	2011
S., M.	2011

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, during the year(s) 2010, 2011 and 2012, you delegated an act as set out in Section 4 of the *Act* except as permitted by the Regulations, relative to the following patients, contrary to paragraphs 3 of Section 2 of the Dentistry Act Regulation.

Patients:	Year(s):
A., R.	2010
B., F.	2011
C., T.	2011
D., S.	2011
E., E.	2011
F., D.	2011
F., Z.	2011
G., M.	2011
G., L.	2011
L., H.	2011
P., D.	2011
P., P.	2011
S., T.	2011
S., K.	2011

S., J.	2011, 2012
Z., D.	2011

Notice of Hearing #2 dated January 22, 2015 (File No. H150001)

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you charged a fee that was excessive or unreasonable in relation to the service performed relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., I.	2011
A., R.	2010, 2011
A., L.	2011, 2012
A., L.-L.	2012
B., F.	2010, 2011
B., R.	2011, 2012
C., T.	2010, 2011
C., B.	2011
D., K.	2011
D., R.	2010, 2011, 2012
D., S.	2011
F.-G., M.	2012
G., J.	2011
G., J.	2012
G., L.	2010
J., F.	2011
J., C.	2011
K., R.	2010, 2011
L., H.	2010, 2011
M., V.	2011
M., J.	2010, 2011
M., S.	2010, 2011
M., D.	2011
M., D.	2011, 2012
M., K.	2011
M., K.	2010, 2011
M., G.	2011, 2012
R., M. A.	2010, 2011, 2012
S., M.	2011
S., T.	2010
S., P.	2010, 2011

S., J.	2010, 2012
Z., S	2011
Z., D.	2010

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that you signed or issued a certificate, report or similar document that you knew or ought to have known contained a false, misleading or improper statement relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 28 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., I.	2011
A., R.	2010, 2011
A., L.	2011, 2012
A., L.-L.	2012
B., F.	2010, 2011
B., R.	2011, 2012
C., T.	2010, 2011
C., B.	2011
D., K.	2011
D., R.	2010, 2011, 2012
D., S.	2011
E., H.	2010
F.-G., M.	2012
G., J.	2011
G., J.	2012
G., L.	2010
J., F.	2011
J., C.	2011
K., R.	2010, 2011
L., H.	2010, 2011
M., V.	2011
M., J.	2010, 2011
M., S.	2010, 2011
M., D.	2011
M., D.	2011, 2012
M., K.	2011
M., K.	2010, 2011
M., G.	2011, 2012
R., M. A.	2010, 2011, 2012
S., M.	2011
S., T.	2010

S., P.	2010, 2011
S., J.	2010, 2012
W., T.	2012
Z., S.	2011
Z., D.	2010

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, you charged a laboratory fee for a dental appliance or device that was more than the commercial laboratory cost actually incurred by you relative to one or more of the following patients during the year and/or one or more of the years specified opposite that patient's name, contrary to paragraph 35 of Section 2 of the Dentistry Act Regulation.

Patients	Year(s)
A., R.	2011
G., J.	2011
M., J.	2011

Reasons for Finding

The Member made the admissions and pled guilty to the allegations set out in the Agreed Statement of Facts. She did not dispute the allegations, particulars or facts presented in the Agreed Statement of Facts. The Panel found that the evidence contained in the Agreed Statement of Facts clearly constitutes professional misconduct and accordingly it accepted the admissions and found the Member guilty of professional misconduct.

PENALTY

A majority of the panel of the Discipline Committee (the "Majority") accepted a joint submission from the parties and imposed the following penalty and costs order, as it was set out in the Joint Submission, upon the Member, namely:

1. Requiring the Member to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

2. Directing the Registrar to suspend the Member's certificate of registration for a period of four (4) months, to run consecutively, such suspension to commence on September 19, 2016;

3. Directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration ("the Conditions"), which conditions

shall continue until the suspension of the Member's certificate of registration as referred to in subparagraph 1(b) above has been fully served, namely:

a) While the Member's certificate of registration is under suspension, the Member shall not be present in her dental office when patients are present, save and except for unforeseen non-patient related emergencies. Where the Member is required to attend for a non-patient related emergency, the Member shall immediately advise the Registrar of that fact including details of the nature of the emergency;

b) Upon commencement of the suspension, the Member shall advise all of the Member's staff as well as any other dentist in the office that the Member engages in practice with, whether that Member is a principal in the practice or otherwise associated with the practice, of the fact that the Member's certificate of registration is under suspension;

c) During the suspension, the Member shall not do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry and shall ensure that the Member's staff is instructed not to do anything that would suggest to patients that the Member is entitled to engage in the practice of dentistry during the suspension;

d) The Member shall permit and co-operate with any office monitoring which the Registrar feels is appropriate in order to ensure that the Member has complied with this Order, and in that connection, the Member shall provide access to any records associated with the practice in order that the College can verify that the Member has not engaged in the practice of dentistry during the suspension; and

e) The Conditions imposed in subparagraphs 3(a)-(d) above shall be removed at the end of the period the Member's certificate of registration is suspended;

4. Directing the Registrar to also impose the following terms, conditions and limitations ("conditions") on the Member's Certificate of Registration, namely:

a) the Member shall successfully complete, at her expense, within twelve (12) months of this Order becoming final, the ProBE Program for Professional/Problem-Based Ethics (must obtain an unconditional pass);

b) the Member shall successfully complete, at her expense, within twelve (12) months of this Order becoming final, a comprehensive hands-on course

approved by the College, with an evaluative component, regarding record-keeping, documenting orders, informed consent and restorative dentistry;

c) after the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served and after the Member successfully completes the courses referred to in subparagraphs 4(a) and 4(b) above, the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, for a period of twenty-four (24) months, or until a panel of the Inquiries, Complaint and Reports Committee is satisfied that monitoring is no longer necessary and has advised the Member of this in writing;

d) the Member shall cooperate with the College during the inspection(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $600.00 per monitoring inspection, such amount to be paid immediately after completion of each of the inspections, regardless of the number of inspections performed;

e) the representative or representatives of the College shall report the results of those inspections to the Inquiries, Complaints and Reports Committee of the College and the Inquiries, Complaints and Reports Committee may, if deemed warranted, take such action as it considers appropriate; and

f) after the suspension of the Member's certificate of registration as referred to in paragraph 2 above has been fully served, the Member shall submit all advertising and promotional material to the College for approval prior to using, disseminating, or publishing it in any medium, for a period of twelve (12) months; and

5. Furthermore, the panel ordered that the member pay costs to the College in the amount of $20,000 in respect of this discipline hearing, such costs to be paid in twelve (12) monthly installments of $1,666.67 each, due on the 1st day of each month commencing on October 1st, 2016, with the final payment due on September 1st, 2017.

Pursuant to the *Code*, the results of these proceedings will be recorded on the Register of the College and the College's publication of this Decision will include the Member's name and address.

Majority Reasons for Penalty

After deliberation, the Majority of the Panel agreed that the proposed order presented in the Joint Submission on Penalty was reasonable and in the public interest.

The Majority believes that the penalty meets the objectives of public protection, specific deterrence for the Member and general deterrence for the profession, and that it will serve to rehabilitate the Member and maintain public confidence in the profession.

The length and terms of the suspension are significant. The suspension, along with the oral reprimand and the publication of the decision, including the name and address of the Member, directly addresses the principles of specific and general deterrence as they are aimed at preventing this kind of conduct from being repeated, either by the Member herself or another member of the profession.

The requirement that the Member successfully complete the ProBe Program for Professional/Problem based Ethics Course (with the requirement for an unconditional pass), a comprehensive hands-on course (including an evaluative component) approved by the College with regard to record-keeping, documenting orders, informed consent and restorative dentistry, will serve to rehabilitate the Member. The requirement to submit to inspections of her practice (at her cost) for a period of 24 months following the suspension and successful completion of the course will serve in the rehabilitation of the Member and the protection of the Public. Additionally the member will be required to submit all advertising and promotional material to the College for approval for a 12 month period.

The Majority was satisfied that the penalty demonstrates to the public that the profession has no tolerance for a dentist who is found to have committed serious acts of professional misconduct and who breached the trust that her employees and patients placed in her.

Finally, the Majority accepts the joint submission on costs and recognizes that the amount of $20,000, while substantial, only partially reimburses the College for costs related to the investigation and hearing in relation to this matter.

In its deliberation on penalty the Majority considered as aggravating circumstances the fact that the conduct involved a breach of trust, the number of patients affected by the Members actions, and that the Member provided treatment that was deemed unnecessary to some patients. The Member did not heed previous “Cautions” and “Undertakings” made by the ICRC in years previously.

The Majority also considered the mitigating factors presented in the hearing which included: the Member’s co-operation with the College, the fact that this is the Member’s

first time before a Discipline panel, and the fact that the Member has taken responsibility for her actions by pleading guilty.

The reprimand was delivered to the Member immediately following the hearing.

I, DR. RICHARD HUNTER, Chairperson of this Discipline Panel sign these reasons on behalf of the Majority.

R Hunter Sept 19, 2016

Dr. Richard Hunter
Chairperson

Date

Dr. Nancy Di Santo
Mr. Manohar Kanagamany

Minority Decision with Respect to Penalty

Mr. G. Larsen and Dr. W. Coyne (the "Minority") dissent with respect to the penalty decision.

As the overarching mandate of the Royal College of Dental Surgeons of Ontario is that of public protection, the minority believes that in the case of Dr. Karen Logan, the principles of specific deterrence and general deterrence were not appropriately addressed by the penalty set out in the Joint Submission on Penalty and Costs which was accepted by the majority.

While the fact that the member has not been before the discipline panel in the past may appear as a mitigating factor, the Minority believes this rationale is insufficient when one considers that the member received cautions and/or monitoring from the College in 2008, 2009, and in 2011 with respect to some of the same behavior that led to this current discipline hearing. The fact that this case came before us demonstrates that the member has failed to sustain her efforts to correct her problematic behaviour.

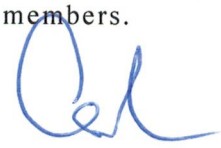
As recidivism is apparent, the Minority was deeply concerned that the suspension of Dr. Logan's certificate of registration for only four months was wholly inadequate to serve the principle of specific deterrence in this case.

Furthermore, as the serious nature of the acts committed by Dr. K. Logan have been impressed upon previously in this decision they need not be repeated here. However their magnitude and significance coupled with the fact that cautions and monitoring has occurred in the past and evidently been ignored, makes it illogical in the minority view, to suggest that a four-month suspension adequately deters other members of the profession.

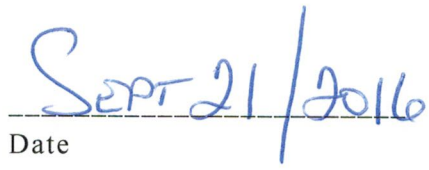
The Minority is of the view that no member of the profession should believe that receiving cautions and monitoring but ultimately disregarding, ignoring, or failing to learn from them over time will result in only a modest penalty of four months' suspension. This has the potential to reflect negatively upon the disciplinary process and may lead the public to believe that this penalty is merely a cost of doing business, as opposed to upholding the interest of public protection.

To merely "rubber stamp" negotiated settlements that do not adequately reflect the underlying misconduct, is in the opinion of the Minority an abdication of responsibility as it sets a poor precedent for similar instances in the future.

In the view of the Minority, the penalty accepted by the majority in this case risks bringing the RCDSO discipline process into disrepute and has the potential to undermine public confidence in the ability of the RCDSO to govern the conduct and behaviour of their members.



Mr. Gregory Larsen



Date

Dr. William Coyne

Date

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Mr. Gregory Larsen — Date

Dr. William Coyne — Date Sept 20/2016