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. BRUCE IVOR FLETCHER**, 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").

Members in Attendance: Ms. Susan Davis (Chair)
Dr. Lisa Kelly
Dr. Carol Janik
Dr. Elliott Gnidec
Mr. Derek Walter

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Johanna Braden
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
- and -	)	Surgeons of Ontario
	)	Ms. Megan Shortreed
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. BRUCE IVOR FLETCHER	)	Mr. Scott Gallagher
	)	For Dr. Bruce Ivor Fletcher

Hearing held on March 29, 2017.

REASONS FOR DECISION

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto March 29, 2017.

PUBLICATION BAN

On the request of the parties, the Panel made an order banning the publication or broadcasting of the names of any patients referred to in the hearing, including in the Notices of Hearing and/or the Agreed Statement of Facts and/or any of the exhibits, as well as an order banning the publication or broadcasting of any information that would identify those patients.

THE ALLEGATIONS

The allegations against Dr. Bruce Ivor Fletcher (the "Member") were contained in two Notices of Hearing. Pursuant to section 40 of the *Health Professions Procedural Code*, the Panel permitted one of the Notices of Hearing to be amended to correct errors of a minor and clerical nature. Following such correction, the allegations against the Member were as follows.

Notice of Hearing #1 dated August 3rd, 2016 (File No. H160009)

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, in 2010, you contravened a standard of practice or failed to maintain the standards of practice of the profession in treating your patient, D. S., contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Code*, in that, in 2010, you treated your patient, D. S., for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without such consent, contrary to paragraph 7 of Section 2 of Dentistry Act Regulation.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, in 2010, you failed to itemize in a statement of account that includes a commercial laboratory fee, the portion of the fee relating to the actual costs associated with the use of the commercial laboratory, contrary to paragraph 24 of Section 2 of the Dentistry Act Regulation.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the *Code*, in that, in 2010, you failed to keep records as required by the regulations, contrary to paragraph 25 of Section 2 the Dentistry Act Regulation.

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

Notice of Hearing #2 dated November 15, 2016 (File No. H160012)

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that you contravened a standard of practice or failed to maintain the standards of practice of the profession 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 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

	Patients	**Year(s)**
1.	A., C.	2011, 2014
2.	B., P.	undated deleted image #13
3.	B., L.	2014
4.	B., C.	2014
5.	C., S.	undated deleted image #16
6.	C., D.	2014
7.	C., L.	2014
8.	D., J.	2014
9.	D., M.	2012 or 2014
10.	D., K.	2012
11.	E., M.	2011
12.	E., B.	2011, 2014
13.	F., M.	undated deleted image #46
14.	F., R.	2013, 2014

15.	G., I.	2014
16.	H., D.	2014
17.	K., A.	2013, 2014 and undated deleted images #66 and #67
18.	K., R.	undated deleted image #70, and 2012
19.	M., A.	2013
20.	M., M.	2014
21.	M.-M., R.	2013, 2014
22.	M., M.	2013
23.	M., D.	2014
24.	M., H.	2012, 2014
25.	O., P.	2014
26.	O., C.	2013, 2014
27.	P., E.	2012
28.	P., Y.	2010
29.	P., S.	2012, 2014
30.	P., D.	2012
31.	P., J.	2014
32.	R., P.	2014
33.	R., M.	2013, 2014
34.	S., L.	2012
35.	S., D.	2014
36.	S., M.	2013
37.	V. D., V.	2011
38.	W., A.	2014
39.	W., M.	2014
40.	W., T.	2014
41.	W. O.	2014

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the Regulated *Health Professions Act*, 1991, Statutes of Ontario, 1991, Chapter 18 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 Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

	Patients	**Year(s)**
1.	M., H.	2012
2.	O., C.	2013
3.	R., M.	2013
4.	S., L.	2012

3. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act*, 1991, Statutes of Ontario, 1991, Chapter 18 in that you failed to keep records as required by the Regulations 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 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

	Patients	**Year(s)**
1.	A., C.	2011, 2014
2.	B., P.	undated deleted image #13
3.	B., L.	2014
4.	B., C.	2014
5.	C., S.	undated deleted image #16
6.	C., D.	2013, 2014
7.	D., J.	2014
8.	D., M.	2012 or 2014
9.	E., M.	2010, 2011
10.	E., B.	2011, 2014
11.	F., M.	undated deleted image #46
12.	F., R.	2012, 2013, 2014
13.	G., I.	2014
14.	H., D.	2004-2014
15.	K., A.	2013, 2014

16.	K., R.	undated deleted image #70, and 2012
17.	M., A.	2013, 2014
18.	M.-M., R.	2002-2014
19.	M., M.	2013
20.	M., W.	2002-2012
21.	M., D.	2002-2014
22.	M., H.	2012, 2013, 2014
23.	O., P.	2014
24.	O., C.	2011, 2012, 2013, 2014
25.	P., E.	1999-2012
26.	P., Y.	2008-2011
27.	P., S.	2009, 2010, 2012, 2014
28.	P., D.	2009, 2010, 2012, 2014
29.	P., J.	2013, 2014
30.	R., P.	2014
31.	R., M.	2013, 2014
32.	S., L.	2012, 2013, 2014
33.	S., R.	1999-2013
34.	S., S.	2013
35.	S., D.	2014
36.	S., M.	2013
37.	V. D., V.	2011
38.	W., A.	2014
39.	W., J.	2001, 2002, 2003, 2004, 2005, 2014
40.	W., M.	2014
41.	W., T.	2014
42.	W., O.	2014
43.	W., S.	2007, 2014

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated*

Health Professions Act, 1991, Statutes of Ontario, 1991, Chapter 18 in that you failed to take reasonable steps to ensure that any information provided by you or on your behalf to the College was accurate, 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 57 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

	Patients	**Year(s)**
1.	A., C.	2011, 2014
2.	B., P.	undated deleted image #13
3.	C., S.	undated deleted image #16
4.	D., M.	2012 or 2014
5.	D., K.	1998-2013
6.	E., M.	2010, 2011
7.	E., B.	2011
8.	F., M.	undated deleted image #46
9.	H., D.	2004-2014
10.	K., A.	2013
11.	K., R.	undated deleted image #70, and 2012
12.	M., A.	2013, 2014
13.	M.-M., R.	2002-2014
14.	M., M.	2013
15.	M., W.	2000-2012
16.	M., D.	2002-2014
17.	M., H.	2012
18.	O., P.	2014
19.	O., C.	2013
20.	P., E.	1999-2012
21.	P., Y.	2008-2010
22.	P., S.	2012
23.	P., D.	2012
24.	R., M.	2013
25.	S., L.	2012, 2013
26.	S., R.	1999-2013

27.	S., D.	2014
28.	S., M.	2013
29.	V. D., V.	2011

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act*, 1991, Statutes of Ontario, 1991, Chapter 18 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 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 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

	Patients	**Year(s)**
1.	A., C.	2011, 2014
2.	B., P.	undated deleted image #13
3.	C., S.	undated deleted image #16
4.	D., M.	2012 or 2014
5.	D., K.	1998-2013
6.	E., M.	2010, 2011
7.	E., B.	2011
8.	F., M.	undated deleted image #46
9.	H., D.	2004-2014
10.	K., A.	2013
11.	K., R.	undated deleted image #70, and 2012
12.	M., A.	2013, 2014
13.	M.-M., R.	2002-2014
14.	M., M.	2013
15.	M., W.	2000-2012
16.	M., D.	2002-2014
17.	M., H.	2012
18.	O., P.	2014
19.	O., C.	2013

20.	P., E.	1999-2012
21.	P., Y.	2008-2011
22.	P., S.	2012
23.	P., D.	2012
24.	R., M.	2013
25.	S., L.	2012, 2013
26.	S., R.	1999-2013
27.	S., D.	2014
28.	S., M.	2013
29.	V. D., V.	2011

6. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act*, 1991, Statutes of Ontario, 1991, Chapter 18 in that you failed to abide by a written Undertaking given by you to the College or to carry out an arrangement entered into with the College, 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 54 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

	Patients	**Year(s)**
1.	A., C.	2011
2.	B., P.	undated deleted image #13
3.	C., S.	undated deleted image #16
4.	D., M.	2012 or 2014
5.	E., B.	2011
6.	F., M.	undated deleted image #46
7.	K., R.	undated deleted image #70 and 2012
8.	M., A.	2013
9.	M., M.	2013
10.	M., D.	2014
11.	M., H.	2012
12.	O., P.	2014
13.	O., C.	2013

14.	P., E.	2012
15.	P., Y.	2010
16.	P., S.	2012
17.	P., D.	2012
18.	R., M.	2013
19.	S., L.	2012
20.	S., D.	2014
21.	V. D., V.	2011

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct. He also made admissions in writing in the Agreed Statement of Facts, which was signed by the Member. The Panel conducted a plea inquiry at the hearing, and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

THE EVIDENCE

On consent of the parties, College Counsel introduced into evidence an Agreed Statement of Facts which substantiated the allegations. The Agreed Statement of Facts (without exhibits) provides as follows.

Background

1. Dr. Bruce Ivor Fletcher (or the "Member") has been registered with the Royal College of Dental Surgeons of Ontario (the "College") as a general dentist since 1983.

2. At the relevant times, he worked as a dentist at his own practice located at 140 Wortley Road in London, Ontario. Between June 23, 2009 and November 2, 2011, he practiced though Fletcher Dentistry Professional Corporation which received a Certificate of Authorization from the College on June 23, 2009.

The Notices of Hearing

3. The allegations of professional misconduct against the Member are set out

in two Notices of Hearing, as follows:

a. H160009: Notice of Hearing dated August 3, 2016;

b. H160012: Notice of Hearing dated November 15, 2016.

4. The parties agree to amend Notice of Hearing H160012 to correct typographical errors as follows:

a. Under Allegation 1, at page 4, the name of patient M. W., listed under the particular "You provided restorations that were inadequate and exhibited residual or recurrent decay, unsupported tooth structure, inadequate contouring and/or proximal overhangs", should be struck;

b. Under Allegation 3, at page 8, the name of the third patient listed under the particular "You failed to update your patients' medical histories in a timely fashion" should be D. P., not P. D.; and

c. Under Allegation 3, at page 8, the name of the last patient listed under the particular "You failed to update your patients' medical histories in a timely fashion" should be T. W., not W. T.

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

Pleas

6. Dr. Fletcher pleads to all of the allegations, and the particulars thereof, set out in Notice of Hearing H160009 and Notice of Hearing H160012 as detailed below.

Facts and Admissions

a. ***H160009***

7. The facts giving rise to the allegations in H160009 came to the attention of the College through a complaint filed by a former patient of Dr. Fletcher, D.S., regarding Dr. Fletcher's restoration of an implant.

8. In particular, the complaint alleged that an implant which was restored by Dr. Fletcher in 2010, failed in 2014 as a result of Dr. Fletcher's improper work.

9. The notice of complaint in this matter was sent to Dr. Fletcher on April 27,

2015; in that letter, the College noted that D.S.'s original records were due in by June 1, 2015. Dr. Fletcher did not provide the College with D.S.'s records until July 30, 2015, and only after numerous reminders.

10. Dr. Fletcher has a lengthy prior history as set out at paragraphs 98 to 103, below. Concerns were brought to his attention in the areas of deficient recordkeeping, poor restorative work, lack of appropriate radiographs, insufficient communication with patients, substandard endodontic treatment and inadequate crown and bridge work. The College asserted that his past history reflected a lack of governability, a cavalier attitude towards the wellbeing of patients and the authority of the College as governing body.

11. In his response to the complaint, Dr. Fletcher asserted that he had been rehabilitated, but he also admitted there were continuing deficiencies in his practice. He denied the severity of the issues in relation to the treatment provided to D.S., and, in denying any governability issues, he submitted that it was the College that had not always acted professionally towards him.

A. Allegation 1 – Failure to Maintain the Standards of Practice in Respect of Treatment Provided to D.S.

12. The College's investigation identified that Dr. Fletcher restored an implant in the site of tooth 14 for patient D.S. in June 2010 by placing a crown on the implant. The implant was a Straumann.

13. In restoring the implant at the site of tooth 14, Dr. Fletcher removed the internal threads of the implant and then placed a cast/post/core as the final restoration of the implant instead of using an appropriate abutment. Removing the internal threads of the implant in the site of tooth 14 ensured that the implant could never be properly restored.

14. The post/core/crown Dr. Fletcher inserted in June 2010 did not fit the implant properly, subjecting the implant to a high probability of failure. An infection did develop in this area approximately three and a half years later and as a result, the implant was lost.

14. Further, on or about May 25, 2010, Dr. Fletcher instructed a lab to fabricate a "post core / porcelain fused to metal crown" on a tooth which had not had previous root canal therapy. This instruction would only have been appropriate for a tooth with previous root canal therapy.

15. Dr. Fletcher admits that he restored his patient's implant in the site of tooth 14 in a manner which contravened the standards of the profession. He also

admits that his instruction to the lab to fabricate the crown was entirely inappropriate, and contravened the standards of practice.

16. Therefore, Dr. Fletcher admits that he contravened a standard of practice or failed to maintain the standards of practice of the profession in treating his patient, D.S., contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

B. Allegation 2 – Treating Patient without Informed Consent

17. Dr. Fletcher did not have an informed consent discussion with patient D.S., on or about May 25, 2010 and/or June 8 or 9, 2010, in that he did not inform D.S. that the approach he was taking to restoring his implant in the site of tooth 14 was highly unusual and not at all in keeping with the standards of the profession.

18. Dr. Fletcher did not provide D.S. with any alternative treatment options for the restoration of his implant and simply proceeded with an unusual method of restoring his implant which led to a very poor prognosis and eventual failure of the implant.

19. Dr. Fletcher billed D.S. for a post and core on a root canal treated tooth when the tooth was not endodontically treated but was in fact an implant. He did this without explaining to his patient that he was being billed for and provided with an incorrect procedure.

20. 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.

21. 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.

22. Dr. Fletcher admits to the above noted conduct. Therefore, Dr. Fletcher

admits that he 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 documenting such a consent, contrary to paragraph 7 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing.

C. Allegation 3 – Failing to Itemize Lab Fees

23. On or about June 8, 2010, Dr. Fletcher billed his patient, D.S., $298 for "Post & Core With Crown on Rct" and $909.50 for "Porcelain Crown, Fused to Metal". The associated laboratory invoice dated June 4, 2010 shows a total charge of $337.50, consisting of $15 for an "articulator", $10.50 for "die", $203 for a "ceramic crown" and $109 for "NP post and core". These laboratory fees were not shown in the total fee Dr. Fletcher billed to his patient.

24. The College's *Dental Recordkeeping Guideline* provides that the financial record for each patient must include an itemized listing of all commercial laboratory fees that were incurred in respect to prosthetic, restorative or orthodontic services.

25. Dr. Fletcher acknowledges that he failed to itemize in a statement of account that includes a commercial laboratory fee, the portion of the fee relating to the actual costs associated with the use of the commercial laboratory. This was contrary to paragraph 24 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

D. Allegation 4 – Failure to Keep Records as Required

26. Dr. Fletcher's records for his patient, D.S., in relation to the restoration of the implant in the site of tooth 14, do not contain any radiographs confirming the placement or seating of the restoration he placed on or about June 8 or June 9, 2010.

27. Dr. Fletcher's documentation of the restoration he performed to the implant in the site of tooth 14 is very scant and does not contain the important information about the treatment provided. His records from June 8 or 9, 2010 do not contain any notation of a try-in of the abutment or restoration that he placed. His records also do not contain any lab prescriptions for the fabrication of the restoration he placed.

28. Dr. Fletcher acknowledges that with respect to patient D.S., his record keeping was not in accordance with the regulations, or the standards of practice of the profession. Dr. Fletcher acknowledges that he breached his

professional, ethical and legal responsibilities that required him 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.

29. Therefore, Dr. Fletcher admits that he failed to keep records as required by the regulations relative to patient D.S., contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 of the Notice of Hearing.

E. Allegation 5 – Disgraceful, Dishonourable, Unprofessional or Unethical Conduct

30. During the investigation into the complaint from D.S., Dr. Fletcher submitted the records requested of him by the College's investigator two months after the original deadline provided. These records were only provided by Dr. Fletcher after the College's investigator followed up with him on multiple occasions regarding the request.

31. Dr. Fletcher's conduct during the investigation, and prior, reflects that of an ungovernable member. His conduct in this case and in previous matters demonstrates a cavalier attitude toward the wellbeing of his patients and the authority of his governing body.

32. Past decisions of the ICRC, and its predecessors, have raised concerns in the areas of deficient recordkeeping, poor restorative work, lack of appropriate radiographs, insufficient communication with patients, substandard endodontic treatment and inadequate crown and bridge work, yet many of these issues surfaced again, in the case of D.S., demonstrating that Dr. Fletcher has not been rehabilitated.

33. Despite a lengthy history of past complaints and outcomes, Dr. Fletcher's conduct does not reflect a willingness to improve or to learn from concerns identified and addressed by remediation in the past. Dr. Fletcher has not demonstrated any insight into his conduct.

34. Therefore, Dr. Fletcher admits that he 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 and unethical, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 5 of the Notice of Hearing.

ii. H160012

35. The facts giving rise to the allegations in H160012 came to the attention of the College through a report from an informant, who wished to remain anonymous, with significant concerns about the care provided by Dr. Fletcher to his patients.

36. In particular, the informant outlined concerns regarding Dr. Fletcher's conduct as follows: lack of ability and dishonesty; lack of moral standards; providing root canal treatment where there is no justification; providing inadequate root canal treatment; placing crowns where there was no justification; failure of recently placed restorations; inaccurate charting; not reviewing medical history prior to treatment; deleting radiographs and having charting "go missing"; and not taking radiographs on emergency patients.

37. The College's investigator, Dr. Helene Goldberg, attended at Dr. Fletcher's office on November 24, 2014. During her visit, Dr. Goldberg obtained patient charts for 48 patients, based on names provided to Dr. Goldberg from the informant. Twelve of the patient charts were incomplete, and included either no paper based records or minimal paper based records. Dr. Goldberg also obtained 209 deleted images from the computer in Dr. Fletcher's office, consisting of both x-rays and intra-oral photographs.

A. Allegations 1 and 2 – Contravening the Standards of Practice and Charging an Unreasonable Fee

(a) *Poor quality digital radiographic x-ray images*

38. Digital x-rays contained in Dr. Fletcher's patient records demonstrate one or more of the following factors which affect the diagnostic quality of the images: foreign marks, overlapping of proximal surfaces on BWs, elongated images and insufficient contrast.

39. The following table lists names of patients whose radiographs demonstrate the presence of some or all of these factors, as well as the date and type of radiographic imaging. In total, there are 69 poor quality digital x-ray images for 19 patients.

Patient	Date	Radiographs Taken PA=periapical x-ray BW=bite-wing x-ray
A., C.	Mar 03/14	1 PA

	May 13/14	2 PAs
B., L.	Jan 28/14	1 PA
	Feb 20/14	2 PAs
	Mar 04/14	1 PA
	Mar 10/14	1 PA
	Mar 10/14	2 BWs
	May 12/14	2 PAs
	May 27/14	1 PA
	Jul 17/14	2 PAs
	Jul 30/14	2 PAs
B., C.	Sep 24/14	2 BWs
C., D.	Mar 27/14	1 PA
	Apr 15/14	3 PAs
D., J.	Jan 23/14	1 PA
	Mar 18/14	2 BWs
	Sep 02/14	2 BWs
F., R.	Mar 10/14	1 PA
	May 14/14	1 PA
	Jun 25/14	1 PA
G., I.	Jul 28/14	2 BWs
K., A.	Nov 12/14	1 PA
M., R.	Jan 08/14	1 PA
	Jul 22/14	2 PAs
	Nov 24/14	2 Pas
M., D.	Apr 24/14	1 PA
	Jun 24/14	2 BWs
	Jun 24/14	1 PA
	Aug 6/14	1 PA
	Aug 20/14	1 PA
	Undated	2 BWs
	Undated	1 PA
M., H.	Apr 15/14	1 PA
	Jul 23/14	2 BWs
O., P.	Sep 02/14	1 PA
O., C.	Jul 07/14	1 PA
P., S.	May 29/14	1 PA
P., J.	Aug 28/14	2 BWs
R., P.	Jan 15/14	2 BWs
	Sep 24/14	2 BWs
W., A.	Sep 18/14	1 PA
	Sep 18/14	1 BW
	Oct 24/14	4 PAs

W., M.	Sep 29/14	1 PA
	Nov 17/14	1 PA
W., T.	Jun 09/14	1 PA

(b) Failure to adequately diagnose and/or treatment plan and/or treat pathology evident radiographically

40. Dr. Fletcher's patient records demonstrate a failure to diagnose, treatment plan and/or treat pathology evident radiographically with respect to 18 patients in the year 2014, as follows:

a. C. A.: On May 13, 2014, Dr. Fletcher performed and billed for an emergency exam and periapical x-ray ("PA"). The PA regarding tooth 17 demonstrates: large periapical radiolucencies; Mroot perforation; and 2 canals obturated – additional canal(s) missed (root canal treatment ("RCT") originally performed and billed 3 canals on April 14, 2011).

The chart entry with respect to May 13/14 stated only "EMERG, 1PA 17". There is no further information provided, such as chief complaint, signs, symptoms, tests performed, findings, diagnoses or treatment plan.

On May 22, 2014, Dr. Fletcher performed and billed for 21 IV for crowned tooth 21. The chart entry states: "21 IV, prepared with air abrasion, bonded with 3M filtek with 3M adhesive...". No diagnosis was provided with respect to this restoration.

b. L. B.: On February 20, 2014, Dr. Fletcher performed root canal treatment on tooth 25. Chart notes state: "Severe fracture during post core/crown preparation". There is no indication in records that the patient was advised of the "severe fracture" or actual or possible consequences.

Also on February 20, 2014, 2 PAs were taken which demonstrated issues regarding tooth 23, specifically, significant coronal radiolucency and possible lost amalgam (when compared with January 28, 2014 PA). There is no diagnosis or treatment plan included in the patient record.

On March 4, 2014, Dr. Fletcher noted in the patient chart: "Pt came in with sore lower left pain took PA of area – placed duraflor on 35 + 36 area where she was feeling sens. when using air in between #35

+ 36 pt felt pain told her to keep us posted". The PA regarding tooth 36 demonstrates: M marginal gap and/or residual/recurrent caries. The same decay was also demonstrated on earlier PAs, dated December 3, 2013 and November 28, 2013. The patient record does not include any diagnosis or definitive treatment plan with respect to the issues regarding tooth 36.

On March 10, 2014, 2 BW radiographs were taken, which demonstrate: coronal radiolucency 45; composite resin overhang tooth 35 D, marginal gap or residual/recurrent decay M of tooth 36. With respect to treatment plan, the patient chart states: "Smooth Contact b/n 35/36". The patient record does not include any diagnoses or treatment plan with respect to teeth 36 and 45V. The treatment plan is inadequate regarding tooth 35.

c. C. B.: On January 6, 2014, Dr. Fletcher performed restorations on teeth 12 DIV and 38 OV. No diagnoses were noted in the patient chart. Dr. Fletcher later performed a repair on tooth 38 OV on August 11, 2014. On September 24, 2014, a BW x-ray demonstrates an obvious V or L radiolucency suggestive of residual/recurrent caries MO on tooth 38. There is no indication that the patient was advised of these factors affecting the restoration and possible consequences on the tooth. Tooth 38 was extracted on October 1, 2014.

On February 11, 2014, Dr. Fletcher performed a restoration on tooth 48 O. No diagnosis was noted in the patient chart. The September 24, 2014 PA x-ray demonstrates that some of the M and D portion of this tooth is not covered with composite resin (note: tooth is not in occlusion with an opposing tooth). There is no indication that the patient was advised of these factors affecting the restoration.

On May 10, 2014, Dr. Fletcher performed restorations on teeth 22 V, 23 DV, and 24 MO. No diagnoses were noted in the patient chart.

On July 7, 2014, Dr. Fletcher performed a restoration on tooth 45 DVL. No diagnosis was noted in the chart.

On October 1, 2014, Dr. Fletcher performed a restoration on tooth 16 MOD and extracted tooth 38. No diagnoses were noted in the patient chart, and a PA of tooth 38 was not taken prior to the extraction. No details regarding the surgery were noted in the patient chart except for "EXT 38".

d. D. C.: On March 27, 2014, Dr. Fletcher performed an emergency examination and PA. The chart entry states: "recurrent decay deep on DO of 16 mesial decay as well". Dr. Fletcher had restored tooth 16 DOV less than two months prior, on January 30, 2014.

The D radiolucency on tooth 16 apparent in the March 27, 2014 PA x-ray shows residual decay under the D portion of the restoration and a deficient d composite margin rather than recurrent decay as noted by Dr. Fletcher. Also, the 16 M caries appears on an earlier January 22, 2013 BW but was not diagnosed at that time. It was diagnosed and restored on January 30, 2014.

e. L. C.: A bridge for this patient with respect to teeth 16-P-14 was placed in 2008. A subsequent bridge was placed in 2011. Dr. Fletcher re-cemented the bridge on January 6, 2014, May 21, 2014 and July 7, 2014.

On July 28, 2014, Dr. Fletcher re-cemented the bridge again and noted in the patient chart: "Discussed that 16 is badly broken down and need to change treatment plan re-cemented but next visit may refer to specialist regarding implants". At that time, there was no current x-ray found in the patient record of the bridge or tooth 16 for diagnosis and treatment planning. The last PA found was dated October 20, 2008.

f. J. D.: On January 23, 2014, Dr. Fletcher performed an emergency exam, PA, and prescribed Penicillin. The PA x-ray of teeth 17, 16 and 15 demonstrates residual/recurrent decay (17 M, 16 D, M and 15 D). There was no diagnosis in the patient chart other than "gum infection" and no comprehensive treatment plan.

g. B. E.: On August 5, 2014, Dr. Fletcher performed a recall exam. The chart entry states: "...deeper pockets along 45 V due to loose crown. 6mm on 45 V". The treatment plan sheet notes: "Recement 45 crown". A PA was not taken and mobility of the tooth was not verified prior to treatment planning to re-cement the tooth.

At a subsequent appointment, on August 12, 2014, instead of re-cementing the crown, Dr. Fletcher performed an extraction of tooth 45. The chart entry states: "Started to remove crown whole tooth extremely mobile". No details regarding the surgery were noted except for "EXT 45". The PA of tooth 45, taken August 12, 2014 prior to the extraction, demonstrated: severe bone loss, large post and M & D residual/recurrent decay; possible periapical

radiolucency.

The August 12, 2014 PA x-ray demonstrates a periapical radiolucency regarding tooth 44 which was not diagnosed at the time.

On September 2, 2014, Dr. Fletcher performed an emergency examination and PA. The chart entry mentions pain and swelling lower right and that the patient had been to Emergency on August 30, 2014 where antibiotics and analgesics were prescribed. The chart entry also states: "44 swelling and mobile p+++ tests non vital. Periapical x-ray large radiolucency apex 44. Discussed guarded prognosis due to mobility and size of radiolucency", but a treatment plan was not documented.

The September 2, 2014 PA of tooth 44 demonstrates severe bone loss, periapical radiolucency, M residual/recurrent decay. The M decay was still not diagnosed or treatment planned at this time.

On September 9, 2014, Dr. Fletcher performed a root canal treatment of tooth 44, and a restoration of 44 O. This root canal treatment was questionable due to extensive distal bone loss and poor prognosis.

On November 3, 2014, Dr. Fletcher re-cemented the crown on tooth 44. The chart entry only states: "crown re-cemented".

h. R. F.: On March 10, 2014, Dr. Fletcher performed an emergency examination and took a PA. The chart entry states: "c/o extreme pain, upper left on the weekend, little better now since taking the antibiotics and a one-week follow-up for the 27/28 area was scheduled". The patient chart includes no documentation of signs, examination, examination findings, diagnoses, and/or definitive treatment plan. The PA demonstrates, with respect to teeth 27 and 28: furcation involvement (radiolucency) tooth 27; moderate to severe bone loss teeth 27 and 28; significant 27 D composite overhang into the carious lesion of tooth 28M (root surface).

On March 17, 2014, Dr. Fletcher performed a follow-up examination, and renewed the prescription of penicillin. A diagnosis was still not made, nor was a definitive treatment plan formulated. The chart entry states: "Patient presents for a follow up, 26 feels better but still tender, mostly on flossing. Pus still draining but in lesser amounts. Penicillin V prescription renewed since the antibiotic is working, but might need longer intake (time)". Note, there is no

tooth 26.

On May 14, 2014, a PA radiograph was taken, and Dr. Fletcher prescribed penicillin and analgesics. The chart entry states: "Swelling upper left near root canal treatment. Fistula buccal to 26 placed gutta percha into fistula indicates furcation as source of infection". Note, there is no tooth 26. Regarding treatment plan, the patient record notes thorough scaling. A diagnosis was still not made regarding the tooth 27 D overhang and 28 M caries, nor was a definitive treatment plan formulated.

i. I. G.: On January 13, 2014, Dr. Fletcher performed a restoration on tooth 43 V. The chart entry states: "43 restoration". No diagnosis was recorded.

On February 3, 2014, Dr. Fletcher re-cemented an existing post, core and crown on tooth 36. The chart entry only states that the 36 PCC re-cemented and "Knocked off crown during night". An earlier PA x-ray, dated April 3, 2012, demonstrates with respect to tooth 36: perforation in furcation area of tooth; furcation area bone loss; and D crown margin overhang.

On April 8, 2014, Dr. Fletcher took impressions for a new PCC tooth 36. The chart entry states: "Will remake with very guarded prognosis". The new PCC on tooth 36 was inserted on April 24, 2014.

On July 29, 2014, Dr. Fletcher performed a recall examination and 2 BWs were taken. The BW of tooth 36 and new PCC demonstrates: D crown/tooth marginal deficiency (and perforation of D root into furcation, severe furcation involvement, as in the April 03/12 PA and the apical portion of the distal canal not obturated, but no history of sequelae from the incomplete D root obturation).

There is no indication in patient record that the patient was advised of the persistent factors affecting the quality of the tooth 36 PCC before and after remake, and possible consequences.

On August 7, 2014, Dr. Fletcher attempted to re-cement the new PCC on tooth 36. The chart entry states: "Crown loose but can't lift off yet. Will wait until it is looser or comes out to assess and hopefully re cement". The new PCC on tooth 36 was re-cemented on August 25, 2014, and again on September 9, 2014. The chart entry on September 9, 2014 states: "roots badly broken down, discussed very

guarded prognosis discussed nothing, bridge, implant, partial lower denture, after root extraction. wanted me to cement it anyway".

On October 21, 2014, Dr. Fletcher extracted tooth 36, and bridge 35-P-37 was provided subsequently.

j. A. K.: On June 2, 2014, Dr. Fletcher billed for both an emergency examination and restoration on tooth 36 MVD. There is no corresponding chart entry regarding the emergency examination.

With respect to the restoration on tooth 36, the patient chart does not include detail regarding an assessment of potential for indirect pulp capping, despite the following chart entry: "Discussed possible future root canal treatment or extraction due to deep filling and close to pulp". A later chart entry, dated October 1, 2014, indicates tooth 36 is nonvital, and a PA dated October 1, 2014 demonstrates a large restoration and a periapical radiolucency.

Additionally, a PA dated December 18, 2013 regarding teeth 36 and 37 demonstrated carious lesion on both teeth. There is no chief complaint, signs, symptoms, examination findings or diagnosis regarding teeth 36 or 37, and no treatment plan regarding tooth 37 included in the patient chart at the time of that x-ray.

On October 1, 2014, Dr. Fletcher prescribed Erythromycin. According to his October 10, 2014 chart entry, root canal treatment on tooth 36 was planned after tooth 37 was extracted.

On November 12, 2014, Dr. Fletcher performed an emergency examination and a PA was taken. The chart entry indicates that the patient had pain lower left, the recent extraction socket of 37 was ok, and states: "36 radiolucent doesn't take antibiotic regularly. Suggested intravenous penicillin V – medical doctor". No reason was noted for this suggestion. The PA of tooth 36 demonstrates: periapical pathology of both roots and large restoration (placed June 2, 2014).

k. H. M.: On March 20, 2014, Dr. Fletcher performed restorations of teeth 26 O and 44 MV. The patient chart does not contain any diagnosis regarding these restorations. With respect to tooth 26 OV, the July 23, 2014 BW demonstrates M and D residual/recurrent caries and large D overhang. There is no indication in the patient record that the patient was advised of the above factors affecting the

quality of the restoration and possible consequences on the tooth.

On March 20, 2014, Dr. Fletcher removed an existing crown from tooth 16, and he inserted a new crown on April 3, 2014. No vitality tests were performed prior to this treatment. A BW radiograph dated May 10, 2012 regarding tooth 16 demonstrated gross caries under the existing crown on the root surface. The patient chart indicates that 16 MV was restored on May 31, 2012. A BW radiograph dated April 3, 2013 regarding tooth 16 demonstrated gross D or V carious lesion and a D restoration provided, but not charted.

On July 23, 2014, Dr. Fletcher performed a recall examination and 2 BW radiographs were taken. The right BW demonstrates: 17 D caries; 15 M composite resin overhang (MO placed May 10, 2012); 46 gross D recurrent caries, perforation into furcation, significant furcation involvement, unobturated M canal (root canal treatment performed January 4, 2012 per PA – no January 4, 2012 chart entry found); and 47 M composite resin overhang (MV placed April 30, 2012). The left BW demonstrates: 25 M & D composite resin overhangs (MV) placed April 3, 2013); 26 M & D residual/recurrent caries and D composite resin overhang (MODL placed May 30, 2011).

The treatment plan in the patient record states: "43I, 34V, 26MOD, 46DO, 23DL Follow up on 17 infection --> May need Extraction" and 6 month hygiene. No diagnoses were noted regarding any of the lesions that were demonstrated radiographically. Teeth 15, 25 and 47 were not treatment planned. The treatment planning with respect to tooth 46 was questionable considering its poor prognosis.

On July 30, 2014, Dr. Fletcher performed restorations of teeth 34V, 31I, and 43I, and extracted tooth 17. No diagnoses were noted with respect to these procedures.

l. C. O.: On July 7, 2014, Dr. Fletcher performed an emergency exam, took PA radiographs and prescribed antibiotics regarding issues with tooth 37. The chart entry states: "PAIN & SWELLING 37", "PA: TOOTH UNRESTORABLE NEEDS EXT" and antibiotics prescribed. The PA, dated July 7, 2014, demonstrates: perforation and presence of instrument in bone; canals of tooth not obturated (root canal treatment done Feb. 27/13 per ledger and per Feb. 27/13 intra-operative PA but no post-operative PA or chart entry found). No diagnoses were made regarding perforation and lack of obturation, and there is no indication with respect to disclosure of radiographic

findings from July 7, 2014, including perforation of tooth, missed canals, misplaced obturation material and related consequences on the tooth and adjacent bone.

m. J. P.: On August 6, 2014, Dr. Fletcher adjusted the patient's occlusion. The chart entry states: "Adjusted occlusion 25". There are no signs, symptoms, or examination findings noted in the patient chart, and no PA was taken.

Issues with respect to tooth 25 were previously dealt with at appointments on October 7, 2013 (root canal treatment), October 8, 2013, November 4, 2013 (Dr. Fletcher determined overhang on filling was causing some infection), December 2, 2013 (DO repaired) and December 9, 2013 (prescription for Clindamycin).

On August 27, 2014, Dr. Fletcher performed a restoration on tooth 17 MO. No diagnosis was recorded in the patient chart.

n. P. R.: On January 8, 2014, Dr. Fletcher performed a restoration on tooth 14 DO. No diagnosis was noted in the patient chart regarding the restoration.

On January 8, 2014, Dr. Fletcher performed a restoration on tooth 47 DO, and on June 16, 2014, he performed a restoration on tooth 47 OL. No diagnosis was noted in the patient chart regarding either restoration. Two BWs, dated January 15, 2014, are in the patient record, but were not noted as being taken in patient chart. The January 15, 2014 BWs demonstrate: residual decay 47 D; D overhang; and DG overhang 14. A later BW x-ray dated September 24, 2014 demonstrates residual decay DG 47. A crown for tooth 47 was prepared on October 22, 2014 and cemented on November 3, 2014.

On February 19, 2014, Dr. Fletcher cemented a crown on tooth 25. The September 24, 2014 BW x-ray demonstrates a damaged D cervical root surface.

Dr. Fletcher performed crown preparations on February 5, 2014 (teeth 25, 26), March 26, 2014 (tooth 37), October 1, 2014 (tooth 36), October 22, 2014 (tooth 47), and November 5, 2014 (teeth 14, 45). With respect to teeth 25 and 26, no PA x-ray of fractured teeth for assessment prior to crown fabrication was available to analyze. With respect to teeth 36, 37, 14 and 45, no rationale for the necessity of a crown was found in the chart.

o. M. R.: On July 7, 2014, Dr. Fletcher took a PA radiograph. The chart entry regarding tooth 16 states: "DISCUSSED POOR PROGNOSIS 16" and MOL restoration treatment planned (and the BW demonstrates a MG radiolucency). The PA regarding root canal treatment tooth 16 demonstrates: incomplete RCT (none of the canals fully obturated), obvious periapical pathology and separated instrument in MV canal (RCT was performed January 14, 2013 per ledger. No RCT x-rays provided and no chart entry found.) Two deleted and recovered PAs of RCT 16 were found – an intra-endo and post-op endo.

On July 21, 2014, Dr. Fletcher performed restoration on tooth 25 DO. No diagnosis was noted in the patient chart. Two surface restorations had previously been performed on tooth 25, as per a December 18, 2013 ledger entry, but there is no chart entry with respect to this treatment.

p. A. W.: On October 24, 2014, Dr. Fletcher performed an extraction of teeth 18, 28, 38 and 48. With respect to tooth 48, the chart entry states: "48 fractured crown during extraction very difficult to remove root. Warned patient highly likely root tips remaining, if symptomatic will refer to specialist". No intra-operative or post-operative PA or panoramic x-ray was taken of tooth 48 to confirm the diagnosis or the amount of root structure remaining and to therefore base any advice about the appropriate management for the degree of root structure remaining. 4 PAs were found in the patient record but were not noted as taken in Dr. Fletcher's chart entry.

On October 30, 2014, Dr. Fletcher performed a post-op examination. The chart entry states: "Post op swelling and sore at 48...", however the patient was not referred to a specialist. The chief complaint of "sore at 48" was not elaborated on, and the location and degree of "post op swelling" was not documented.

q. M. W.: On January 16, 2014, Dr. Fletcher performed restorations on teeth 45 OL and 37 V. No diagnoses were included in the patient chart.

On August 19, 2014, Dr. Fletcher performed a restoration on tooth 37 MOVL. No diagnosis was included in the patient chart.

On September 29, 2014, Dr. Fletcher performed an emergency examination and PA. The chart entry states: "38 [sic: should be

tooth 37] BROKEN DOWN BADLY NO SYMPTOMS" and options of an extraction or a PCC were discussed. The chart entry also states: "POST CORE/CROWN VERY GUARDED PROGNOSIS BUT PATIENT DESPERATELY WANTS TO KEEP LHS [meaning left hand side] IN TACT".

The PA regarding tooth 37 demonstrates: gross loss of coronal tooth structure; incomplete RCT; separated instrument in D canal; periapical pathology (root canal treatment performed June 18, 2012). The PA regarding tooth 36 demonstrates: gross D composite resin overhang; M and D residual/recurrent decay or marginal cavosurface defects; incomplete obturation M canal (RCT performed January 9, 2012); separated instrument M canal; PDL widening along the mesial of the root.

In summary, tooth 37 had a hopeless prognosis (given the extent of decay, little clinical crown, incomplete root canal treatment with separated instrument, periapical pathology). A predetermination for a PCC (incorrectly indicating tooth 38) was found, dated August 10, 2014. Regarding tooth 36, no pathology was diagnosed and no treatment plan was formulated.

On November 17, 2014, Dr. Fletcher performed a restoration on tooth 12 VL and 13 DVL. No diagnosis was included in the patient chart.

r. O. W.: On April 16, 2014, Dr. Fletcher performed restorations of teeth 17O and 37O. No diagnoses were included in the patient chart.

(c) *Failure to obtain informed consent*

41. Dr. Fletcher did not include any notes regarding informed consent, reason for treatment, options and possible complications of treatment with respect to the following 8 services rendered for the following 4 patients:

a. C. B.: On July 17, 2014, Dr. Fletcher took impressions for a night guard. The night guard was fabricated and delivered on or around July 29, 2014. There are no signs, symptoms, examination findings or diagnosis to justify a night guard included in the patient chart. There are also no notes demonstrating a discussion with the patient regarding reasons for treatment, options and possible complications, or informed consent.

b. P. R.: Dr. Fletcher performed crown preparations on February 5,

2014 (teeth 25, 26), March 26, 2014 (tooth 37), October 1, 2014 (tooth 36), October 22, 2014 (tooth 47), and November 5, 2014 (teeth 14, 45). The patient chart does not include any notes regarding informed consent, reason for treatment, options and possible complications of treatment.

c. D. S.: On May 26, 2014, Dr. Fletcher performed a root canal treatment on tooth 36. The patient chart does not include any notes regarding informed consent, reason for treatment, options and possible complications of treatment.

d. O. W.: On May 14, 2014, Dr. Fletcher took impressions for a night guard. The patient chart does not include any notes regarding informed consent, reason for treatment, options and possible complications of treatment.

42. As noted above, the College's Practice Advisory on *Informed Consent* Issues advises dentists his notes of conversations regarding the nature and scope of the informed consent discussions should be fully documented in the patient's chart.

(d) *Inadequate restorations*

43. Dr. Fletcher's patient records revealed a number of issues with respect to the quality of restorations, such as residual or recurrent decay, unsupported tooth structure, inadequate contouring and proximal overhangs. These issues were observed for 19 restorative services provided to 12 different patients, as follows:

a. L. B.: On March 12, 2014, Dr. Fletcher performed a restoration of tooth 23 DL. A May 12, 2014 PA demonstrates gross D overhang. The patient chart notes "FOS" which stands for "checked for the interproximal contacts of the restoration with floss, checked the occlusion and smoothness, as per Dr. Fletcher".

On June 11, 2014, Dr. Fletcher performed a restoration of tooth 13 DV. A July 17, 2014 PA demonstrates a distal overhang.

b. C. B.: On January 6, 2014, Dr. Fletcher performed restorations on teeth 12 DIV and 38 OV. Dr. Fletcher later performed a repair on tooth 38 OV on August 11, 2014. The September 24, 2014 BW demonstrates an obvious V or L radiolucency suggestive of residual/recurrent caries MO on tooth 38. Tooth 38 was extracted on October 1, 2014.

On February 11, 2014, Dr. Fletcher performed a restoration on tooth 48 O. The September 24, 2014 PA demonstrates that some of the M and D portion of this tooth is not covered with composite resin (note: tooth is not in occlusion with an opposing tooth).

On July 17, 2014, Dr. Fletcher performed a restoration on tooth 26 DO. The September 24, 2014 BW demonstrates an obvious DG radiolucency suggestive of residual/recurrent caries.

c. D. C.: on January 30, 2014, Dr. Fletcher performed restorations on teeth 17 MO and 16 DOV. A PA taken on March 27, 2014 demonstrates M residual caries on tooth 17 MO and obvious DG and M radiolucency suggestive of residual/recurrent caries on tooth 16 DOV.

d. J. D.: On January 29, 2014, Dr. Fletcher performed a restoration on tooth 17 MOB. On March 24, 2014, he performed a 17 ML repair, and on April 15, 2014, a 17 MO "redo". The BW dated September 2, 2014 demonstrates mesial overhang and lack of mesial proximal contour.

e. R. F.: On February 14, 2013, Dr. Fletcher performed a restoration on tooth 28 MO. A PA dated March 10, 2014 demonstrates D overhang 27, and MG residual/recurrent decay 28.

f. A. K.: On June 2, 2014, Dr. Fletcher performed a restoration on tooth 36 MVD. A later chart entry, dated October 1, 2014, indicates tooth 36 is nonvital, and a PA dated October 1, 2014 demonstrates a large restoration and a periapical radiolucency.

g. R. M.-M.: On January 14, 2014, Dr. Fletcher billed for a restoration of tooth 36 ("White Fill-molar 5 of 5 surfaces"). A PA dated March 24, 2014 demonstrates MG radiolucency suggestive of residual/recurrent caries, mesial root.

h. W. M.: This patient complained that the fillings Dr. Fletcher had placed kept falling out.

i. H. M.: On March 20, 2014, Dr. Fletcher performed restorations of teeth 26 O and 44 MV. With respect to tooth 26 OV, the July 23, 2014 BW demonstrates M and D residual/recurrent caries and large D overhang.

j. J. P.: On January 8, 2014, Dr. Fletcher performed a restoration on tooth 16 MOD. A BW radiograph dated August 18, 2014 demonstrates: 17 damaged (flattened) M wall (iatrogenic); and uncontoured marginal ridge 16 M.

k. P. R.: On January 8, 2014, Dr. Fletcher performed a restoration on tooth 47 DO, and on June 16, 2014, he performed a restoration on 47 OL. A January 15, 2014 BW demonstrates: residual decay 47 D; D overhang; and DG overhang 14. A September 24, 2014 BW demonstrates residual decay DG 47.

(e) *Failure to use a rubber dam*

44. Dr. Fletcher performed endodontic treatment without using a rubber dam to isolate teeth in respect of the following 7 patients:

Patient	**Date of Intra-Operative PAs that Do Not Demonstrate a Rubber Dam Clamp**	**Tooth No.**	**Where Dr. Fletcher's Chart Notes Indicate the use of a Rubber Dam (note: RD=rubber dam placed)**
B., L.	Feb 20/14	25	yes "**RD**"
	Jul 30/14	45	yes "**RD**"
C., D.	Apr 15/14	16	no
E., B.	Sep 09/14	44	no
M., D.	Aug 20/14 deleted x-ray image #102	24	progress notes not provided
O., P.	Sep 02/14	24	progress notes not provided
R., M.	Jul 14/14	15	no
S., D.	May 14/14 chart and ledger May 26	36	no

45. In addition, Dr. Fletcher failed to use a rubber dam clamp when performing endodontic treatment on the following 3 unidentified patients:

a. 136: An endodontic PA, image 136, mislabelled "S. S." for an unknown patient was recovered from deleted files in Dr. Fletcher's office. It does not appear to demonstrate a rubber dam clamp.

b. 187/189: Two endodontic PAs, images 187 and 189, corresponding to the same unknown patient, were recovered from deleted files in

Dr. Fletcher's office. They do not appear to demonstrate a rubber dam clamp.

c. 191: An endodontic PA, image 191, for an unknown patient was recovered from deleted files in Dr. Fletcher's office. It does not appear to demonstrate a rubber dam clamp.

(f) *Inadequate endodontic treatment*

46. Dr. Fletcher performed inadequate endodontic treatment that resulted in incomplete obturations, perforations and/or separated instruments in canals, in respect of the following 24 patients and 3 unidentified patients:

a. C. A.: On April 14, 2011, Dr. Fletcher performed a root canal treatment of tooth 17. An intra-operative PA was taken, which demonstrates a distal root perforation.

b. P. B.: A deleted, undated endodontic PA was found with respect to P. B. The PA demonstrates approximately ½ of the proximal portion of the canal is not obturated with respect to tooth 25.

c. S. C.: A deleted, undated endodontic PA was found with respect to S. C. The PA demonstrates that the mesial root is perforated with respect to tooth 36.

d. M. D.: Dr. Fletcher performed root canal treatment on either May 18, 2012 or September 22, 2014 on tooth 16 D canal. An intra-operative PA was taken, which demonstrates 2 file perforations.

e. K. D.: Dr. Fletcher performed a root canal treatment on tooth 37 on February 15, 2012. A PA dated January 16, 2013 demonstrates a perforation and obturation into the bone of tooth 37. A PA dated November 12, 2013 demonstrates a separated instrument at the apical 1/3 of tooth 14.

f. M. E.: Dr. Fletcher performed a root canal treatment on tooth 37 on March 31, 2011. A PA dated March 31, 2011 demonstrates two separated instruments in the mesial root of tooth 37 and inadequate instrumentation and obturation of the mesial canal.

g. B. E.: On May 16, 2011, Dr. Fletcher performed a root canal treatment of tooth 35. An intra-operative PA was taken, which demonstrates a distal root perforation.

h. M. F.: A deleted, undated endodontic PA was found with respect to M. F[redacted]. The PA demonstrates that the obturation of the distal canal(s) is/are short.

i. R. K[redacted]: On May 31, 2011, Dr. Fletcher performed a root canal treatment of tooth 46. A post-operative PA was taken which demonstrates a perforation on the mesial root.

On August 9, 2012, Dr. Fletcher performed a root canal treatment of tooth 13. An intra-operative PA was taken which demonstrates a file perforation.

j. A. M.: The College located a deleted PA of an incomplete root canal treatment of tooth 46, dated April 16, 2013. The PA demonstrates an obturated perforation, and was not found in the patient's records. Two additional PAs, which also demonstrate the perforation, were found in the patient's records. The first PA found in the patient record, dated April 16, 2013, demonstrates a perforation through the furcation and a file extending apically through the distal root of tooth 3. The second PA, dated May 6, 2013, demonstrates a perforation through the furcation and obturation into the bone/periodontal ligament of tooth 36. The tooth also appears to be non-restorable due to the extent of the furcation perforation.

k. R. M.-M.: A PA dated October 1, 2014 shows missed mesial buccal and distal buccal canals in the endodontically treated tooth 27 and a possible perforation through the furcation.

l. M. M.: On March 4, 2013, Dr. Fletcher performed a root canal treatment of tooth 46. An intra-operative PA was taken, which demonstrates a perforation and file separation. Dr. Fletcher deleted this PA.

m. D. M.: On August 20, 2014, Dr. Fletcher performed root canal treatment on tooth 24. An intra-operative PA demonstrates intra-operative mesio-lateral perforation. A post-operative PA, dated August 20, 2014, demonstrates deep obturation into inter-dental bone through perforation or a separated instrument.

n. H. M.: On January 4, 2012, Dr. Fletcher charged for a root canal treatment (3 canals) and restoration on tooth 46. There are no chart entries for January 4, 2012 in the patient record. 2 PAs dated January 4, 2012 show perforation and obturation incomplete.

On December 12, 2012, Dr. Fletcher performed a root canal treatment of tooth 22. An intra-operative PA was taken, which demonstrates a perforation.

o. P. O.: On September 2, 2014, Dr. Fletcher performed a root canal treatment on tooth 24. A post-operative PA of root canal treatment 24 demonstrates an obturated perforation and an unfilled canal. An intra-operative PA also demonstrates a file perforation.

p. C. O.: On February 27, 2013, Dr. Fletcher performed a root canal treatment on tooth 37. A post-operative PA demonstrates a perforation that was obturated.

q. E. P.: On October 11, 2012, Dr. Fletcher performed a root canal treatment on tooth 36. An intra-operative PA of RCT 36, which Dr. Fletcher deleted, demonstrated a perforation. The tooth also appears to be non-restorable due to the extent of the furcation perforation. A post-operative PA also demonstrates the repaired perforation.

r. Y. P.: On November 18, 2010, Dr. Fletcher performed a root canal treatment on tooth 17. An intra-operative PA of RCT 17 demonstrates a file perforation through the distal canal into the bone of tooth 17. Another intra-operative PA demonstrates a possible separated file in the mesial canal and no repair of the distal perforation.

A PA of tooth 47 and 48, dated January 18, 2011, demonstrates a poorly obturated tooth 48 (short mesial obturation) and a possible separated file(s) in the mesial canal of tooth 47.

s. S. P.: On March 22, 2012, Dr. Fletcher performed a root canal treatment on tooth 37. An intra-operative PA of RCT 37 and a post-operative PA of RCT 37 demonstrate a separated instrument and a perforation.

t. D. P.: On May 24, 2012, Dr. Fletcher performed a root canal treatment on tooth 14. A deleted intra-operative PA of RCT 14 demonstrates a perforation.

u. M. R.: On January 14, 2013, Dr. Fletcher performed a root canal treatment on tooth 16. A post-operative PA demonstrates an incomplete obturation and a separated instrument.

v. L. S.: On December 4, 2012, Dr. Fletcher performed a root canal

treatment of tooth 31. An intra-operative PA and post-operative PA both demonstrate a perforation.

w. D. S.: On May 14, 2014, Dr. Fletcher performed a root canal treatment of tooth 36. An intra-operative PA demonstrates an incomplete (short) obturation of the D canal.

x. V. V.: On May 30, 2011, Dr. Fletcher performed a root canal treatment on tooth 24. Two intra-operative PAs demonstrate perforations.

y. Image 136: An endodontic PA mislabelled "S. S." for an unknown patient was recovered from deleted files in Dr. Fletcher's office. It demonstrates tooth 16 is perforated and approximately ½ of the proximal portion of the distal canal is not obturated.

z. Images 187/189: Two endodontic PAs, corresponding to the same unknown patient, were recovered from deleted files in Dr. Fletcher's office. They demonstrate perforation in tooth 14 or 15. As well, the tooth had not been sealed prior to providing endodontic treatment (obvious D radiolucency) hence the canal could have become contaminated during or after the endodontic treatment. The PAs also demonstrate that the tooth may not have been restorable due to the lack of coronal tooth structure remaining and the lack of remaining biologic width.

aa. Image 191: An endodontic PA for an unknown patient was recovered from deleted files in Dr. Fletcher's office. It demonstrates that tooth 24 is perforated.

(g) *Post, core and crown provided to wrong tooth*

47. In 2013, Dr. Fletcher provided a post, core and crown to the incorrect tooth for patient M. S., and that tooth was vital.

48. Dr. Fletcher was unable to provide a complete paper based chart for this patient – only electronic ledgers, digital photographs and digital x-ray images were provided.

49. Specifically, pre-operative periapic radiographs dated January 23, 2013 show pre-existing endodontic treatment and crowns on teeth 11 and 21. Tooth 12 had not been endodontically treated. On April 10, 2013, Dr. Fletcher provided a post, core and crown to tooth 12, the incorrect tooth, and that tooth was vital.

(h) *Inadequate posts, cores and crowns*

50. Dr. Fletcher placed posts, cores and crowns that were inadequate with respect to the following 5 patients:

a. L. B.: On February 20, 2014, Dr. Fletcher performed root canal treatment on tooth 25. Chart notes state: "Severe fracture during post core/crown preparation". There is no indication in the records that the patient was advised of the "severe fracture" or actual or possible consequences.

b. D. M.: On July 28, 2014, Dr. Fletcher performed a post, core and crown on tooth 22 and a crown on tooth 23. With respect to the post and core, the August 6, 2014 PA demonstrates: post diameter, root diameter ration with possible risk for root fracture; and length of post in portion of root supported by alveolar bone appears to be short. With respect to the crown on teeth 22 and 23, the August 6, 2014 PA demonstrates prosthetic crown-root margin M discrepancy.

c. D. P.: On June 27, 2012, Dr. Fletcher inserted a post, core and crown in tooth 14. An undated deleted PA demonstrates a short post and a failing crown on tooth 14.

d. P. R.: On February 19, 2014, Dr. Fletcher cemented a crown on tooth 25. The September 24, 2014 BW demonstrates a damaged D cervical root surface.

e. M. S.: Dr. Fletcher provided a post, core and crown to the incorrect tooth for patient M. S[redacted], and that tooth was vital, as set out above. On April 10, 2013, Dr. Fletcher placed a post in a vital tooth 12 (non-endodontically treated). Post-operative x-rays also demonstrate poor crown margins on teeth 12 and 11, and a possible mesial perforation of the post in tooth 11 with a short mesially angled post.

(i) *Crown placed on tooth with a hopeless prognosis*

51. With respect to patient I. G., as set out above, Dr. Fletcher repeatedly recemented and replaced a crown on a tooth he ultimately extracted. Specifically, on February 3, 2014, Dr. Fletcher re-cemented existing post, core and crown on tooth 36. The chart entry states the 36 PCC re-cemented and "Knocked off crown during night". The April 3, 2012 PA of tooth 36 demonstrates: perforation in furcation area of tooth; furcation area bone

loss; and D crown margin overhang.

52. On April 8, 2014, Dr. Fletcher took impressions for a new PCC tooth 36. The chart entry states: "Will remake with very guarded prognosis". The new PCC on tooth 36 was inserted on April 24, 2014.

53. On July 29, 2014, Dr. Fletcher took 2 BWs. The BW of tooth 36 and new PCC demonstrates: D crown/tooth marginal deficiency (and perforation of D root into furcation, severe furcation involvement, as in the April 03/12 PA and the apical portion of the distal canal not obturated, but no hx of sequelae from the incomplete D root obturation).

54. On August 7, 2014, Dr. Fletcher attempted to re-cement the new PCC on tooth 36. The chart entry states: "Crown loose but can't lift off yet. Will wait until it is looser or comes out to assess and hopefully re cement". The new PCC on tooth 36 was re-cemented on August 25, 2014, and again on September 9, 2014. The chart entry on September 9, 2014 states: "roots badly broken down, discussed very guarded prognosis discussed nothing, bridge, implant, partial lower denture, after root extraction. wanted me to cement it anyway".

55. On October 21, 2014, Dr. Fletcher extracted tooth 36, and a bridge 35-P-37 was provided subsequently.

(j) *Attempt to fabricate crowns on teeth with guarded/hopeless prognoses*

56. With respect to patient M. M., Dr. Fletcher attempted to fabricate crowns on teeth with a guarded or hopeless prognosis. A letter found in the patient chart from the Dental Design Centre ("DDC"), in London, Ontario, dated January 8, 2014, states that the DDC is unable to fabricate crowns for teeth 34, 35 and 36 "due to the visibility of the margins in certain areas of the tooth preparations".

(k) *Extractions*

57. Dr. Fletcher failed to extract portions of the roots of teeth in 2 patients, as follows:

a. A. K.: On November 7, 2013, Dr. Fletcher extracted tooth 27. The root tips were retained, and the patient was not advised of the issue. There is no chart entry for this date.

b. D. H.: Dr. Fletcher was unable to provide a paper based chart for

this patient – only radiographs and print outs for ledger entries were provided. On July 21, 2014, the ledger indicates that Dr. Fletcher billed for an "Ext Erupted Tooth Complicated" with respect to tooth 36. A PA dated September 3, 2014 demonstrates a retained distal root of tooth 36, damage to the root of tooth 35 and recurrent decay and mesial overhang on tooth 37. The damage to tooth 35, the adjacent premolar, occurred while Dr. Fletcher was attempted to extract tooth 36.

(l) *Fail to disclose adverse treatment outcomes*

58. Dr. Fletcher failed to disclose adverse treatment outcomes for the following patients:

a. L. B.: On February 20, 2014, Dr. Fletcher performed root canal treatment on tooth 25. Chart notes state: "Severe fracture during post core/crown preparation". There is no indication in records that patient advised of the "severe fracture" or actual or possible consequences.

On March 12, 2014, Dr. Fletcher performed a restoration of tooth 23 DL. A May 12, 2014 PA demonstrates gross D overhang. There is no indication in patient record that patient advised of gross distal overhang, possible consequences on the surrounding periodontium, and adjacent tooth.

b. C. B.: On January 6, 2014, Dr. Fletcher performed restorations on teeth 12 DIV and 38 OV. Dr. Fletcher later performed a repair on tooth 38 OV on August 11, 2014. The September 24, 2014 BW demonstrates an obvious V or L radiolucency suggestive of residual/recurrent caries MO on tooth 38. There is no indication that the patient was advised of these factors affecting the restoration and possible consequences on the tooth. Tooth 38 was extracted on October 1, 2014.

On February 11, 2014, Dr. Fletcher performed a restoration on tooth 48 O. The September 24, 2014 PA demonstrates that some of the M and D portion of this tooth is not covered with composite resin (note: tooth is not in occlusion with an opposing tooth). There is no indication that the patient was advised of these factors affecting the restoration.

c. D. C.: On January 30, 2014, Dr. Fletcher performed restorations on teeth 17 MO and 16 DOV. A PA taken on March 27, 2014

demonstrates M residual caries on tooth 17 MO and obvious DG and M radiolucency suggestive of residual/recurrent caries on tooth 16 DOV. There is no indication in the patient chart that the patient was advised of these factors affecting the restorations or possible consequences on vitality of the tooth. Subsequently, on April 15, 2014, Dr. Fletcher performed a root canal treatment, 1 surface composite filling, on tooth 16.

d. R. F.: On February 14, 2013, Dr. Fletcher performed a restoration on tooth 28 MO. A PA dated March 10, 2014 demonstrates D overhang 27, MG residual/recurrent decay 28. There is no indication that the patient was advised of these factors affecting the restoration, periodontal tissues and adjacent tooth.

e. I. G.: On April 8, 2014, Dr. Fletcher took impressions for a new PCC tooth 36. The chart entry states: "Will remake with very guarded prognosis". The new PCC on tooth 36 was inserted on April 24, 2014.

On July 29, 2014, Dr. Fletcher performed a recall examination and 2 BWs were taken. The BW of tooth 36 and new PCC demonstrates: D crown/tooth marginal deficiency (and perforation of D root into furcation, severe furcation involvement, as in the April 03/12 PA and the apical portion of the distal canal not obturated, but no history of sequelae from the incomplete D root obturation).

There is no indication in patient record that patient was advised of the persistent factors affecting the quality of PCC before and after remake, and possible consequences.

f. H. M.: On March 20, 2014, Dr. Fletcher performed restorations of teeth 26 O and 44 MV. With respect to tooth 26 OV, the July 23, 2014 BW demonstrates M and D residual/recurrent caries and large D overhang. There is no indication in the patient record that the patient was advised of the above factors affecting quality of restoration and possible consequences on the tooth.

g. C. O.: On July 7, 2014, Dr. Fletcher performed an emergency exam, took PA radiographs and prescribed antibiotics regarding issues with tooth 37. The chart entry states: "PAIN & SWELLING 37", "PA: TOOTH UNRESTORABLE NEEDS EXT" and antibiotics prescribed. The PA, dated July 7, 2014, demonstrates: perforation and presence of instrument in bone; canals of tooth not obturated (RCT done Feb. 27/13). There is no indication with respect to disclosure to the

patient of radiographic findings from July 7, 2014, including perforation of tooth, missed canals, misplaced obturation material and related consequences on tooth and adjacent bone.

h. S. P.: On May 29, 2014, Dr. Fletcher performed an emergency examination and a PA was taken. The May 29, 2014 PA demonstrates: M root perforation (tooth 37); incomplete obturation M root; obturation into bone through perforation; and separated file, M root. There is no indication in the patient record that the patient was advised of these issues.

i. J. P.: On January 8, 2014, Dr. Fletcher performed a restoration on tooth 16 MOD. A BW radiograph dated August 18, 2014 demonstrates: 17 damaged (flattened) M wall (iatrogenic); and uncontoured marginal ridge 16 M. There is no indication that the patient was advised of the damage to adjacent tooth.

59. Dr. Fletcher admits that the conduct outlined above contravened the standards of practice of the profession. Accordingly, in respect of all of the above noted issues, Dr. Fletcher admits that he contravened a standard of practice or failed to maintain the standards of practice of the profession, contrary to paragraph 1 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 1 of the Notice of Hearing.

60. Additionally, Dr. Fletcher admits with respect to the root canal treatment provided to patients H. M. (2012), C. O. (2013), M. R. (2013), and L. S. (2012), for which he charged fees, this treatment was substandard and should not have been billed. Accordingly, Dr. Fletcher admits that he charged a fee that was excessive or unreasonable in relation to the service performed, contrary to paragraph 31 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 2 of the Notice of Hearing.

B. Allegations 3, 4, 5 and 6 – Failure to Keep Records as Required, Providing Accurate Information to the College, DDU, and Breach of Undertaking

(a) *Illegible record entries*

61. Dr. Fletcher's hand-written progress notes were difficult to decipher. As a result, it was necessary for the College to obtain transcripts from Dr. Fletcher.

62. The College's *Dental Recordkeeping Guideline* states that all entries must

be clear and legible. If the practitioner of record were for any reason to become unable to practice, another dentist should be able to easily review the chart and carry on with the care of the patient.

(b) *Medical Histories*

63. Dr. Fletcher's patient records were missing information from the medical history. In the case of the following 11 patients, the information was still undocumented after subsequent appointments where the medical history was updated:

Patient	**Initial Medical History**		**Dates Medical Histories Updated but Missing Information Still Not Recorded**
	Date	**Missing Information**	
F., R.	Nov 07/12	contact information of physician	Nov 21/12 Dec 05/12 Jan 29/13 Feb 06/13 Mar 21/13 Aug 21/13 Jan 21/14 May 20/14 Jun 11/14
M., H.	May 22/12	date of birth, sex, weight	Oct 21/13 Jul 23/14
O., C.	Dec 12/11	name of physician and contact information	Dec 20/11 Jan 18/12 Jun 11/13 Nov 19/13
P., S.	Nov 25/09	contact information of physician	Not updated at any appointment since Nov 25/09
P., D.	Nov 23/09	contact information of physician date of birth of patient	Oct 07/10 Oct 25/10
P., J.	Nov 04/13	physician contact information	Nov 04/13 Feb 05/14 Feb 24/14 Aug 18/14
S., L.	undated (Nov 27/12	contact information of physician	Dec 18/13 Sep 24/14
S., S.	Feb 13/13	contact information of physician	Feb 27/13

			Apr 15/13
W., A.	Sep 18/14	name of physician and contact information	Sep 24/14 Sep 30/14 Oct 01/14 Oct 06/14
W., J.	Oct 17/01	name of physician and contact information	Sep 24/02 Dec 17/02 Mar 25/03 Jun 24/03 Oct 01/03 Mar 31/04 Jul 06/04 Oct 07/04 Jan 20/05 May 17/05 Sep 25/14
W., S.	Oct 22/07	phone number of physician	Mar 19/14

64. Further, medical histories were not updated in a timely fashion. In respect of the following 4 patients, the medical history was not updated for a period of more than 6 months:

a. H. M.: On May 7, 2014, Dr. Fletcher prescribed Clindamycin. On July 16, 2014, he prescribed Erythromycin. In both cases, the patient's medical history had not been updated for more than 6 months (last updated October 21, 2013).

b. C. O.: On July 8, 2014, Dr. Fletcher prescribed Amoxicillin when the patient's medical history had not been updated for more than 6 months (last updated November 19, 2013).

c. D. P.: On March 17, 2014, Dr. Fletcher prescribed medication when the patient's medical history had not been updated for more than 6 months (last updated October 25, 2010).

d. T. W.: On June 9, 2014, Dr. Fletcher prescribed Clavulin and Tylenol when the patient's medical history had not been updated for more than 6 months (last updated May 12, 2008).

65. The Regulation governing clinical records requires that the dentist's record for each patient shall contain the patient's history.

66. The College's *Medical History Recordkeeping Guide* (revised in May 2008) states that, in order to allow for the provision of safe dental care, dentists must ensure that all necessary and relevant medical information is obtained prior to initiating treatment – including the missing information noted above. Further, it is equally important that the patient's medical information, once obtained, should be updated on a regular basis.

(c) *Failure to document signs, symptoms, findings, diagnoses and/or treatment plans*

67. Dr. Fletcher failed to document important information in the patient chart with respect of the following patients in 2013 and/or 2014:

a. C. A. (2014)
b. L. B. (2014)
c. C. B. (2014)
d. D. C. (2013 and 2014)
e. J. D. (2014)
f. B. E. (2014)
g. R. F. (2014)
h. I. G. (2014)
i. A. K. (2014)
j. H. M. (2014)
k. C. O. (2014)
l. J. P. (2014)
m. P. R. (2014)
n. M. R. (2014)
o. A. W. (2014)
p. M. W. (2014)
q. O. W. (2014).

68. The information missing from these patient records includes signs, symptoms, findings, diagnoses and/or treatment plans, as detailed above. The College's *Dental Recordkeeping Guideline* states that a dentist's professional, ethical and legal responsibilities dictate that a complete chart and record documenting all aspects of each patient's dental care be maintained. The baseline data required in all circumstances includes signs, symptoms, findings, diagnoses and treatment plans.

(d) *Failure to document x-rays*

69. Dr. Fletcher failed to document x-rays taken in progress notes with respect to the following 4 patients:

a. C. A.: A PA x-ray dated March 3, 2014 is in the patient record for C. A. There is no mention of this PA in the patient chart.

b. L. B.: A PA x-ray dated October 1, 2014 is found in the patient record, but there is no corresponding chart note indicating that a PA was taken.

c. P. R.: Two BW x-rays, dated January 15, 2014, are in the patient record, but were not noted as being taken in patient chart.

d. A. W.: 3 PA x-rays were found in patient record but not noted as taken in chart entry on October 24, 2014.

70. The College's *Dental Recordkeeping Guideline* states that the patient record should include, among other things, a record of all treatment and the significant findings of all supporting diagnostic aids, such as radiographs.

(e) *Failure to document details of surgery*

71. Dr. Fletcher failed to document the details of surgery corresponding to the complicated/surgical extractions he billed with respect to the following 3 patients:

a. C. B.: On October 1, 2014, Dr. Fletcher performed a restoration on tooth 16 MOD and extracted tooth 38. No diagnoses were noted in the patient chart, and a PA of tooth 38 was not taken prior to the extraction. No details regarding the surgery were noted in the patient chart except for "EXT 38".

b. B. E.: On August 12, 2014, Dr. Fletcher performed an extraction of tooth 45. The chart entry states: "Started to remove crown whole tooth extremely mobile". No details regarding the surgery were noted except for "EXT 45".

c. C. O.: On July 17, 2014, Dr. Fletcher extracted Tooth 37. No details regarding the surgery were noted.

72. The Regulation governing clinical records requires that the dentist's record for each patient shall contain the examination procedures used, the clinical findings obtained, and the treatment prescribed and provided.

73. The College's *Dental Recordkeeping Guideline* states that the patient record should include, among other things, a record of the treatment provided and,

where appropriate, the outcome of the treatment.

(f) *Inaccurate tooth number*

74. Dr. Fletcher recorded inaccurate tooth numbers with respect to the following 3 patients:

a. L. B.: On May 8, 2014, Dr. Fletcher charted: "Removed loose 26 post and core/crown...". However, there was no tooth 26.

b. R. F.: On March 17, 2014, Dr. Fletcher made a chart note: "Patient presents for a follow up, 26 feels better but still tender, mostly on flossing. Pus still draining but in lesser amounts." However, there was no tooth 26.

On May 14, 2014, a PA radiograph was taken, and Dr. Fletcher prescribed penicillin and analgesics. The chart entry states: "Swelling upper left near root canal treatment. Fistula buccal to 26 placed gutta percha into fistula indicates furcation as source of infection". However, there was no tooth 26.

c. M. W.: On September 29, 2014, Dr. Fletcher performed an emergency examination and PA. The chart entry states: "38 BROKEN DOWN BADLY NO SYMPTOMS" and options of an extraction or a PCC were discussed. However, the tooth at issue was tooth 37, not tooth 38.

75. The College's *Dental Recordkeeping Guideline* states that the patient record should accurately include all details of treatment.

(g) *Periodontal pocket depths*

76. Dr. Fletcher did not record periodontal pocket depths appropriately with respect to patient L. B. The progress notes from March 10, 2014 state: "Pockets remain @ 1-4 m" and "loc early Chronic Periodontitis". However, full periodontal charting was not performed and had not been performed since November 17, 2009.

77. The College's *Dental Recordkeeping Guideline* states that the patient record should include an accurate description of the conditions that are present upon initial examination, among other things. Specific mention is made of completing periodontal evaluation.

(h) *Prescriptions*

78. Dr. Fletcher failed to document prescriptions and the justification for them with respect to the following 3 patients:

a. L. B.: Dr. Fletcher prescribed antibiotics on numerous occasions between January 31, 2014 and October 30, 2014. However, copies of the prescriptions are not contained in the patient record and chart notations regarding the prescriptions are incomplete, in that quantity, instructions, reason for prescription and/or symptoms were not noted in each case. A summary of the prescription history with respect to this patient is as follows:

Date	**Antibiotic Prescriptions**	**Documentation not found**
Jan 31/14	300 mg Clindamycin	-Quantity not noted -Instructions not noted
Feb 06/14	40 x 250 mg Erythromycin 1 q 6 h (Rx faxed in)	-Reason for prescription not documented
Feb 11/14	40 x 300 mg Clindamycin 1 q 6 h	-Reason for prescription not documented: "Follow up"
May 12/14	40 x 500 mg Clindamycin 1 q 6 h	-Emergency exam and PA but symptoms not noted
May 16/14	30 x 500 mg Clavulin 1 q 8 h for 10 days (Rx faxed in)	-Reason for prescription not documented
Jun 11/14	500 mg Clavulin 1 q 8 h for 10 days	-Symptoms not documented -Reason for prescription not documented -Quantity not noted explicitly
Jul 17/14	300 mg Clindamycin 1 q 8 h for 10 days	-Quantity not noted explicitly
Jul 28/14	40 x 300 mg Clindamycin 1 q 6 h (Rx phoned in)	-Reason for prescription not documented
Aug	250 mg Erythromycin	-Quantity not noted explicitly

05/14	1 q 6 h for 10 days	
Oct 01/14	30 x 500 mg Clavulin 1 q 8 h	-Symptoms not documented
Oct 10/14	40 x 250 mg Erythromycin 1 q 6 h until finished (Rx faxed in)	-Reason for prescription not documented
Oct 30/14	500 mg Flagyl bid for 10 days	-Reason for prescription not documented -Quantity not noted explicitly

b. D. C.: On January 30, 2014, Dr. Fletcher prescribed Erythromycin and Tetracycline. The Erythromycin was not documented in the patient chart. The Tetracycline was documented, but no reason for the prescription was noted. The patient had been taking Seroquel and Celexa since her initial appointment in 2013, as per the patient chart. On January 30, 2014, following the prescription, the patient's pharmacist advised Dr. Fletcher, via fax, that Erythromycin interacts with Seroquel (quetiapine) and Celexa (citalopram).

c. C. O.: On July 8, 2014, Dr. Fletcher prescribed Amoxicillin when the patient's medical history had not been updated for more than 6 months (last updated November 19, 2013).

79. The College's *Dental Recordkeeping Guideline* states that the patient record should accurately include a description of all treatment provided, including any drugs that are prescribed and the quantity and dose of each. It further states that drugs must only be prescribed for dental conditions being treated and according to accepted dispensing protocols.

(i) *Deleted radiographic images and intra-oral photographs*

80. In accordance with an Undertaking/Agreement entered into with the College, Dr. Fletcher was required to maintain any and all intra-operative (trial file and master cone) and post-operative endodontic radiographs taken in order to facilitate the monitoring of his practice. A copy of the Undertaking/Agreement is attached at Tab C.

81. During the College's investigation, 209 deleted images, consisting of both x-rays and intra-oral photographs, were recovered from a deleted files folder on the computer in Dr. Fletcher's office. After eliminating duplicates and other file types, 170 x-ray images and 16 intra-oral

photographs were left.

82. The 170 deleted x-rays consisted of panoramic images, PAs and BWs. Of these, 149 were labeled with a patient's name and 21 were not labeled with a patient's name. Some of the x-ray images are not diagnostic, are cone-cut, do not demonstrate the apices, and/or appear to be duplicates of x-ray images that were found in patient records. These x-ray images do not form part of the allegations.

83. In the case of the following 13 patients, the patient records were available to the College, and the deleted x-ray images were not part of the patients' records. In each case, Dr. Fletcher was providing endodontic treatment.

84. A summary with respect to the deleted records for these 13 patients is as follows:

Patient Name	Deleted Images
A., C.	**Deleted**: Intra-operative PA of RCT 17 (image 203, Apr 14/11) No intra-operative PAs were found in the patient's records/undeleted images, and provided to the College, including the PA above which demonstrates a distal root perforation. A post-operative PA was found in the patient records/undeleted images and that was provided to the College does not demonstrate the distal root perforation (Apr 14/11).
D., M.	**Deleted**: Intra-operative PA of RCT of 16 D canal (image 37, Sep 22/14 or May 18/12) (M & P canals obturated and RCT billed September 2004) The above PA demonstrates 2 file perforations. It was not found in the patient records/undeleted images and was not provided to the College. Two other PAs dated May 18/12, that do not demonstrate the perforations, were found in the patient's records/undeleted images and were provided to the College.
E., B.	**Deleted**: Intra-operative PA of RCT 35 (image 45, May 16/11) The PA demonstrates a file perforation. It not found in the patient's records/undeleted images and was not provided to the College.

	Another intra-operative PA, dated May 16/11, that does not demonstrate a file perforation was found in the patient records/undeleted images and provided to the College.
K., R.	**Deleted**: Post-operative PA of RCT 46 (image 70, date unknown) which demonstrates a perforation on the mesial root. No post-operative PAs were found in the patient's records/undeleted images that were provided to the College, including the PA noted above. An intra-operative PA, dated May 31, 2011, that does not demonstrate the perforation was found in the patient's records/undeleted images and was provided to the College.
	Deleted: Intra-operative PA of RCT 13 (image 71, Aug 09/12) The intra-operative PA demonstrates a file perforation. It was not found in the patient's records/undeleted images and was not provided to the College. Another intra-operative PA, dated Aug 09/12. that does not demonstrate the perforation was found in the patient's records/undeleted images and was provided to the College.
M., M.	**Deleted**: Intra-operative PA of RCT 46 (image 92, Mar 04/13) No intra-operative RCT PAs were provided to the College, including the PA noted above that demonstrates a perforation and file separation. The post-operative PA, dated Mar 04/13, was found in the patient's records/undeleted images and was provided to the College.
M., H.	**Deleted**: Intra-operative PA of RCT 22 (image 103, Dec 12/12) No intra-operative PAs of RCT 22 were found in the patient's records/undeleted images and provided to the College, including the PA noted above that demonstrates a perforation. The post-operative RCT PA, dated Dec 12/12, was found in the patient records/undeleted images, and provided to the College.

O., C.	**Deleted**: Post-operative PA of RCT 37 (image 109, Feb 27/13) No post-operative PAs of RCT 37 were found in the patient records/undeleted images for Feb 27/13, the day the root canal treatment was completed and billed, including the PA noted above that demonstrates a perforation that was obturated. The intra-operative PA, dated Feb 27/13, that does not demonstrate a perforation was found in the patient records/undeleted images, and provided to the College.
P., S.	**Deleted**: Intra-operative PA of RCT tooth 37 (image 114, Mar 22/12) **Deleted**: Post-operative PA of RCT tooth 37 (image 115, Mar 22/12) No RCT PAs of tooth 37 were found in the patient records for the day the root canal treatment was billed (Mar 22/12), including the 2 deleted PAs noted above that demonstrate a separated instrument and a perforation.
P., D.	**Deleted**: Intra-operative PA RCT 14 (image 116, May 24/12) No intra-operative RCT PAs of tooth 14 were found in the patient records, including the PA noted above, that demonstrates a perforation. The post-operative RCT PA of tooth 24, dated May 24/12, that does not demonstrate a perforation was found in the patient records/undeleted images, and provided to the College.
	Deleted: PA of a post, core and crown tooth 14 (image 117, date unknown, but PCC was inserted Jun 27/12) The deleted PA noted above demonstrates a short post and a failing crown on tooth 14
R., A.	**Deleted**: Intra-operative PA RCT tooth 16 (image 119, Jan 14/13) **Deleted**: Post-operative PA RCT 16 (image 120, Jan 14/13?) No RCT PAs of tooth 16 for Jan 4/13, the day the root canal treatment was billed, were found in the patient records/undeleted images including the intra-operative and post-operative PAs noted above that demonstrate

	an incomplete obturation and a separated instrument.
S., L.	**Deleted**: Intra-operative PA of RCT tooth 31 (image 125, Dec 04/12) **Deleted**: Post-operative PA of RCT tooth 31 (image 126, Dec 04/12) No RCT PAs of tooth 31 for Dec 04/12, the day the root canal treatment was billed, were found in the patient records/undeleted images, including the 2 PAs noted above that demonstrate a perforation.
S., D.	**Deleted:** Intra-operative PA of RCT 36 (image 138, May 14/14) The deleted PA noted above demonstrates an incomplete (short) obturation of the D canal. Two PAs, dated May 14/14, were found in the patient records/undeleted images.
V., V.	**Deleted**: Two intra-operative PAs of RCT tooth 24 (images 145 and 146, May 30/11) No RCT PAs for tooth 24 were found in the patient records/undeleted images, including the 2 PAs noted above that demonstrate perforations.

85. In the case of an additional 5 patients, Dr. Fletcher was unable to provide paper-based records. Digital x-rays and photographs were provided, however the below noted deleted images were not included in the patient record of images provided. A summary of the information available with respect to these deleted images is as follows:

Patient Name	**Deleted Image**
M., A.	**Deleted**: PA of incomplete RCT tooth 46 (image 84, Apr 16/13) The PA noted above, which demonstrates an obturated perforation, was not found in the patient's records or provided to the College. 2 PAs, dated April 16/13 and May 06/13, which also demonstrate the perforation, were found in the patient's records and were provided to the

	College.
M., D.	**Deleted**: Intra-operative PA of RCT tooth 24 (image 102, Aug 20/14) No intra-operative RCT PAs of the tooth were found in the patient's records/undeleted images, including the PA noted above that demonstrates 2 file perforations. The post-operative PA of the obturated tooth, dated Aug 20/14, that demonstrates an obturated perforation or a separated instrument was found in the patient's records and was provided to the College.
O., P.	**Deleted**: Post-operative PA of RCT 24 (image 108, Sep 02/14) No post-operative RCT PAs of the tooth were found in the patient's records/undeleted images provided to the College, including the PA noted above that demonstrates an obturated perforation and an unfilled canal (tooth 24). A poor quality, intra-operative PA, dated Sep 02/14, that also demonstrates a file perforation was found in the patient's records/undeleted images and was provided to the College.
P., E.	**Deleted**: Intra-operative PA RCT 36 (image 112, Oct 11/12) No intra-operative RCT images of the tooth were found in the patient's records/undeleted images provided to the College, including the PA noted above that demonstrates a perforation. The post-operative PA, dated Oct 11/12, was found in the patient's records/undeleted x-ray images and provided to the College, and it demonstrates the repaired perforation.
P., Y.	**Deleted**: Intra-operative PA RCT 17 (image 113, Nov 18/10) The intra-operative PA noted above was not found in the patient's records/undeleted images and provided to the College. It demonstrates a file perforation. Another intra-operative PA, dated Nov 18/10, was found in the patient's records/undeleted images but it does not demonstrate the perforation.

86. In addition, 8 recovered endodontic PAs (undated) were found in the

deleted items. In the case of 3 of these PAs, they relate to patients for whom the College did not request patient records. The other 5 PAs were either mislabelled or not labelled with a patient name. These 8 PAs also appear to be problematic, in that they appear to demonstrate missed canals, poorly obturated, perforations, and attempting to restore teeth with guarded or hopeless prognosis.

87. A summary of the information with respect to these deleted endodontic PAs is as follows:

Patient Name	**Deleted Image**
B., P.	Image 13
C., S.	Image 16
F., M. J.	Image 46
Mislabelled as "S. S."	Image 136 and image 137
Labelled as "W."	Image 187, image 189 and image 191

88. In addition, 16 deleted digital intra-oral photographs were recovered from the deleted items folder (identified as images 0, 15, 22, 28, 40, 49, 82, 90, 95, 96, 97, 105, 139, 140, 142 and 199). Neither patient names nor dates could be identified.

89. Pursuant to the Undertaking/Agreement, Dr. Fletcher was under monitoring by the College at the time many of the above noted x-rays and photographs were deleted. By deleting these x-rays and photographs, many of which demonstrated adverse outcomes from the patient record, the College monitor was not able to review these materials as part of the monitoring process.

90. During the College's investigation, Dr. Fletcher told the College investigator that he had only deleted "blurry" images where he could not identify what he had taken an x-ray of. This was not accurate, as Dr. Fletcher also deleted numerous digital radiographic images that clearly showed adverse outcomes of his endodontic treatment.

91. The Regulation governing clinical records requires x-rays and photographs to be maintained as part of the "clinical findings". Such records are required to be kept in a systematic manner for a period of at least 10 years.

92. The College's *Electronic Records Management Guideline* requires electronic records to be authentic, reliable, useable, have integrity, and

should be stored in a manner such that they can be located and retrieved. Deleting patient records is inconsistent with these guidelines and the Undertaking signed by the Member.

(j) *Failure to provide paper based records*

93. Upon request by the College's investigator, Dr. Fletcher was unable to provide the College with paper-based records that would include his progress notes for the following 11 patients: K. D., M. E., D. H., A. M., R. M.-M., D. M., P. O., E. P., Y. P., R. S., and M. S. Only electronic ledgers, digital x-rays and digital photographs were provided with respect to these patients. The electronic files did not include any progress notes, including histories, examination procedures, clinical findings, and treatments prescribed and provided.

94. With respect to a 12th patient, W. M., Dr. Fletcher was only able to provide one page of progress notes for treatment rendered on December 7, 2011 and June 6, 2012 (not dated), along with the electronic ledger, digital photograph and digital x-ray images for this patient. The ledger for W. M. indicates the patient was billed for procedures from 2000 to June 6, 2012.

95. A summary of information with respect to the patient records provided is below:

Patients	**Ledgers indicate procedures were provided from...**	**Paper-Based Records Provided**
D., K.	1998–Dec 10/13	None
E., M.	2010–Mar 31/11	None
H., D.	2004–Sep 17/14	None
M., A.	Apr 09/13-Mar 19/14	None
M.-M., R.	2002–Oct 01/14	None
M., W.	2000-Jun 06/12	One page of progress notes for treatment rendered on December 7, 2011 and June 6, 2012
M., D.	2002-Oct 29/14	None

O., P.	Aug 07/14- Sep 02/14	None
P., E.	1999-Oct 25/12	None
P., Y.	2008-Apr 06/11	None
S., R.	1999-Apr 17/12	None
S., M.	Jan 23/13-May 22/13	None

96. The Regulation governing clinical records requires that dentists must keep clinical and financial records, as described above in a systematic manner and for 10 years.

97. The College's *Dental Recordkeeping Guideline* provides that records must be kept and stored securely.

(k) *Failure to make chart entries*

98. Dr. Fletcher failed to make chart entries in patient records corresponding to procedures or treatment provided with respect to the following 7 patients:

a. C. A.: On May 13, 2014, Dr. Fletcher performed and billed for an emergency exam and PA. The chart entry with respect to these procedures stated only "EMERG, 1PA 17". There is no further information provided, such as chief complaint, signs, symptoms, tests performed, findings, diagnoses or treatment plan.

b. A. K.: On November 7, 2013, Dr. Fletcher extracted tooth 27. There is no chart entry for this date.

c. H. M.: On January 4, 2012, Dr. Fletcher charged for a root canal treatment (3 canals) and restoration on tooth 46. There are no chart entries for January 4, 2012 in the patient record.

d. L. S.: On December 4, 2012, Dr. Fletcher performed a root canal treatment of tooth 31. However, there is no chart entry for this date.

On May 23, 2013, Dr. Fletcher billed for 1 PA x-ray. There is no chart entry for this date.

On August 8, 2013, Dr. Fletcher billed for a complicated extraction of tooth 31. There is no chart entry or radiographic image for this date.

e. C. O.: Dr. Fletcher's ledger indicates that he billed $746.00 for "37 RCT 3 canals" and $138.00 for "37 restoration" on February 27, 2013. The ledger also includes an entry of $0.00 for "post operative" on March 8, 2013. There are no chart entries in the patient record for either February 27 or March 8, 2013.

f. M. R.: On January 14, 2013, Dr. Fletcher performed a root canal treatment on tooth 16. Dr. Fletcher billed $746.00 for "16 RCT 3 canals" and $138.00 for "16 restoration" on January 14, 2013. The chart contained a sticky note stating: "16 RCT needs to be charted", with no further note.

99. The College's *Dental Recordkeeping Guideline* states that the patient record should accurately include all details of treatment.

100. Dr. Fletcher acknowledges, in respect of all of the above noted issues, that his recordkeeping was not in accordance with the regulations, or the standards of practice of the profession. Dr. Fletcher admits that he breached his professional, ethical and legal responsibilities that required him to maintain a complete and accurate records documenting all aspects of each patient's dental care, per the College's *Dental Recordkeeping Guideline*, and s. 38 of Regulation 547.

101. Therefore, Dr. Fletcher admits that he failed to keep records as required by the regulations relevant to the above noted patients, contrary to paragraph 25 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 3 of the Notice of Hearing.

102. Additionally, in respect of the issues involving deleting digital radiographs and intra-oral photographs, misleading the College's investigator, and not providing the College with copies of paper-based charts, set out in sections (i) and (j), above, Dr. Fletcher admits that he:

a. failed to take reasonable steps to ensure that any information provided by him to the College was accurate, contrary to paragraph 57 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 4 of the Notice of Hearing; and

b. he engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as

disgraceful, dishonourable, unprofessional and unethical, contrary to paragraph 59 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 5 of the Notice of Hearing.

103. Finally, in respect of deleting endodontic radiographs, and in light of the Undertaking entered in to by Dr. Fletcher with the College to maintain any and all intra-operative and post-operative endodontic radiographs, Dr. Fletcher admits that he failed to abide by a written Undertaking given by him to the College or to carry out an agreement entered into with the College, contrary to paragraph 54 of Section 2 of the Dentistry Act Regulation, as set out in Allegation 6 of the Notice of Hearing.

Past History

104. Dr. Fletcher has been specifically warned by the Discipline Committee, ICRC and its predecessor committees about some of the very conduct he is now admitting he engaged in.

105. In particular, on October 21, 1992, Dr. Fletcher was found guilty of professional misconduct by the Discipline Committee for numerous instances of poor endodontic and restorative treatment and a failure to maintain records. He was ordered to take courses relating to oral diagnosis, oral radiology, endodontic treatment and restorative dentistry, and be subjected to monitoring.

106. The Complaints Committee raised concerns and offered advice to Dr. Fletcher on both May 9, 1997 and April 20, 2001, relating to recordkeeping, and specifically keeping more detailed chart notes.

107. As a result of further complaints, Dr. Fletcher entered into an Undertaking (dated April 8, 2003) to complete courses in crown and bridge work treatment and be subject to monitoring, and a further Undertaking (dated August 17, 2009) to take coursework in endodontic therapy and be subject to monitoring.

108. Following the investigation of a subsequent complaint in 2015, the ICRC noted that it would have required Dr. Fletcher to take courses regarding endodontics, but did not do so as the treatment in question had taken place prior to the most recent Undertaking and monitoring. The same ICRC panel provided Dr. Fletcher with advice regarding his prescribing practices and referring patients to a specialist.

109. As a result of a complaint, on April 24, 2009, Dr. Fletcher was cautioned with respect to ill-fitting crowns.

110. The parties agree that the facts in relation to this history are relevant to the issue of sanction.

General

111. Dr. Fletcher admits that the acts described above constitute professional misconduct and he now accepts responsibility for his actions and the resulting consequences.

112. Dr. Fletcher has had the opportunity to take independent legal advice with respect to his admissions.

DECISION

Having considered the evidence and submissions of the parties, the Panel found that the Member committed professional misconduct as alleged in the Notice of Hearing.

REASONS FOR DECISION

Dr. Fletcher admitted that the acts outlined in the agreed statement of facts constitute professional misconduct. Dr. Fletcher had independent legal advice with respect to his admissions.

The Panel found that the evidence in the detailed and thorough Agreed Statement of Facts clearly supports the allegations. For Notice of Hearing 160009, the Member's conduct regarding the patient D.S. feel so far outside the standards of practice that it amounted to treatment without informed consent. It also involved record-keeping failures, including the failure to itemize fees in the matter required by the College.

For Notice of Hearing 160012, the Member's treatment of numerous patients fell below the standard of care. The College's ability to monitor this Member and hold him accountable was threatened by the deficiencies in record-keeping and the Member's failure to provide accurate information to the College as required. The Member breached an undertaking with the College. When the Member's conduct is viewed in its totality, the Panel agrees with the College and the member that it would reasonably be regarded by members of this profession as disgraceful, dishonourable, unprofessional and unethical.

PENALTY SUBMISSIONS

The parties presented the Panel with a joint submission with respect to penalty and costs, which requested that the Panel make an order as follows.

1. Requiring the Member appear before the Panel of the Discipline Committee to be reprimanded, within ninety days of the Order becoming final or on a date fixed by the Registrar;
2. Directing the Registrar to revoke the Member's certificate of registration effective immediately; and
3. Requiring the Member to pay costs to the College, in the amount of $2,500.00, such costs to be paid within thirty days of the Order becoming final.

The parties submitted that the Panel should accept this penalty as it falls within the range of appropriate penalties given the particular facts of this case. College Counsel submitted that the large number of patients affected, combined with the extent of the professional misconduct, make it clear that revocation is the only appropriate penalty. Counsel for the Member did not disagree with this submission.

The parties submitted that this penalty serves the primary goal of public protection, acts as a deterrent to members of the profession and maintains public confidence in the ability of the profession to regulate itself in the public interest. Dr Fletcher has a prior discipline finding against him, was cautioned by the Inquiries, Complaints and Reports Committee or its predecessor, and has had several interactions with screening committees of the College. Numerous opportunities were given to the Member to rehabilitate his practice. Dr Fletcher was required to take several educational courses and was subject to monitoring of his practice but he failed to make the changes necessary to improve his practice.

PENALTY DECISION

The Panel ordered that:

1. The Member shall appear before the Panel to be reprimanded, within ninety days of the Order becoming final or on a date fixed by the Registrar;
2. The Registrar is directed to revoke the Member's certificate of registration effective immediately; and

3. The Member is required to pay costs to the College, in the amount of $2,500.00, such costs to be paid within thirty days of the Order becoming final.

REASONS FOR PENALTY DECISION

The Panel is aware that joint submissions should be respected unless they fall so far outside the range of an appropriate sanction that they would bring the administration of justice at the College into disrepute, or are otherwise contrary to the public interest.

The Panel is of the view that Dr Fletcher's conduct demonstrated his disregard for his patients and the profession as a whole. His professional misconduct was widespread, repeated and ongoing. On a review of 48 patients there were several breaches of the standard of care including poor or no patient records, inappropriate billing, failures of basic dentistry and some egregious cases of treatment on the wrong tooth or the wrong treatment. Dr Fletcher has appeared before several screening committees over the years and courses have been ordered and monitoring has taken place on different areas of practice. Attempts were made to remediate the member but they did not result in a better dental practice.

Revocation is generally reserved for the most serious cases. It is the opinion of the Panel that revocation is the only penalty that meets the objectives of protecting the public, serving as a deterrent for the profession and maintaining public confidence in the profession and its ability to regulate itself in the public interest. This is not a case where specific deterrence and mediation are applicable goals. Dr Fletcher conceded that revocation was the only option in the circumstances of this case.

I, Susan Davis, sign these Reasons for Decision as Chairperson of this Discipline Panel.

Susan Davis
Chairperson

31/07/17
Date