H170007

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. ADAM BURTON**, of the City of Toronto 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: Susan Davis, Chair
Bill Coyne
Lisa Kelly
Ram Chopra
Ben Lin

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS	)	Appearances:
OF ONTARIO	)	
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the
	)	Royal College of Dental
	)	Surgeons of Ontario
- and -	)	
	)	Ms. Dayna Simon
	)	For the Royal College of
	)	Dental Surgeons of Ontario
	)	
DR. ADAM BURTON	)	Mr. Earl Heiber
	)	For Dr. Adam Burton

Hearing held on February 15, 2018

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 on February 15, 2018.

PUBLICATION BAN

On the request of the College and on the consent of the Member, 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. Adam Burton (the "Member") were contained in the Notice of Hearing, dated February 15, 2017. The allegations against the Member were as follows:

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, during the years 2011, 2012 and/or 2013, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely L F , contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about April 15, 2012, April 24, 2012 and/or May 24, 2012, you extracted teeth 37, 47, 46, 42, 41, 31 and/or 32, without justification and/or the investigation of other irreversible treatment options.
   - In or about 2011, 2012 and/or 2013, you failed to consider referrals to appropriate specialist(s) at an earlier juncture given the complexity of the treatment required for this patient and in the face of your decision to extract teeth 37, 47, 46, 42, 41, 31 and 32.

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, during the year 2012, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one of your patients, namely L F , contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - On or about April 15, 2012, April 24, 2012 and/or May 24, 2012, you failed to have a fulsome discussion with L F about the extraction of teeth 37, 47, 46, 42, 41, 31 and/or 32, or the option to investigate alternatives to this irreversible treatment.

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, during the years 2011, 2012 and/or 2013, you failed to keep records as required by the regulations relative to one of your patients, namely, L F , contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

   - In or about 2011, 2012 and/or 2013, your records were incomplete with respect to the level of pain reported by your patient and her need to take medication to address this.
   - On or about April 15, 2012, April 24, 2012 and/or May 24, 2012, your decision to extract teeth 16, 31, 32, 37, 41, 42, 46 and 47 was unsupported by your records and radiographs. Your records failed to include necessary diagnostic testing, your diagnosis and justification for these extractions.
   - Your records were inaccurate and/or unclear with respect to the date that teeth 16, 31, 32, 37, 41, 42, 46 and 47 were extracted.
   - Your chart entry dated “May 30/12” with the notation “Surgical ext 16” was struck-through which indicates that this

treatment was not provided. However, the subsequent chart entry suggests that it was provided that same date. Accordingly, your record of the treatment provided on May 30, 2012 is confusing, unclear and/or inaccurate.

- In or about 2011, 2012 and/or 2013, your recordkeeping was inadequate for the treatment you provided in that it did not include:
    - A record of your clinical exam findings, including periodontal probings and mobilities, and radiographic observations.
    - A diagnosis and treatment plan, including alternative treatments and options along with the risks and benefits of treatment.
    - A notation that informed consent had been obtained for treatment.
    - A description of treatment provided, including materials and methods used.
    - Clear indication as to the treating practitioner.
    - Notations of discussions with treatment being provided by other practitioners which would affect the treatment provided by you.
    - Notations of your telephone and/or other discussions with your patient about the treatment provided and/or her concerns.

4. *Withdrawn*.

5. *Withdrawn*.

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, during the years 2011, 2012 and/or 2013, 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 of your patients, namely L F contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- In or about 2011, 2012 and/or 2013, you demonstrated an overall disregard for the irreversible, life-altering treatment you performed for a patient who came to your office for treatment and ended up with multiple extractions without justification.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct, as set out in allegations 1,2,3 and 6 of the Notice of Hearing. 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.

1. Dr. Adam James Burton first registered with the Royal College of Dental Surgeons ("College") in 1993, as a general dentist.

2. Dr. Burton received a Notice of Hearing, dated February 15, 2017 and reviewed it with his legal counsel.

3. The Notice of Hearing particularizes six allegations of professional misconduct all with respect to Dr. Burton's treatment of and conduct in respect of his patient Ms. L F , specifically, he:

   - Contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of his patients

- Treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation where consent is required by law
- Failed to keep records as required by the regulations
- Signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement
- Submitted an account or charge for dental services that he knew or ought to have known was false or misleading
- 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.

Withdrawals

4. The College seeks to withdraw, on consent of both parties, Allegations 4 and 5 as set out in the Notice of Hearing, namely that Dr. Burton signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement and submitted an account or charge for dental services that he knew or ought to have known was false or misleading. The College is now satisfied that any billing issues were attributable to poor recordkeeping or not attributable to Dr. Burton. While not required, the complainant expressed to the College prosecutor that she was amenable to having the billing allegations in respect of Dr. Burton withdrawn.

Admissions

5. Dr. Burton admits to Allegations 1, 2, 3 and 6 and the particulars therein as set out in the Notice of Hearing.

6. Dr. Burton further admits that these allegations together with the particulars and facts set out in the Notice of Hearing, and this Agreed

Statement of Facts, constitute professional misconduct, as set out in the professional misconduct regulation.

Facts

7. In a letter received by the College on May 16, 2014, Ms. L F , a patient of Dr. Adam Burton, wrote to the College filing a formal complaint about the treatment she had received from Dr. Burton and another dentist that Dr. Burton practices with at Northland Dental Centre, Dr. Brock Rondeau. The essence of Ms. F 's complaint was that the treatment for her temporomandibular joint (TMJ) caused her to lose 10 teeth and that the denture and "build ups" performed by Dr. Burton were inadequate and as a result both her dental health and overall health were severely adversely affected.

8. In summary, the essence of Ms. F 's complaint is:

- She saw Dr. Rondeau in 2009 who diagnosed her with a dislocated jaw and TMJ. Dr. Rondeau planned to fix her jaw, put crowns on all her teeth and prescribed her Percocet for pain. Dr. Rondeau made her a day splint and a night splint.
- The night splint made her teeth loose and Dr. Burton had to extract them, along with her "back teeth" that Dr. Rondeau had neglected. By the time Dr. Rondeau sent her to Dr. Burton, Dr. Burton said 10 teeth had to be extracted, which left her unable to smile or chew and she lost so much weight she was weak and bedridden.
- Dr. Rondeau made her a splint and then when that did not work, made her a denture. Dr. Burton put "build ups" on her bottom teeth to match the denture but the denture and "build ups" were too big on the teeth and left her jaw open too wide.
- When she called the office, Dr. Burton could not see her for 14 days so she went to another dentist who said she had to go back to the dentist who did the work. She went to the hospital for pain control and waited in bed

for the appointment. Dr. Burton then "shortened the build-ups" and told her to throw away the new denture.

- Her dental health is "a mess".

9. Dr. Burton was notified of the complaint, asked to provide his original patient records for Ms. F and was given an opportunity to respond to the substance of the complaint. Dr. Burton's letter of response and his patient records for Ms. F were received by the College on July 4, 2014.

10. In summary, Dr. Burton's response to Ms. F 's complaint was as follows:

- Ms. F was first seen in his office by his colleague, Dr. Christopher Ciriello, in September 2010 for jaw pain, headaches and sensitive teeth. Dr. Ciriello fabricated a crown for tooth #26 to protect an endodontically treated tooth. Dr. Ciriello proposed full mouth treatment consisting of 28 crowns to restore her bite and protect her sensitive teeth. Dr. Ciriello also placed temporary composite restorations (i.e., "composite buildups") on six teeth to see if this would help her TMJ pain.
- Dr. Burton first saw Ms. F in February 2011. It was obvious the endodontic treatment and crown on tooth #26 had failed and she had a buccal abscess and extreme pain. He extracted tooth #26 at her request.
- He next saw the patient in August 2011 when he restored tooth 31 and removed the mandibular composite buildups at her request.
- Six months later he saw her along with the denturist in his office, Mr. Jason Gillooly. Tooth #36 had fractured and been removed by another dentist. Due to pain and use of opioids to deal with it, she wanted all of her teeth removed and full dentures placed. Both he and Mr. Gillooly advised this was not the best option and recommended a complete exam and new treatment plan.
- On clinical examination, four mandibular anterior teeth (31, 32, 41, 42) were mobile and one of them (31) had a buccal abscess. She did not want

endodontic treatment for #31 or any of her symptomatic molars and just wanted the "teeth out".

- On February 28, 2011 his office contacted Ms. F with a proposed treatment plan. Dr. Burton did not agree with the option of full mouth clearance but agreed to remove the four loose mandibular anterior teeth, including the abscessed tooth. Also, he could remove her posterior molars and fabricate removable appliances that could be adjusted to minimize her TMJ pain. Then, final restoration of her remaining teeth could be considered. The patient was "eager to start".
- The results of the complete exam show a notation of a buccal abscess on tooth #41, but that was charted in error and should have been tooth #31.
- On April 24, 2012, he removed teeth #37, 47, 46, 42, 41, 31 and 32 and Mr. Gillooly placed an acrylic partial lower denture (PLD). The occlusion for the PLD was determined by tests done by Dr. Rondeau.
- On May 30, 2012, Dr. Burton extracted tooth #16 as it was in the treatment plan and Ms. F was in extreme pain. Over the next several months she could not tolerate the acrylic PLD. On October 2, 2012 he added composite buildups to try to stabilize her occlusion.
- On October 16, 2012, at the patient's request he removed the composite buildups.
- In November 2012, it was concluded that the acrylic PLD was not tolerable for the patient. She said she wanted a cast partial and over the next few months he worked with the denturist, a cast PLD was made and he placed temporary composite buildups. In December 2012, the patient told Mr. Gillooly that she was finally comfortable.
- Early in 2013, Ms. F advised that she could not tolerate the cast PLD. On April 2, 2013 a referral was made to an oral surgeon for implant consultation, which Dr. Burton says was at his expense. She also made a request to the office for reimbursement. Discussions in this regard between Ms. F , himself and Dr. Rondeau broke down.
- She was taking large amounts of opioids before she started treatment with him so this was not due to his treatment.

11. The College investigator collected Ms. F ’s dental records from 11 other peripheral practitioners plus a health organization who were involved in her care. The records of the treating denturist were also obtained as they were contained in her patient file submitted by Northland Dental Centre.

12. Full disclosure of the complete Record of Investigation, including all of the records collected, was provided to both the member and the complainant at the completion of the investigation and they were each given a final opportunity to respond before the matter was considered by a panel of the ICR Committee.

13. After receiving the Record of Investigation, Ms. F contacted the College investigator and advised him about her continuing pain and health issues, including osteoarthritis, which she says are attributable to the treatment performed by Dr. Burton and Dr. Rondeau.

14. When a panel of the ICR Committee met to consider this matter on April 11, 2016, it reviewed the complete Record of Investigation in this matter and requested that the investigator obtain further information. Specifically, the panel wished to see Ms. F ’s insurance records for all treatment provided at Northland Dental Centre, including but not limited to, treatment provided by Dr. Burton, Dr. Rondeau and Mr. Gillooly (denturist). The panel also wanted confirmation of the identity of all treatment providers, by chart entry, for treatment rendered at Northland Dental Centre.

15. The investigator contacted Ms. F to seek her consent to obtain her insurance records. She said that she only had insurance coverage for one year of the treatment and the majority of costs were paid for out of pocket.

16. The College investigator wrote to Dr. Burton and provided a table with each treatment date noted in Ms. F 's chart and asking that Dr. Burton complete the table by indicating who the treatment provider was on each date.

17. As there were some entries on the table that were left blank, the investigator wrote to Dr. Burton again and asked that for an explanation.

18. In Dr. Burton's letter of response he writes that some of the previous dates provided were not correct. The date for extraction of 37, 47, 46, 42, 41, 31 and 32 was May 24, 2012 and not April 15, 2012 or April 24, 2012 as written in previous reports. Dr. Burton says no treatment was rendered on April 15, April 24 or May 12, 2012 and he provides the amended table.

19. On November 25, 2016, the panel of the ICR Committee met again to consider the investigation along with the further information it had requested. During its discussion, the panel expressed very serious concerns about the adequacy of the treatment Dr. Burton provided to Ms. F , his recordkeeping, his informed consent protocols, his billing practices and what they viewed as his "overall disregard for the irreversible, life-altering treatment he performed for a patient who came to the office for temporomandibular joint disorder treatment but ended up with multiple extractions". Accordingly, the panel formed an intention to refer specified allegations of professional misconduct to the Discipline Committee.

20. In particular, the panel was concerned that:

- Dr. Burton did not recognize at an earlier stage that the temporomandibular joint therapy was unable to attain an ideal position for Ms. F 's jaw.

- Dr. Burton did not consider more temporary, less invasive means by which to increase the patient's vertical dimension before placing large build-ups on teeth 33, 34, 35, 43, 44, 45.
- Dr. Burton did not consider referrals to specialists at an earlier juncture in Ms. F 's treatment.
- Dr. Burton's decision to unnecessarily remove enamel in an attempt to try to find a proper occlusal relationship for this patient caused sensitivity as dentin was also removed.
- Dr. Burton's records were incomplete with respect to the level of pain reported by his patient and her need to take medication to address this.
- Dr. Burton's decision to extract teeth 16, 31, 32, 37, 41, 42, 46 and 47 was unsupported by his records and radiographs. There was no diagnostic testing, no diagnosis or any justification for these extractions.
- Dr. Burton did not have a fulsome discussion with Ms. F about the need for the extractions or the option to investigate alternatives to this irreversible treatment.
- Dr. Burton's financial records indicated that the extraction of teeth 31, 32, 37, 41, 42, 46 and 47 was performed on May 24, 2012, yet his clinical chart entry recording these extractions was dated "Apr 15/12."
- Overall, his recordkeeping was inadequate for the treatment he provided.

21. Before finalizing the decision, as per the College's protocol, the panel extended the opportunity to Dr. Burton to attend before the panel to make submissions.

22. Dr. Burton retained a lawyer, Mr. Earl Heiber, to attend with him before the panel and make submissions. On January 9, 2017, Dr. Burton and Mr. Heiber submitted as follows:

- Ms. F came to see Dr. Burton for tooth pain and dental treatment as a general dentist; she was referred to him by Dr. Rondeau
- He made it clear to the patient that he "doesn't do" TMJ treatment.
- The composite buildups he placed were not for TMJ treatment but to give the patient more surface area to chew on.

- He didn’t remove enamel or dentin from the teeth.
- When she came to see him for treatment planning for general dentistry, she was complaining about a lot of pain in her teeth and she was on large amounts of opioid medication.
- At the complete exam, all she wanted to do was have all of her teeth extracted. He told her this was not a viable treatment plan and went tooth by tooth to convince her not to extract all of her teeth.
- He could have performed root canal therapy on many of her teeth to save them, but the patient didn’t want endodontic treatment.
- The treatment plan was to perform root canal therapy on symptomatic teeth and to maintain the bulk of her teeth.
- He discussed all of the options, including replacement of teeth.
- His records don’t document all of the conversations he had with her.
- There were no documented findings/diagnosis for individual teeth; he tried to find these records but could not locate them.
- He accepts that he has no documentation to defend his position.
- The denture was placed by the denturist.
- The patient had trouble with the denture; it was uncomfortable, it moved and it dug into her gums.
- He referred the patient to an oral surgeon for implants to replace her missing teeth instead of her using a denture.
- The treatment he provided was less invasive than her desired treatment.
- During treatment, the patient came off her pain medication and she was finally out of pain; she was making progress.
- He did not provide treatment for financial gain.
- There is no doubt that his recordkeeping was inadequate.
- The need for informed consent was met but there was no record of it
- The patient came back to Dr. Burton requesting that all of her teeth be extracted.
- Dr. Burton convinced the patient not to extract all of her teeth.
- The extracted teeth were non-restorable.
- With respect to the panel’s concern about an overall disregard for the patient, the patient came to Dr. Burton for extractions, not TMJ therapy.

- Ms. F agreed to save her teeth and proceed with a partial denture.
- Dr. Burton referred the patient to a specialist when it came to replacing her teeth.
- This matter could be dealt with through a recordkeeping course and monitoring.
- There is no basis for this referral other than an absence of records.
- The composite buildups did not involve cutting of the teeth.
- The panel should take rehabilitative action and not punitive action.
- The dentist has learned a lesson about his recordkeeping.

23. After considering the submissions made on January 9, 2017, the panel of the ICR Committee decided to confirm its intention and finalized its decision to proceed with a referral of specified allegation of professional misconduct to the Discipline Committee for a hearing.

Summary

24. Dr. Burton admits the facts as set out in the remaining allegations and particulars of the Notice of Hearing to which he has pleaded guilty, and admits the facts as set out above.

25. Dr. Burton further admits that these acts constitute professional misconduct.

26. Dr. Burton has demonstrated his remorse by pleading guilty.

27. Dr. Burton successfully completed a recordkeeping course in August 2017 and submitted proof of completion to the College.

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. Burton pled guilty to the allegations set out in Paragraphs 1, 2, 3 and 6 the Notice of Hearing, together with the particulars set out therein and the facts presented in the Agreed Statement of Facts. The panel was of the view that the evidence clearly substantiates the allegations of professional misconduct. Dr. Burton failed to meet the standards of practice expected of a general dentist in respect to his treatment of the patient's temporomandibular joint disorder. Dr. Burton extracted several teeth without justification and/or investigation of other treatment options. Given the complexity of this case, Dr.Burton should have referred to a specialist but instead demonstrated a disregard for the irreversible, life-altering treatment he performed on this patient. His patient suffered greatly and continues to suffer to this day. Dr. Burton's record keeping was inadequate as it did not include any necessary diagnostic testing, diagnosis and treatment plan, including alternative treatments and options along with the risks and benefits of treatment and justification for all the extractions.The lack of any notation of informed consent discussions with the patient is unacceptable.
e. Dr. Burton admitted to this professional misconduct in the Agreed Statement of Facts.

PENALTY SUBMISSIONS

1. The Royal College of Dental Surgeons of Ontario ("College") and Dr. Adam James Burton ("Member") jointly submit that this panel of the Discipline Committee, impose the following penalty on the Member as a result of the panel's finding that the Member is guilty of professional misconduct, namely, that it make an order:

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

    2. directing that the Registrar impose the following terms, conditions and limitations on the Member's Certificate of Registration ("Conditions"), namely:

(i) the Member shall not alter any patient's vertical dimension of occlusion (including but not limited to the use of "build ups"), until such time as he provides proof of successful completion to the College of the course set out in paragraph 1(b)(iii) set out below

(ii) the Member shall not perform any TMD cases until such time as he provides proof of successful completion to the College of the educational requirements as set out in the College's Guidelines on Diagnosis & Management of Temporomandibular Disorders & Related Musculoskeletal Disorders and provides proof of successful completion of the course set out in paragraph 1(b)(iii) set out below

(iii) requiring that the Member successfully complete a comprehensive one-on-one course on occlusion, including but not limited to crown and bridge cases, to include: diagnosis, case selection, appropriate treatment options for altering vertical dimension of occlusion, conditions which may necessitate a referral to a specialist or other practitioner, responsibilities of the referring dentist (including continued communication with the involved practitioners, patient monitoring, re-evaluation and regular follow-up care during the course of a referral) and informed consent as it pertains to the risks and benefits of the proposed treatment, in particular for inalterable consequences and possible adverse outcomes of the proposed treatment. This course shall be at the Member's expense, approved by the College, and he shall provide proof of successful completion in writing to the Registrar within twelve (12) months of this Order becoming final; and

(iv) the Member shall successfully complete a course in recordkeeping, including a component of financial recordkeeping. This course shall be at the Member's expense, approved by the College, and the Member must provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(v) the Member shall successfully complete a course in informed consent. This course shall be at the Member's expense, approved by the College, and the Member must provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(vi) the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the date of the finalization of this Order and ending thirty-six (36) months from the College receiving proof of the Member's successful completion of the courses or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(vii) that the Member shall cooperate with the College during the inspection(s) and further, shall pay to the College in respect of the costs of monitoring, the amount of $600.00 per monitoring, such amount to be paid immediately after completion of each of the inspections, provided that the overall cost of monitoring paid by the member shall not exceed $3,600.00, regardless of the number of inspections performed;

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

3. that the member pay costs to the College in the amount of $2,500.00 in respect of this discipline hearing, such costs to be paid in full within six (6) months of this Order becoming final.

2. The Conditions imposed by virtue of subparagraph 1(b)(i) shall be removed from the Member's certificate of registration upon providing proof of successful completion of the course to the Registrar.

3. The College and the Member further submit that pursuant to the *Code*, as amended, the results of these proceedings must be recorded on the Register of the College and publication of the Decision of the panel would therefore occur with the name and address of the Member included.

4. This joint submission on penalty and costs was reached as a result of a pre-hearing conference held with respect to these matters before Dr. Cam Witmer, and received his endorsement.
   In this case both the College and the Member are of the view that the principles of deterrence and rehabilitation can be met without a suspension, for reasons that will be set out in oral submissions.

5. Dr. Burton has not previously appeared before the Discipline Committee of the College.

PENALTY DECISION

The Panel accepted the parties' submission and so ordered as follows:

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

2. The Registrar impose the following terms, conditions and limitations on the Member's Certificate of Registration ("Conditions"), namely:

(i) the Member shall not alter any patient's vertical dimension of occlusion (including but not limited to the use of "build ups"), until such time as he provides proof of successful completion to the College of the course set out in paragraph 1(b)(iii) set out below

(ii) the Member shall not perform any TMD cases until such time as he provides proof of successful completion to the College of the educational requirements as set out in the College's Guidelines on Diagnosis & Management of Temporomandibular Disorders & Related Musculoskeletal Disorders and provides proof of successful completion of the course set out in paragraph 1(b)(iii) set out below

(iii) requiring that the Member successfully complete a comprehensive one-on-one course on occlusion, including but not limited to crown and bridge cases, to include: diagnosis, case selection, appropriate treatment options for altering vertical dimension of occlusion, conditions which may necessitate a referral to a specialist or other practitioner, responsibilities of the referring dentist (including continued communication with the involved practitioners, patient monitoring, re-evaluation and regular follow-up care during the course of a referral) and informed consent as

it pertains to the risks and benefits of the proposed treatment, in particular for inalterable consequences and possible adverse outcomes of the proposed treatment. This course shall be at the Member's expense, approved by the College, and he shall provide proof of successful completion in writing to the Registrar within twelve (12) months of this Order becoming final; and

(iv) the Member shall successfully complete a course in recordkeeping, including a component of financial recordkeeping. This course shall be at the Member's expense, approved by the College, and the Member must provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(v) the Member shall successfully complete a course in informed consent. This course shall be at the Member's expense, approved by the College, and the Member must provide proof of successful completion in writing to the Registrar within six (6) months of this Order becoming final;

(vi) the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College at such time or times as the College may determine with advance notice to the Member, during the period commencing with the date of the finalization of this Order and ending thirty-six (36) months from the College receiving proof of the Member's successful completion of the courses or until the Inquiries, Complaints and Reports Committee is satisfied that the Member has successfully completed the monitoring program, whichever date is later;

(vii) that the Member shall cooperate with the College during the inspection(s) and further, shall pay to the

College in respect of the costs of monitoring, the amount of $600.00 per monitoring, such amount to be paid immediately after completion of each of the inspections, provided that the overall cost of monitoring paid by the member shall not exceed $3,600.00, regardless of the number of inspections performed;

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

3. The member pay costs to the College in the amount of $2,500.00 in respect of this discipline hearing, such costs to be paid in full within six (6) months of this Order becoming final.

4. The Conditions imposed by virtue of subparagraph 1(b)(i) shall be removed from the Member's certificate of registration upon providing proof of successful completion of the course to the Registrar.

5. The College and the Member further submit that pursuant to the *Code*, as amended, the results of these proceedings must be recorded on the Register of the College and publication of the Decision of the panel would therefore occur with the name and address of the Member included.

6. This joint submission on penalty and costs was reached as a result of a pre-hearing conference held with respect to these matters before Dr. Cam Witmer, and received his endorsement.

In this case both the College and the Member are of the view that the principles of deterrence and rehabilitation can be met without a suspension, for reasons that will be set out in oral submissions.

7. Dr. Burton has not previously appeared before the Discipline Committee of the College.

REASONS FOR PENALTY DECISION

The Panel concluded that the proposed penalty was appropriate in all circumstances of this case. Upon review of the Joint Submission the Panel was concerned about one provision and sought clarification from the parties. The Joint Submission originally provided that the Member "shall not perform any TMD cases or alter any patient's vertical dimension of occlusion (including but not limited to the use of "build ups"), until such time as he provides proof of successful completion to the College of a course…". The next paragraph of the Joint Submission referenced a "one-on-one course on occlusion" with no further reference to TMJ treatment. The panel's concern was that a course on occlusion would not adequately address the very complicated treatment of TMJ. As such the panel felt that the member's ability to treat TMJ cases should not be tied to the successful completion of the course on occlusion. After hearing the panel's concerns, the parties agreed to amend the Joint Submission to address the concerns of the panel.

The Panel accepted the amended Joint Submission and ordered its terms implemented. The panel was satisfied that a reprimand and the terms, conditions and limitations placed upon Dr. Burton's Certificate of Registration, namely the educational and monitoring requirements, and the recording of the results of these proceedings on the College Register will act to deter the member from behaving in this matter again. It will also send a clear message to the profession that such behavior by its members will not be tolerated. The panel was satisfied that all goals of penalty orders have been met and the public will be adequately protected.

At the conclusion of the hearing, the Member waived his right to an appeal from the decision on liability and penalty.

COST SUBMISSIONS

The College sought $10,000.00 from the Member for a portion of its costs

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

Susan Davis
Chairperson

April 2, 2018
Date

Schedule A

Reprimand for Dr. Adam Burton   February 15, 2018

Dr. Burton, as you know, as part of the penalty, the Discipline panel has ordered you to be given an oral reprimand.

The fact you have received this reprimand will be part of the public portion of the Register and as such, part of your record with the College.

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found you have engaged in acts of professional misconduct in the following ways:

1. You extracted teeth without justification and/or the investigation of other treatment options and you failed to refer to an appropriate specialist given the complexity of the cases and treatment proposed for this patient.

2. You failed to obtain informed consent and keep proper records.

3. You demonstrated an overall disregard for the irreversible, life altering treatment you performed on a patient who came to your office for treatment and ended up with multiple extractions without justification.

The fact that you engaged in professional misconduct is a matter of concern. You have brought discredit to yourself. Your patient has suffered and continues to do so to this day and has lost trust in dentists in general. Public confidence and trust in dentists is paramount and unfortunately your behavior has led to an erosion of such public trust.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is **not** an opportunity for you to debate the merits or the correctness of the decisions we have made.

Thank you for attending today. We are adjourned.