Dental Assistants: A Jurisprudence Review

Health Professions Regulatory Advisory Council (HPRAC)

Ontario
Health Professions Regulatory Advisory Council
Conseil consultatif de réglementation des professions de la santé

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Prepared by:
Secretariat of Health Professions Regulatory Advisory Council

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Table of Contents

Objective:

This jurisprudence review explores legal cases relevant to the profession of dental assistant, to support a determination of the need for regulation of dental assistants under the *Regulated Health Professions Act, 1991* (*RHPA*). More specifically, this review aims to provide insight into the risk posed to the public by dental assistants.[1] Statutes and regulations are not included in this review, as they are discussed in detail in a jurisdictional review of the profession. This review was conducted between February 14, 2011 and April 1, 2011. Since certain cases are decided at more than one level of court, this review includes only the decision of the highest level court at which the relevant substantive issues were decided.

Search Methodology:

HPRAC conducted searched three legal databases (Quicklaw, CanLII and WestLaw) using a variety of search terms (see below). As noted above, searches focused primarily on Canadian case law, with some attention given to decisions from the United Kingdom (see Appendix A for a description of each database).

Quick Law

The Administrative Boards and Tribunals database was searched on February 14, 2011 using the terms "dental /5 assistant" and "misconduct". Of the resulting 20 cases, one was found to be relevant. The Canadian cases database was also searched. It contains 427 repositories of cases, two of which (H*ealth Law Digest* and *Professions*) were found to be relevant. This search also used "dental /5 assistant". Under the *Health Law Digest*, 7 relevant cases were located.

On February 17, 2011 the administrative law and judicial review database were searched. It employed "dental assistant" and "risk", which were found to be commonly used in the administrative database (all boards and tribunals).

WestLaw Canada

This database was searched on March 11, 2011 and March 31, 2011. The search query "dental assistant" /5 "risk" did not result in any hits. However, the phrase "dental assistant" produced 494 documents on March 11 and 497 documents on March 31. Much of this material was irrelevant e.g. family law disputes involving dental assistants. We were able to narrow down the search on March 31, 2011 by using the following query: "dental assistant" AND risk. This search produced 144 hits.

Other searches that were not fruitful were: i) "dental assistant" within five words of patient safety and ii) "dental assistant" in the same sentence as risk.

[1] Cases discussing the risks posed to dental assistant by their workplace (e.g. latex allergy) were excluded from these reviews, as they were not found to be relevant to the issue of risk to the public posed by the profession.

Canadian Legal Information Institute (CanLii)

CanLii may be accessed on the Internet. Its coverage, which includes HPARB as well as Canadian courts, is described on the following web page: http://www.canlii.org/en/databases.html.

We searched this database on March 30, 2011. The search terms used were "dental assistant" AND risk. This search produced 119 results.

College Council decisions have not been included in this review.

Summary of Findings:

Searches in the above mentioned databases yielded 9 relevant cases. Topics relevant to risk of harm and regulation include:

- unauthorized practice by the dental assistant due to improper delegation by the employing dentist (see *Kanigan v. College of Dental Surgeons of British Columbia*);
- improper record keeping and ordering of charts (see *Health Sciences Centre*);
- unnecessary irradiation (see *Health Sciences Centre*);
- failure to place gauze between oral and nasal cavities of a paediatric patient (see *Health Sciences Centre*);
- use of latex gloves on clients with a known latex allergy (see *Health Sciences Centre*);
- risks associated with the use of a trainee dental assistant vs. a certified dental assistant (see *Handley v. Punnett*);
- failure to preload an application syringe with the proper condense (see *Handley v. Punnett*);
- failure in duty to explain risks of increased sensitivity due a filling (see *P.P., DDS v. K.R.*);

None of the listed decisions relate to harm caused directly by a dental assistant, but rather errors of a procedural and competency nature that could potentially lead to harm. Improper delegation is alleged in several decisions, speaking to the need for dental assistants to know their professional limits, and for dentists to comply with laws addressing delegation. *Failure to place gauze between oral and nasal cavities when treating infants and babies* was found by an arbitrator in *Health Sciences Centre* to be a potentially fatal error. When a risk is identified, the courts point to the dentist as ultimately responsible for harm cause to clients/patients.

Title	Merelie v. General Dental Council & Others (High Court of Justice Queen's Bench Division)
Citation	2009 EWHC 1165 (QB).
Noted up	Followed – 1; Explained – 1; Mentioned – 5; Dissention – 1 not done
Database	Quicklaw
Search terms	Dental nurse
Accessed	February 17, 2011
Relevance	Regulation of dental nurses in the U.K.
Summary	The claimant was a dentist who made a complaint to a Primary Care Trust ("Trust") that employed both the dentist and the dental nurses. The dental nurses had previously complained to the Trust about the dentist. The dentist also began civil proceedings against the Trust and various other defendants. After the civil proceedings were dismissed, the dentist made a complaint to the General Dental Council (GDC). Subsequently, she instituted civil proceedings against the GDC in which she alleged that the GDC had breached its statutory duty to her by failing to refer her complaint to an investigating committee. She also alleged that the GDC was negligent (this was a tort claim) and that the GDC should be found liable for the tort of malfeasance in public office. In addition to making a complaint to the GDC with respect to the dental assistant, the dentist also contacted the Council for HealthCare Regulatory Excellence. The Council is constituted under the National Health Service Reform and Healthcare Professions Act 2002 as a "superregulator". According to section 25 of the Act, it promotes the best interest of patients as well as of the public. It also formulates general principles and promotes cooperation between regulatory bodies such as the General Dental Council. The powers and duties of the Council are set out in s. 26 of the National Health Service Reform and Healthcare Professions Act 2002. Breach of statutory duty: The Court found that there was no such breach. Section 36N(5) of the Dentists Act 1984 provides that where an allegation is made to the Council against a registered dental care professional that her fitness to practice is impaired, the Registrar is to refer the allegation to the Investigating Committee. The Council is performing quasi-judicial functions. In certain circumstances, an allegation will not be referred immediately because there are other matters that require investigation. Tort claims: dismissed because the Court found that the GDC did not owe a duty of care to the dentist; nor could it be established that the GDC had acted in bad faith. The Court concluded with respect to the dentist's arguments that "her case is hopeless".

Title	Kanigan v. College of Dental Surgeons of British Columbia (British Columbia Supreme Court 1989)
Citation	[1999] B.C.J. No. 1200
Noted up	Yes
Source	QuickLaw
Search terms	"dental assistant" – (searched in Health Law Digest and Professions databases of QuickLaw)
Link	not available
Accessed	February 14, 2011
Relevance	British Columbia legislation did not permit certified dental assistants to perform scaling procedures. Two dental assistants were found to have engaged in the unauthorized scaling of teeth.
Summary	Kanigan and Rybalka worked in a dentist's office. After an investigation, they were charged with unauthorized practice. More specifically, they were charged with having performed the procedure of scaling teeth, an Act which only dentists are authorized to perform according to the Dentists Act, R.S.B.C. 1979 c. 92, the legislation in force at the time (the Act was amended in 1996). An Inquiry Committee of the College of Dental Surgeons of British Columbia found that both had performed the procedure of scaling teeth, a procedure that they were not authorized to perform. They appealed to the BC Supreme Court. The Court concluded that the Dentists Act did allow the dentist to delegate certain procedures, although scaling was not one of them. (Rules of the Dental Council did allow dentists to delegate scaling to dental hygienists). According to paragraph 42 of the decision, "Rules 10:17 and 10:19 set out what dental assistants are authorized to do. Although these Rules are directed to what dentists may delegate, they also perform the function of setting out, with some precision, the tasks which a certified dental assistant may or may not perform. Were it not for the existence of these Rules, the certified dental assistant would not be permitted to perform any dental tasks. It is this Rule which informs the certified dental assistants about which tasks may be properly delegate to them". Kanigan and Rybalka appealed the findings of the Inquiry Committee. The Court dismissed the appeals.

Title	Health Sciences Centre (Re) Manitoba Grievance Arbitration
Citation	[2000] M.G.A.D. No. 16
Noted up	Yes
Source	Quicklaw
Search terms	"Dental assistant" and "misconduct"
Accessed	February 14, 2011
Relevance	Although this case involved a labour dispute, it is highly relevant because of the discussion concerning the risks posed to the public by the dental assistant (please see paragraph 184).
Summary	The Health Sciences Centre (HSC) in Winnipeg fired a dental assistant (Werner) who worked in the Paediatric Dental Centre (PDC). This case is the decision of a labour arbitrator; a grievance was filed on behalf of the dental assistant by the Canadian Union of Public Employees. The PDC dealt with patients between the ages of a few months to age seventeen. Werner was a Level II dental assistant. The team which worked in the PDC at the time consisted of a paediatric dentist, who was the Director; several Phase II dental assistants; and a dental intern who was a recent graduate from a Faculty of Dentistry. The PDC consisted of both an outpatient treatment area as well as an operating room where procedures requiring general anaesthetic were performed. There were various deficiencies in Werner's employment performance which were cited by HSC: It was alleged that she made errors in ordering charts. The Arbitrator found that her error rate was no greater than that of her co-workers. It was suggested that Werner lacked knowledge of her job e.g. she passed etchant before passing the linter to the dentist. The arbitrator concluded that her knowledge of the dental materials being used at the PDC was deficient. Werner's dental assisting skills in the O.R. were deficient. More specifically, she stood too far away from patients when suctioning; she dropped a curing light, the cords and hoses for the hand pieces on the equipment on the dental cart became tangled when handed to the dentist during an operation. Patient Safety: It was alleged that Werner had caused a young boy to be unnecessarily irradiated three times. The arbitrator said no evidence had been introduced as to the amount of extra radiation the boy was exposed to; nor were the risks associated with the extra exposure explained. Therefore, he was unable to asses the seriousness of Werner's effort. In addition, it was alleged that Werner has not placed gauze between a patient's oral and nasal cavity during a procedure. The arbitrator found that this error could have had fatal consequences for a patient. It was also alleged that Werner wore latex gloves during a procedure despite having been warned by the dentist that the patient had a latex allergy. The final patient safety incident involved the use of a "throat pack" during

	an operation. (A moist gauze called a “throat pack” is placed in the back of a patient’s throat to catch debris and blood clots; the patient is under general anaesthetic at the time). According to the dentist, the anaesthetist has the responsibility for removing the throat pack as well as the nurse to confirm that the throat pack has been removed. The dental assistant has no role to play in the process. However, in this case, Werner had announced that the throat pack had been removed as the dentist was leaving the O.R., contrary to standard operating procedure. The arbitrator concluded that it was troubling that Werner did not acknowledge responsibility for this incident (i.e. the throat pack incident) and that her conduct had endangered the patient. The arbitrator also found that some of the deficiencies in Werner’s performance were serious because they indicated that she may not have had the ability to function at optimal efficiency in the O.R. and, to a lesser extent in the outpatient clinic. However, the arbitrator also concluded that while the HSC had defined the level of job performance required of Werner, it did not properly communicate to Werner the standards that she was required to meet during a period in which her employment was being reviewed. HSC should have provided more direct supervision and instruction. Further, the employer should have provided warnings to Werner that a failure to meet the applicable performance standard could result in her being removed from the position of dental assistant at the PDC. Werner’s grievance was allowed. However, because the relationship between Werner and her colleagues at the PDC had been damaged as well as the high-risk nature of the patient population served, it would not be appropriate for her to be reinstated. HSC was ordered to pay Werner damages representing the monetary value of the loss of her employment.

Title	Handley v. Punnett British Columbia Supreme Court
Citation	2003 BCSC 369
Noted up	I noted up this case; however, the only references were to documents in the court file.
Source	Westlaw
Search terms	"dental assistant"
Accessed	March 11, 2011
Relevance	The case involves a lawsuit brought by a patient against a dentist following a root canal procedure. One of the components of the lawsuit involves the role played by the dental assistant in the circumstances that gave rise to the lawsuit.
Summary	A dentist was sued by a patient who alleged that he had negligently performed a root canal procedure. More specifically, the patient claimed that she suffered sever pain during the root canal procedure after the dentist injected a substance into her mouth. Either a trainee dental assistant or a regular (non-trainee) assistant had preloaded the application syringe which was injected into the patient's mouth in this circumstance. After the freezing wore off, the pain became intense. After spending several days in bed, the patient went to a walk-in clinic for relief. She ended up seeking help from an emergency room because she was unable to eat due to the intense pain in her mouth. The dentist argued that the incident had been caused by a viral infection. The Court found the following: (see page 10) The use of a trainee dental assistant in no way affected the services provided by the dentist. The dentist was responsible for anything which was done or not done by the dental assistant in the office that day. The regular assistant was sufficiently experienced not to have mistaken a preloaded application syringe containing some other substance for a preloaded application syringe containing Astringedent, the substance that was injected in this instance. There was no substance in the dentist's office which would be of a colour to have allowed another substance to have been incorrectly injected into the patient's mouth in this case. The substance that was applied to the three canals of the tooth in question was astringent; however, astringedent could not have caused the ulcerations experienced by the patient. The patient almost immediately felt a pain after the astringedent was applied to her tooth; further, this pain was caused by a failure to administer sufficient anaesthesia. Neither the dentist nor the assistant responded to the patient's questions with respect to what substance had been administered in this case. However, the dentist did offer further anaesthesia as well as Advil when the patient complained of pain immediately following the procedure.

	The patient was in great pain for at least ten days after the procedure; two large ulcerations appeared in her mouth. The ulcerations appeared to have been caused by a “chemical burn”. The patient suffered sever pain for two weeks and less severe, but some additional pain for an additional two weeks. She lost the ability to taste and has experienced a partial loss of her ability to small. The dentist was not negligent in his delivery of dental services to the patient. The ulcerations were not caused by the injection of the substance into the patient’s mouth. While the pain she experienced was caused by a root canal procedure, it might have been caused by a viral infection. The possibility of viral infection was not under the control of the dentist. The claim was dismissed.

Title	P.P., DDS v. K.R.
Citation	Health Profession Appeal and Review Board File #09-CRV-0006[2]
Noted Up	Not done
Search Terms	"dental assistant" AND risk
Source	Canadian Legal Information Institute
Link	http://www.canlii.org/en/on/onhparb/doc/2010/2010canlii66619/2010canlii66619.pdf
Relevance	Ontario case concerning a complaint made against a dentist with respect to the treatment provided by the dentist but also arising from the conduct of the dental assistant.
Summary	A dentist appealed a decision of the RCDSO Complaints Committee to HPARB. The Committee had issued a written caution to the dentist. In its decision, expressing concern regarding the lack of documentation of discussions that the dentist and staff (including a dental assistant) had held with the patient with respect to diagnosis, treatment options, and other issues. The Committee also cautioned the dentist to advise the patient about the possibility of further endodontic treatment as well as post-operative sensitivity. The dentist was ordered to record this information in the patient's chart. See Paragraph 23 for a discussion of the role of dental assistant in explaining the risk of increased sensitivity due to the white filling used in this case. Also please see paragraph 24 of the decision (p. 7) in which HPARB notes that it had requested clarification from the College representative with respect to the status of dental assistants and was told that they are not regulated health professionals. HPARB notes that some are certified after they have received appropriate training. Further, the College does recognize and allow its members to rely on their assistants to provide options and explain risks to patients. In assessing a complaint, the Committee looks to the entries in the record to see if it reflects whether such discussions have taken place. It does not matter whether the member of the College or the assistant have had the discussion with the patient. Para 25: depending on the nature of the procedures, a dental assistant may be well trained enough to provide the options and associated risks with the treatment. The key is not by whom such options have been outlined to the patient but rather whether there is appropriate documentation regarding the diagnosis, reasons for the appointment, risks and anything related to the treatment. Paragraph 28: the Board finds the Committee's decision to caution the dentist reasonable. The fact that the complainant referred to certain discussions that were held with the assistant "does not take away the Applicant (i.e. the dentist's) own responsibility to record those conversations". HPARB confirmed the decision of the RCDSO Complaints Committee.

[2] Please note that HPARB decisions have been accessible online since relatively recently.

Title	Mansfield v. Vollmer Ontario Court of Justice (General Division) Small Claims Court
Citation	[1995] O.J. No. 4540
Noted up	Not done
Source	QuickLaw
Link	Not available
Accessed	February 2011.
Relevance	This case mentions that preventative dental assistants were regulated under a Health Disciplines Act regulation. The HDA was the legislation governing health professions in Ontario prior to the RHPA. The fact situation in this case occurred in 1994; it is not clear why the Judge assumed that the HDA was the governing legislation since it appears that the RHPA would have been in force at that time.
Summary	Employment dispute. Mansfield was a preventative dental assistant. Paragraph 19: she believed that she had been dismissed because she had expressed the opinion that dental assistants (as opposed to preventative dental assistants) should not be required to take dental impressions. According to the Court, the regulation under the HDA prohibited dental assistants from engaging in this activity, although it did allow preventative dental assistants to take impressions. The dental assistant had testified that during her employment dental assistants were required to take impressions. The Court reached no conclusion on this issue since none was required for the disposition of this case. The court allowed the wrongful dismissal claim made by the dental assistant

Title	Roberts v. College of Dental Surgeons (British Columbia) British Columbia Supreme Court
Citation	[1997] B.C.J. 1126
Noted up	This case was reversed by the BC Court of Appeal [1999] B.C.J. No. 357. Both cases have been included in the file.
Source	QuickLaw/WestLaw
Link	Not available
Accessed	February 2011 Citation record accessed March 31, 2011.
Relevance	The dentist was charged by the BC College of Dental Surgeons with misdelegation; more specifically, it was alleged that the dentist has improperly delegated tasks to two dental assistants.
Summary	Paragraph 5: The dentist was charged with having misdelegated tasks to two dental assistants (there were other alleged offences). There were seven types of tasks alleged to have been improperly delegated to one of the assistants and five types of tasks alleged to have been improperly delegated to the other. Paragraph 15: dentist pled guilty to the charge of misdelegation as it related to one of the two dental assistants. The charge was withdrawn as it related to the other. Paragraph 19: A penal of the College of Dental Surgeons determined that misdelegation warranted a fine of $6500 as well as a six month suspension from practice. There were other penalties ordered corresponding to additional findings of misconduct. The dentist appealed from the penalty to the BC Supreme Court. The Court concluded that it had not been shown that the Panel had made an error with respect to the penalty imposed.

Title	Findlay v. College of Dental Surgeons of British Columbia British Columbia Supreme Court
Citation	1997 CarswellBC 1982.
Noted up	Yes; see the file for a copy of the citation record. An interlocutory decision in this matter is reported at 1996CarswellBC 2440.
Source	WestLaw
Link	Not available
Accessed	March 31, 2011
Relevance	Illustrates the existence of rules with respect to delegation by dentists to certified dental assistants in BC
Summary	The BC College of Dental Surgeons began an investigation into an allegation that a dentist had improperly delegated duties to certified dental assistants employed by him. There were other allegations also. The Registrar informed the dentist that a review penal would be formed. The dentist brought a petition for an order against the College that would prevent them from continuing the investigation. The Court concluded that the College had appropriately investigated the allegations. Although an error had occurred, it had taken steps to remedy the mistake. The College had not lost jurisdiction over the complaints as a consequence of the error. The dentist's petition was dismissed.

Title	Jackman v. Newfoundland (Dental Board)/Musseau v. Newfoundland Dental Board Newfoundland Supreme Court, Trial Division
Citation	76 Nfld & P.E.I.R. 72 (Related proceedings are reported at 82 Nfld. & P.E.I.R. 91).
Noted Up	Yes – followed (twice); considered (once) and referred to (three times)
Source	Quicklaw
Search terms	Dental assistant, risk
Accessed	March 11, 2011
Relevance	In Newfoundland and Labrador, the Dental Board heard complaints of professional misconduct with respect to dentists on the basis that they had employed unqualified persons to perform dental procedures.
Summary	Five registered dentists made formal complaints to the Newfoundland Dental Board alleging that two dentists were guilty of professional misconduct on the basis that they had employed unqualified or unlicensed personnel to perform dental procedures. More specifically, it was alleged that locally trained dental assistants had performed a variety of intra-oral procedures including placing a filling in a tooth, taking x-rays, fluorides, impressions, and restorative procedures including the placement in patients' mouths of rubber dams, cavity liners, matrix bands, bases, liners, and amalgam. Provisions with respect to professional misconduct in Newfoundland law at the time provided that permitting, counselling, or assisting any person who is not licensed under the Dental Act 1983 to engage in the practice of dentistry except as provided in the Act and regulations constituted professional misconduct. After investigating the complaints, the Board advised the two dentists that it had decided to conduct a hearing into the matter. The dentists made applications to the Newfoundland Supreme Court, Trial Division, asking that the decision of the Dental Board to conduct a hearing into the complaint be quashed. The dentists also sought an order that the Board be prohibited from conducting further proceedings with respect to the complaints. The Court denied the dentists' applications. The effect of this decision is that the Board was permitted to continue with its decision to conduct a hearing into the matter. Section 27 of the Dental Act, S.N. 1983, c. 26, gives the Board the power to discipline dentists. The lawyer for the dentists argued that they had been denied the right to procedural fairness during the initial investigative stage of the proceedings under s. 27 of the Act. The Court determined that since the decision to hold an inquiry does not affect the right to practice, there is no duty of fairness at the initial investigative stage of the proceedings.

Appendix A: Description of Databases

CanLII[3]

CanLII (Canadian Legal Information Institute) is a free online legal website providing access to primary sources of Canadian law. The site contains statutes and regulations published by official printers from the federal and provincial jurisdictions. Legislative updates are carried out on a weekly basis.[4] Sources include decisions of the Supreme Court of Canada from 1948 to date, some decisions prior to 1948 and all Ontario judgments since 1876. Practice rules are also provided.[5]

LexisNexis Quicklaw[6]

LexisNexis Quicklaw offers access to a collection of databases including case law from all Canadian jurisdictions, administrative tribunal decisions, legislation and legal commentary in the form of texts, journals, newsletters and indexes. In addition to Canadian materials, LexisNexis Quicklaw includes American case law and legislation and selected U.K. and Commonwealth judgments. Decisions are in the form of digests or full text. They may be either electronic versions of printed reports (e.g., Ontario Reports) or unreported current judgments[7] as received directly from the courts. [8]

Westlaw Canada

Westlaw Canada provides online access to the Canadian Encyclopedic Digest, Carswell Law Reports, unreported court decisions, the Canadian Abridgement and secondary legal sources such as journal articles and commentary. U.S. case law and legislation from the state and federal levels may also be accessed through Westlaw.[9]

[3] http://rc.lsuc.on.ca/library/research_law_ca_cases.htm#canada
[4] http://rc.lsuc.on.ca/library/research_law_ca_legis.htm
[5] http://rc.lsuc.on.ca/library/research_law_ca_cases.htm#canada
[6] http://rc.lsuc.on.ca/library/research_databases.htm
[7] Unreported full text judgements from Canadian courts can be accessed through the "All Canadian Court Cases" group source. (QuickLaw Source Information)
[8] http://rc.lsuc.on.ca/library/research_databases.htm
[9] http://rc.lsuc.on.ca/library/research_databases.htm

Health Professions Regulatory Advisory Council
55 St. Clair Avenue West
Suite 806 Box 18
Toronto, Ontario, Canada M4V 2Y7

Telephone: 416-326-1550
Toll-Free: 1-888-377-7746
Fax: 416-326-1549

Website: **www.hprac.org**

Email: **hpracwebmaster@ontario.ca**