RESEARCH PAPER

Dentist Disciplinary Action: What Do Dentists Get in Trouble for?

Mesures disciplinaires imposées aux dentistes : pour quelles raisons les dentistes ont-ils des ennuis?

AI-LENG FOONG-REICHERT, BSc, PharmD
PhD Candidate
School of Pharmacy
University of Waterloo
Kitchener, ON

SHERILYN K.D. HOULE, BSP, PhD
Assistant Professor
School of Pharmacy
University of Waterloo
Kitchener, ON

ZUBIN AUSTIN, BScPhm, MBA, MISc, PhD, FCAHS
Professor
Leslie Dan Faculty of Pharmacy
University of Toronto
Toronto, ON

DAVID J. EDWARDS, BScPhm, PharmD, MPH
Professor
School of Pharmacy
University of Waterloo
Kitchener, ON

KELLY A. GRINDROD, BScPharm, PharmD, MSc
Associate Professor
School of Pharmacy
University of Waterloo
Kitchener, ON
Professor in Pharmacy Innovation
Ontario College of Pharmacists
Toronto, ON

Abstract

Objective: This study aims to determine the reasons for disciplinary action, the consequences and any associations with demographic factors for Canadian dentists.
Methods: Publicly available regulatory body disciplinary action cases from 10 Canadian provinces were coded. Demographic factors were also coded.
Results: There were 344 dentist cases from five provinces between January 2010 and December 2020. The rate of disciplinary action was low (1.38 cases/1,000 practitioners/year). Clinical incompetence was the most common category of disciplinary action, followed by professional misconduct and dishonest business practices. Male dentists were overrepresented in the disciplinary action cases compared to the rest of the workforce.
Conclusion: This study is the first, to our knowledge, to describe the outcomes of regulatory body disciplinary action for Canadian dentists.

Résumé

Objectif : Cette étude vise à déterminer les raisons pour lesquelles sont prises des mesures disciplinaires envers les dentistes canadiens et les conséquences qui en résultent ainsi que toute association avec des facteurs démographiques.
Méthodes : Les cas, publiquement accessibles, de sanctions disciplinaires d'organismes de réglementation de 10 provinces canadiennes ont été codés. Les facteurs démographiques ont également été codés.
Résultats : Il y a eu 344 cas de sanctions disciplinaires envers des dentistes provenant de cinq provinces entre janvier 2010 et décembre 2020. Le taux de mesures disciplinaires est faible (1,38 cas/1 000 dentistes/an). L'incompétence clinique constitue la catégorie la plus courante liée aux mesures disciplinaires, suivie des fautes professionnelles et des pratiques commerciales malhonnêtes. Les hommes dentistes sont surreprésentés dans les cas de mesures disciplinaires par rapport au reste de la main-d'oeuvre.
Conclusion : Cette étude est la première, à notre connaissance, à décrire les résultats des mesures disciplinaires prises par les organismes de réglementation à l'encontre des dentistes canadiens.

Introduction

In Canada, health professional regulatory bodies handle disciplinary action processes when practitioners are clinically incompetent or act unprofessionally. In recent years, the Canadian media has put pressure on physicians and physician regulators to increase transparency at work. In 2016, the Canadian Broadcasting Corporation (CBC) published a series on physician disciplinary action, highlighting the lack of transparency in disciplinary action reporting, which often leads to physicians being given a "second chance" to practise after committing serious patient violations (Kubinec 2016). In 2018, the *Toronto Star* criticized regulators for allowing physicians who were disciplined in the US for serious clinical incompetence or sexual abuse to practise in Canada without a public record of past disciplinary

concerns (Zlomislic et al. 2018). Characterizing the current disciplinary action processes is an important step toward transparency, but it also offers the opportunity to guide improvements to policy and disciplinary processes.

Research focusing on dentist disciplinary action is scant. A scoping review of health professional disciplinary action identified only seven papers that focused specifically on dentist disciplinary action; none of which was from Canada (Foong-Reichert et al. 2021a). Some of these publications focused on a single type of complaint (e.g., complaints about local anaesthetic use [Scofield et al. 2005], social media use [Neville 2017] or inappropriate delegation of controlled acts to dental assistants [Feine 1991]) but did not capture overall reasons for disciplinary action. Other papers were published over two decades ago and did not reflect recent changes to disciplinary processes (Damiano et al. 1993; Feine 1991).

Research from Australia has found that compared with other professions, dentists are at the highest risk of a complaint (Spittal et al. 2016; Thomas et al. 2018), with another study finding that both dentists and physicians had the highest rates of complaints (Walton et al. 2020). Australian researchers agreed that the most common reasons for complaints against dentists are issues related to clinical incompetence, such as clinical performance and treatment (Thomas et al. 2018; Walton et al. 2020), but a US review of 21 state dental boards found that most cases involved emotional intelligence concerns, defined as violations of moral turpitude, followed by clinical incompetence concerns (Munk 2016). In Canada, reviews of pharmacist and physician disciplinary activity have been conducted (Alam et al. 2011; Foong et al. 2018), but a similar review has not been conducted for dentists. In order to broaden our understanding of the disciplinary practices of health professional regulators in Canada, this study analyzed disciplinary action cases in order to determine the reasons for disciplinary action, the resultant consequences and any differences based on demographic factors for dentists in Canada.

Methods

Inclusion and exclusion criteria

In Canada, health professions are regulated at the provincial level (Government of Canada 2019). In this study, regulatory body disciplinary action cases for dentists from 10 Canadian provinces were included. The three Canadian territories were excluded as they do not have profession-specific regulatory bodies but are often regulated by a branch of the government such as the Department of Health (National Association of Pharmacy Regulatory Authorities n.d.).

Publicly available disciplinary action cases were obtained from regulatory body websites or online from the Canadian Legal Information Institute. Ethics approval was not required as the cases were publicly available. Cases were included if they described both a violation and a penalty and if they were heard from January 2010 to December 2020. Cases were excluded if they involved students, if the initial hearing was before 2010 but subsequent

hearings or penalty decisions were after 2010 or if the hearing involved an appeal, a request for reinstatement or a motion to remove conditions on a licence. In cases where the healthcare professional was regulated and disciplined for the same violation in more than one province, the case was counted only in the province that conducted the full investigation. Instances where a disciplinary hearing involved the same violations and penalties for more than one healthcare professional were counted as separate cases in order to capture the total number of professionals who were disciplined.

Case coding

Codes from our previous research on pharmacist disciplinary action (Foong et al. 2018) were revised to ensure applicability to dentists. Using this preliminary set of codes, AFR coded a selection of cases in an inductive approach, adding and refining codes as needed. AFR and research assistant Ariane Fung independently coded 50 cases to further refine codes. The finalized codes were used by AFR and research assistant Karolina Suszek to independently code the data in a deductive approach using Microsoft Excel. Differences in coding were resolved through discussion.

For each case, violations, demographic factors of the professionals and penalties were recorded. Violations were coded according to three categories, adapted from the categories used in our previous review of pharmacist disciplinary action (Foong et al. 2018): (1) professional misconduct, (2) clinical incompetence and (3) dishonest business practices. Professional misconduct was defined as a violation of the professional standards of practice or legislations governing practice, excluding clinical incompetence, such as improper use of health information, sexual abuse, failure to obtain informed consent or intentionally stealing narcotics/drug trafficking. Clinical incompetence involved any violations involving clinical skills and incompetent practice. Dishonest business practices involved violations with financial gain as a motive, such as fraudulent billing.

Demographic factors (age, gender, practice setting, practice specialty, number of years in practice, country of education and previous disciplinary action) were also extracted from the case and/or from each regulatory body's online register of professionals. Analysis of some demographic factors was limited due to the lack of publicly available information. For this reason, age, practice setting and country of entry-to-practice education were not examined further.

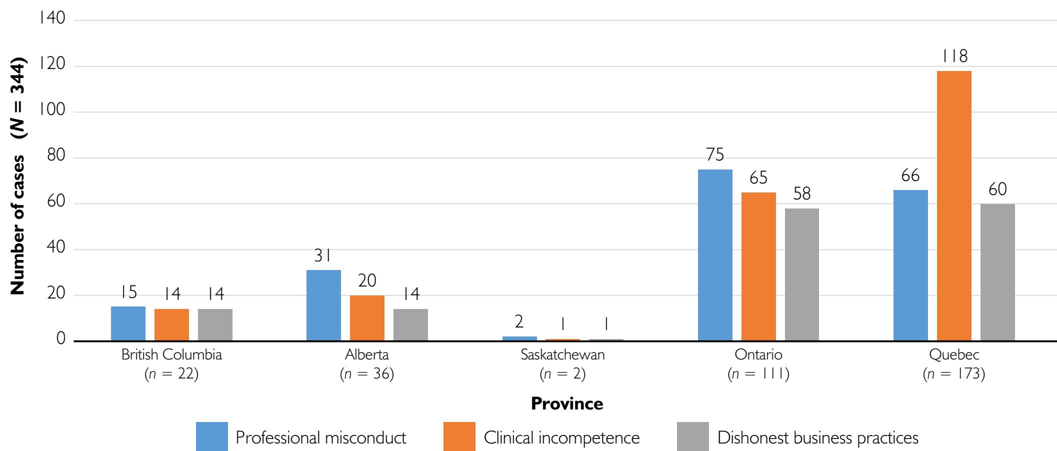
The rate of disciplinary action was calculated using the average total number of practising clinicians from 2010 to 2020 from the Canadian Institute for Health Information (CIHI 2021, 2022). The number of practising clinicians was calculated using the provinces that were included in the sample.

Results

Overall, 344 dentist cases from five Canadian provinces were included in this study: British Columbia, Alberta, Saskatchewan, Ontario and Quebec. Distribution by province is

illustrated in Figure 1. Despite multiple e-mails to each regulatory body, we were unable to obtain disciplinary cases from the remaining five dental regulators. In addition, information available on regulatory bodies' online registers of professionals was not consistent, which limited the information that could be collected on demographic factors.

FIGURE 1. Disciplinary action cases against dentists according to province



Rate of disciplinary action

Overall, the rate of disciplinary action for dentists was low: 1.38 cases/1,000 practitioners/year. This rate varied by province, with an eightfold variation between Saskatchewan with the lowest rate and Quebec with the highest rate. The rate of disciplinary action for each province is listed in Table 1.

TABLE 1. Rate of disciplinary action against dentists by province, reported as number of cases per 1,000 practitioners per year

Province	Rate
British Columbia	0.55
Alberta	1.22
Saskatchewan	0.35
Manitoba	–
Ontario	0.96
Quebec	2.94
New Brunswick	–
Nova Scotia	–
Newfoundland and Labrador	–
Prince Edward Island	–
Overall	**1.38**

Source of complaint

Information on the source of the complaint was not included in the disciplinary case report in 51% of the cases (174/344). For cases where a source was indicated, the most common sources were the patient or the patient's family/agent (109/344 cases, 32%), the regulatory body (32/344 cases, 9%) and third-party insurance companies (11/344 cases, 3%).

Reasons for disciplinary action

Reasons for disciplinary action were divided into three categories: professional misconduct, clinical incompetence and dishonest business practices. Many cases involved multiple violations and two or more categories of disciplinary action, meaning that the overall percentages sum up to more than 100%. As seen in Table 2 (available online at www.longwoods.com/content/27033), clinical incompetence was the most common category overall (64%), followed by professional misconduct (55%) and dishonest business practices (43%). However, just over 50% (173/344) of the cases in this study were from Quebec, where 68% of the cases involved clinical incompetence. When the cases from British Columbia, Alberta, Saskatchewan and Ontario are analyzed separately from the cases from Quebec, professional misconduct becomes the most frequent category of disciplinary action, with 71% of the cases involving professional misconduct, 59% involving clinical incompetence and 51% involving dishonest business practices. Twenty-five cases involved a one-time incident that resulted in disciplinary action, and 15 of these cases involved clinical violations.

Penalties

Types of penalties were similar across provinces and included reprimand, publication of the case details, fines, payment of the costs of the investigation, conditions placed on the licence to practice, professional development, ongoing fitness to practice assessments or counselling, temporary licence suspension and permanent revocation of a licence. The frequency of use of certain penalties varied across provinces. Penalties are outlined in Table 3, available online at www.longwoods.com/content/27033.

Characteristics of those disciplined

GENDER

Information on gender was available in 99% (342/344) of the cases. Male dentists were disciplined in 79% (272/344) of the cases. Female dentists were disciplined in 20% (70/344) of the cases, and gender was unknown in two cases. In comparison, male dentists comprise 52% of the general dentist population in these five provinces combined (CIHI 2022).

PRACTICE SPECIALTY/PRACTICE SETTING

Practice specialty for dentists was known in only 194 of 344 (56%) cases. The most common specialty was general dentistry (163), followed by orthodontics/dentofacial orthopaedics (10),

oral and maxillofacial surgery (10), paediatrics (5), periodontics (2), prosthodontics (2) and endodontics (1), and one case with both prosthodontic and periodontic specialties.

YEARS IN PRACTICE

We used both "years licensed" and "years since graduation" to estimate the professional's years of experience, where "years licensed" is the number of years the professional has been licensed with that particular regulatory body but does not capture previous periods of licensure in other jurisdictions. Information on years licensed was available for 97 of 171 (57%) dentists, with a median of 24 years (range: 2–52).

Information on years since graduation was available for 100% of the cases involving Ontario dentists and 64% (14/22) of the cases involving British Columbia dentists. The mean and median years since graduation was 25 years for Ontario dentists. For British Columbia dentists, the mean years since graduation was 24 years and the median was 25.5 years.

Previous disciplinary action

Among dentists, 32 (9%) cases involved previous disciplinary action. Of the cases where a defendant had been disciplined previously, all repeat offenders were required to pay the costs of the investigation, 23 (72%) had their licence suspended for a median length of six months, 5 (16%) had their licence revoked, 5 (16%) were required to pay a fine, 21 (66%) were required to complete professional development training and 22 (69%) had their offence(s) published on the regulatory college's website or newsletter. Men were involved in 91% of the cases where there was a repeat offence, while women were involved in 9% of the cases with a repeat offence.

Most cases where there was a repeat offence involved multiple violations. The most common reasons for repeated disciplinary action were inadequate documentation (11), fraudulent billing (11), breaching a condition on the licence (8), substandard technique or conditions (9), inadequate/inappropriate treatment (8) and failing to cooperate with college investigations/communications (7).

Discussion

This review of regulatory body disciplinary action cases found that disciplinary action impacts only a small number of dentists in five Canadian provinces. Clinical incompetence was the most common category of discipline for dentists overall, but professional misconduct was the most common category for dentists from British Columbia, Alberta, Saskatchewan and Ontario. This study is the first to describe the outcomes of regulatory body disciplinary action for Canadian dentists.

In contrast to our findings, Walton et al. (2020) and Thomas et al. (2018) found that most dentist cases involved performance or clinical incompetence concerns. However, this difference in findings could be due to these researchers analyzing complaint cases, while we looked only at the higher level disciplinary cases. Previous research on Canadian physicians

found that sexual misconduct was the most common reason for disciplinary action (Alam et al. 2011). However, this was not a common reason for disciplinary action against dentists. In previous work on pharmacists, professional misconduct was the most common category overall, similar to that reported for dentists, but fraudulent billing was found to be the most common reason for disciplinary action, which was not found to be a common reason for dental disciplinary action (Foong et al. 2018).

Our research agrees with research from other professions, which report that the dentists disciplinary rate is low overall (Foong-Reichert et al. 2021a). This is an expected finding since disciplinary action is typically reserved for serious cases or repeated violations. Our research also agrees with previous work stating that there is a variation in disciplinary cases and rates across provinces (Damiano et al. 1993; Harris and Byhoff 2017; Munk 2016). However, this variation in disciplinary rates and outcomes across Canada despite the same goal of public protection begs this question: Why are there differences? Researchers hypothesize that differences in medical board composition in different jurisdictions and differences in thresholds for disciplinary action could result in different decisions being made at each step of the disciplinary process (Harris and Byhoff 2017). As regulators increasingly include public members on disciplinary panels, it is possible that different disciplinary decisions could be made in the future. Differences in time and resources might also influence which cases are pursued through the disciplinary process and which cases might be resolved at a lower level or dismissed (Damiano et al. 1993; Harris and Byhoff 2017). Researchers also suggest that differences in education could lead to differences in clinical competence (Damiano et al. 1993) or emotional intelligence (Munk 2016); such differences could produce variations in reasons for disciplinary action between states or provinces, assuming that most graduates remained in the jurisdiction in which they were educated.

Since legislation governing health professionals outlines the disciplinary process, differences in legislation between provinces or within a province could also influence disciplinary outcomes. Depending on the province, such legislation can encompass multiple regulated health professions or there can be different legislations for each profession resulting in differences between professions within a province. Legislations outlining mandatory penalties for certain offences also affect disciplinary outcomes compared with provinces without mandatory penalties – for example, Alberta, Ontario and Quebec have legislations about how cases of sexual misconduct should be handled, with minimum punishments outlined in law (*An Act to Protect Patients* 2018; Inquiries Division 2018; Owens 2018; *Protecting Patients Act* 2017). Similar to legislative differences, internal regulatory body policies could affect disciplinary action or transparency as could differences in case precedents within a province that might perpetuate certain practices. More research into the influence of legislation, policy and processes across provinces or within provinces on disciplinary outcomes is needed.

Demographic factors

GENDER

Our finding that male dentists were overrepresented in disciplinary action cases is similar to previous research on dentists (Walton et al. 2020) and research on physicians (Alam et al. 2011; Unwin et al. 2015).

PRACTICE SPECIALTY

This study is the first to report associations with dental specialty, to our knowledge, as existing research has analyzed only the risk of disciplinary action according to the licence type (e.g., dentists, dental prosthetists, dental hygienists and dental therapists; Thomas et al. 2018). Most dentists subjected to disciplinary action were general dentists, which likely reflects the proportion of general dentists in the workforce. This could be similar to research showing that most pharmacists disciplined are community pharmacists versus hospital pharmacists (Foong et al. 2018) and similar to research showing that family medicine is one of the highest risk physician specialties (Alam et al. 2011).

YEARS IN PRACTICE

Years in practice, years since graduation and age are different ways of attempting to capture a similar measure. Other studies on dentists have reported age in cases of disciplinary action (Foong-Reichert et al. 2021a; Thomas et al. 2018; Walton et al. 2020), but not years in practice, finding that older practitioners had a higher risk of facing disciplinary action than younger practitioners. This finding could be due to a higher cumulative risk over time as someone who is older has had more patient encounters than someone who is younger.

PREVIOUS DISCIPLINARY ACTION

Our findings on previous disciplinary action agree with the literature, in that those who have been subjected to disciplinary action in the past tend to be dealt harsher penalties if disciplined again. Dentists in our study who had been previously disciplined were more likely to be punished with a suspension or licence revocation than those who had not been disciplined before. Research on physicians has shown that men are more likely to be repeat offenders and that breaching a condition on a licence was a common reason for being disciplined, which is consistent with our findings. While we found that 9% of the cases involved previous disciplinary action, it is possible that this number is underestimated as not all regulatory body registers of professionals have a full disciplinary action history available online and not all disciplinary case transcripts included this information. This value of 9% is similar to that reported for other professions, although it is likely on the lower end of the range (Foong-Reichert et al. 2021a).

Transparency

Although the aim of this study was to characterize disciplinary cases, an unexpected but highly important finding was the significant difficulty we had in obtaining cases from half of the Canadian dental regulators. This is not the same as with physician regulators or pharmacist regulators, where previous Canadian reviews of disciplinary action have been conducted using publicly available data from all 10 provinces for physicians (Alam et al. 2011) and nine provinces for pharmacists (Foong et al. 2018). For regulators and policy makers, findings from this study suggest that transparency is limited. Implementation of transparent practices could better protect the public and keep regulators accountable. Of note, there has been some attention to the need for more transparency in nursing as highlighted in the public inquiry into the Ontario healthcare serial killer Elizabeth Wettlaufer (Foong-Reichert et al. 2021b). The Wettlaufer case identified a lack of transparency as a contributing factor in the failure to detect her criminality earlier. However, little has been written about the need for transparency in dentistry. The impact of transparency in hiring practices should not be underestimated, and regulatory body records of complaints and disciplinary action are key tools for employers to use. Health professional regulators, especially dental regulators, should ensure that complaints and disciplinary action information is publicly available and that a comprehensive register of health professionals is maintained online. In Canada, the more comprehensive registers include details, such as academic training, practice specialty and disciplinary history, while the simplest registers include only the professional's place of practice and status of their licence (e.g., active, non-practising or suspended). Such registers give the appearance of being transparent while not actually providing the public with useful information, such as history of past complaints or disciplinary action. The information that must be published on online registers is often dictated by provincial health professional regulations, meaning that changes may be required in legislation in order for regulators to change their practices.

Limitations

In addition to the limitations associated with the lack of transparency of some regulatory colleges, the ability of this study to determine associations with demographic factors was limited due to inconsistent and low reporting of demographic factors by regulatory bodies. Also, this study does not take into account variations in regulatory body disciplinary processes that might affect the types of cases that are disciplined. For example, some regulatory bodies have a lower level complaint committee that handles most complaints, while cases with certain criteria (e.g., repeated violations, sexual abuse) are handled by a higher level disciplinary committee. In addition, different regulatory bodies might have different thresholds for processing complaints at the lower level, meaning that one regulator might resolve a case at the lower level but another might refer it to the higher level disciplinary committee, leading to a higher number of disciplinary cases at the latter college.

Conclusion

This study is the first, to our knowledge, to describe regulatory body disciplinary action outcomes for Canadian dentists. However, gaps in the reporting of disciplinary cases and practitioner characteristics limit the conclusions that can be drawn for Canadian dentists. While this study and others have identified associations with certain demographic factors or characteristics, future studies could focus on a professional's motives or psychosocial factors that might be relevant to why a professional might misbehave and be subjected to disciplinary action. In addition, future research using data about complaints could complement our findings on disciplinary action. Such research, together with existing research, could demystify the disciplinary action process, improving the clarity of the process for both professionals and the public.

Funding

Ai-Leng Foong-Reichert was funded by the Ontario Graduate Scholarships and the Canadian Institutes for Health Research.

Acknowledgment

The authors gratefully acknowledge Ariane Fung and Karolina Suszek for their work in coding disciplinary cases.

Correspondence may be directed to: Kelly A. Grindrod. Kelly can be reached by e-mail at kelly.grindrod@uwaterloo.ca.

References

Alam, A., J. Klemensberg, J. Griesman and C.M. Bell. 2011. The Characteristics of Physicians Disciplined by Professional Colleges in Canada. *Open Medicine* 5(4): e166–72.

An Act to Protect Patients, SA 2018, c 15. Alberta. Retrieved February 1, 2023. <https://www.canlii.org/en/ab/laws/stat/sa-2018-c-15/latest/sa-2018-c-15.html>.

Canadian Institute for Health Information (CIHI). 2021. A Profile of Selected Mental Health and Substance Use Health Care Providers in Canada, 2021 [Infographic]. Retrieved January 27, 2023. <https://www.cihi.ca/en/a-profile-of-health-care-providers-in-canada-2020>.

Canadian Institute for Health Information (CIHI). 2022. Canada's Health Care Providers, 2016 to 2020 – Data Tables. Retrieved February 1, 2023. <https://www.cihi.ca/sites/default/files/document/canada-health-care-providers-2016-2020-data-tables-en.xlsx>.

Damiano, P.C., D.A. Shugars and J.R. Freed. 1993. Assessing Quality in Dentistry: Dental Boards, Peer Review Vary on Disciplinary Actions. *Journal of the American Dental Association* 124(5): 113–31. doi:10.14219/jada.archive.1993.0124.

Feine, J.S. 1991. The Enforcement of Regulations Restricting Expanded Duties by Dental Auxiliaries: An Analysis of the Recent Disciplinary Actions of the Texas State Board of Dental Examiners. *Journal of Public Health Dentistry* 51(2): 73–77. doi:10.1111/j.1752-7325.1991.tb02184.x.

Foong, E.A.-L., K.A. Grindrod and S.K.D. Houle. 2018. Will I Lose My License for That? A Closer Look at Canadian Disciplinary Hearings and What It Means for Pharmacists' Practice to Full Scope. *Canadian Pharmacists Journal* 151(5): 332–44. doi:10.1177/1715163518790773.

Foong-Reichert, A.-L., A. Fung, C.A. Carter, K.A. Grindrod and S.K.D. Houle. 2021a. Characteristics, Predictors and Reasons for Regulatory Body Disciplinary Action in Health Care: A Scoping Review. *Journal of Medical Regulation* 107(4): 17–31. doi:10.30770/2572-1852-107.4.17.

Foong-Reichert, A., K.A. Grindrod and S.K.D. Houle. 2021b. Exploring Health Professional Criminality and Competence Using the Case of Canadian Health Care Serial Killer Elizabeth Wettlaufer. *Journal of Medical Regulation* 107(3): 19–27. doi:10.30770/2572-1852-107.3.19.

Government of Canada. 2019, September 17. Canada's Health Care System. Retrieved February 1, 2023. <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html>.

Harris, J.A. and E. Byhoff. 2017. Variations by State in Physician Disciplinary Actions by US Medical Licensure Boards. *BMJ Quality and Safety* 26(3): 200–08. doi:10.1136/bmjqs-2015-004974.

Inquiries Division. 2018, March. *Sexual Misconduct. Collège des médecins du Québec*. Retrieved February 1, 2023. <http://www.cmq.org/publications-pdf/p-3-2018-02-28-en-inconduite-sexuelle.pdf>.

Kubinec, V.-L. 2016, January 21. Disciplined Doctors Often Given 2nd Chance to Practise. *CBC News*. Retrieved February 1, 2023. <https://www.cbc.ca/news/canada/manitoba/doctors-discipline-patient-boundaries-1.3405780>.

Munk, L.K. 2016. Implications of State Dental Board Disciplinary Actions for Teaching Dental Students about Emotional Intelligence. *Journal of Dental Education* 80(1): 14–22. doi:10.1002/j.0022-0337.2016.80.1.tb06053.x.

National Association of Pharmacy Regulatory Authorities. n.d. Pharmacy Regulatory Authorities. Retrieved February 1, 2023. <https://napra.ca/pharmacy-regulatory-authorities>.

Neville, P. 2017. Social Media and Professionalism: A Retrospective Content Analysis of Fitness to Practise Cases Heard by the GDC Concerning Social Media Complaints. *British Dental Journal* 223(5): 353–57. doi:10.1038/sj.bdj.2017.765.

Owens, B. 2018. Tightening Sanctions for Physician Sexual Conduct. *CMAJ* 190(47): E1398–99. doi:10.1503/cmaj.109-5687.

Protecting Patients Act, 2017, S.O. 2017, c. 11 – Bill 87. Government of Ontario. Retrieved February 1, 2023. <https://www.ontario.ca/laws/statute/s17011>.

Scofield, J.C., M.E. Gutmann, J.P. DeWald and P.R. Campbell. 2005. Disciplinary Actions Associated with the Administration of Local Anesthetics Against Dentists and Dental Hygienists. *Journal of Dental Hygiene* 79(1): 8.

Spittal, M.J., D.M. Studdert, R. Paterson and M.M. Bismark. 2016. Outcomes of Notifications to Health Practitioner Boards: A Retrospective Cohort Study. *BMC Medicine* 14(1): 198. doi:10.1186/s12916-016-0748-6.

Thomas, L.A., H. Tibble, L.S. Too, M.S. Hopcraft and M.M. Bismark. 2018. Complaints about Dental Practitioners: An Analysis of 6 Years of Complaints about Dentists, Dental Prosthetists, Oral Health Therapists, Dental Therapists and Dental Hygienists in Australia. *Australian Dental Journal* 63(3): 285–93. doi:10.1111/adj.12625.

Unwin, E., K. Woolf, C. Wadlow, H.W.W. Potts and J. Dacre. 2015. Sex Differences in Medico-Legal Action against Doctors: A Systematic Review and Meta-Analysis. *BMC Medicine* 13: 172. doi:10.1186/s12916-015-0413-5..

Walton, M., P.J. Kelly, E.M. Chiarella, T. Carney, B. Bennett, M. Nagy et al. 2020. Profile of the Most Common Complaints for Five Health Professions in Australia. *Australian Health Review* 44(1): 15–23. doi:10.1071/AH18074.

Zlomislic, D., R. Mendleson, R. Cribb and M.C. Oved. 2018, May 1. Bad Doctors Who Cross the Border Can Hide Their Dirty Secrets. We Dug Them Up. Medical Disorder, Part 1. *Toronto Star*. Retrieved February 1, 2023. <https://projects.thestar.com/doctor-discipline/>.