NOTICE TO DENTISTS

IN ACCORDANCE WITH BYLAW 19(7) OF THE ALBERTA DENTAL ASSOCIATION AND COLLEGE

On May 25, 2015, a Hearing Tribunal of the Alberta Dental Association and College found Dr. Murray Knebel guilty of unprofessional conduct and he was sanctioned.

Dr. Knebel admitted he was guilty of unprofessional conduct because:

1. He failed to prepare an appropriate treatment plan for the patient.
2. He failed to obtain informed consent of the patient or failed to meet his ongoing obligations for informed consent, including one or more of:
    a. Failing to discuss treatment and non-treatment recommendations;
    b. Failing to discuss the risks, benefits, prognosis, advantages and disadvantages of treatment; and
    c. Failing to provide the patient with reasonable expectations regarding the outcome of treatment.
3. He failed to maintain accurate dental records.
4. He failed to provide sufficient notice of the intention to discontinue care for the patient or failed to arrange for continuity of care, contrary to Article A11 of the Code of Ethics.

The Hearing Tribunal found that Dr. Knebel had provided complex and invasive orthodontic and prosthodontic dental treatment without a treatment plan and informed consent. The treatment changed throughout Dr. Knebel's care of the patient but eventually resulted in orthodontic treatment, followed by preparing the patient's teeth for full coverage crowns on 14 teeth, a three unit bridge, a dental implant and ongoing changes to the prosthetic plan.

Dr. Knebel first saw the patient on October 22, 2007 for a fractured tooth 46 and it was extracted. On February 25, 2008, Dr. Knebel took orthodontic records including upper and lower impressions, photos, a panoramic x-ray, a bite record and facebow. In March of 2009, Dr. Knebel commenced the orthodontic treatment of the patient. Twelve months after the orthodontic treatment had started and the patient was in braces for twelve months, Dr. Knebel proposed extending the orthodontic treatment for an additional three months, placing seven crowns and inserting a dental implant. The patient did not agree and the brackets were removed in March of 2010. In March of 2010, after the brackets were removed, Dr. Knebel prepared the patient's teeth 26, 27 and 36 for crowns and prepared teeth 45 – 47 for a bridge (46 was the dental implant site). At this point, the patient was experiencing constant pain in his mandibular teeth.

Ten months later, in January of 2011 Dr. Knebel referred the patient to another general dentist. In November 4, 2011, the patient returned to Dr. Knebel and he prepared the patient's teeth 17 to 11, 27 to 21 for full coverage crowns. Crowns were inserted on these teeth on November 24, 2011. Through October, November and December of 2011, there was significant email correspondence between Dr. Knebel and the patient regarding the status of the patient's treatment. On December 20, 2011, Dr. Knebel wrote to the patient by email to advise that the patient should seek treatment from a different dentist.

The Hearing Tribunal described the supporting evidence of each charge admitted to by Dr. Knebel and their findings, as summarized below.

1. Dr. Knebel failed to prepare an appropriate treatment plan for the patient.

The Hearing Tribunal found that Dr. Knebel was providing complex and invasive dental treatment to the patient where the patient's teeth were irreversibly prepared for full coverage crowns. Although the treatment included orthodontic treatment, and extensive prosthodontic treatment over a two year period, a proper treatment plan was not provided to the patient. Dr. Knebel did not prepare and record an initial treatment plan or a plan as the treatment progressed and changed.

The Hearing Tribunal stressed that a treatment plan is an essential part of any proposed dental treatment. It must also be updated and modified where necessary as the treatment progresses.

The Hearing Tribunal also noted that Dr. Knebel did not set out the treatment objectives and presenting concerns of the patient.

1. He failed to obtain informed consent of the patient or failed to meet his ongoing obligations for informed consent, including one or more of:
    a. Failing to discuss treatment and non-treatment recommendations;
    b. Failing to discuss the risks, benefits, prognosis, advantages and disadvantages of treatment; and
    c. Failing to provide the patient with reasonable expectations regarding the outcome of treatment.

Dr. Knebel admitted he did not discuss the risks, benefits, prognosis, advantages and disadvantages of the proposed treatment or the option of non treatment, on an ongoing basis and after each phase of treatment.

The Hearing Tribunal found that the lack of informed consent was particularly serious in this case because it involved prolonged and invasive dental treatment. Ongoing informed consent was necessary but was not obtained by Dr. Knebel from the patient.

2. Failing to keep or maintain accurate dental records.

The Hearing Tribunal found serious deficiencies in Dr. Knebel's records. It could not be determined from Dr. Knebel's dental records what the patient's chief presenting complaint was, or what the treatment objectives were. There was no documentation of informed consent as the patient's needs and the treatment plan changed. There is no record of discussions with the patient of the risks, benefits, advantages and disadvantages of treatment options.

The Hearing Tribunal found that Dr. Knebel's records did not reference Dr. Knebel's clinical findings such as extra-oral evaluation, soft tissue evaluation, vital signs, arch relationship, face profile, smile analysis, occlusal plane analysis, midline relationship, facial asymmetry, periodontal status, periodontal probing, mucogingival defects, missing and restored teeth and mobility. There is no record of the evaluation of the temporomandibular joints and associated musculature.

3. Failing to provide sufficient notice of intention to discontinue care for the patient or failing to arrange for continuity of care, contrary to Article A11 of the *Code of Ethics*.

The Hearing Tribunal, after considering the seriousness of discontinuing active invasive dental treatment, found that Dr. Knebel did not provide sufficient notice to the patient that he intended to discontinue the dental care and did not make arrangements for the continuity of care. The ethical duty in Article A11 of the Code of Ethics to provide proper notice when discontinuing care and to attempt to arrange for continuity of care is essential to protect patients. The Hearing Tribunal stated that Dr. Knebel clearly failed this duty.

The Hearing Tribunal accepted the Joint Submission on Penalty and issued the following orders:

a. Dr. Knebel will complete the ADA+C Ethics Program, totaling 30 hours, on or before June 1, 2016. The Ethics Program will be paid for by the ADA+C but will not count toward Dr. Knebel's continuing education credits.
b. Dr. Knebel will complete a 10 hour record keeping course on or before June 1, 2016. The Record Keeping Course will not count toward Dr. Knebel's continuing education credits.
c. Dr. Knebel will serve a four week suspension before June 1, 2016 and the dates must be approved in advance by the Complaints Director.
d. Dr. Knebel will pay a fine of $10,000 on or before August 1, 2015.
e. Dr. Knebel will pay the costs of the investigation and hearing of $75,736.62 on or before June 1, 2016 on equal monthly installments.