Date Issued: June 28, 2013
File: 8671

Indexed as: The Patient v. The Dentist, 2013 BCHRT 169

IN THE MATTER OF THE *HUMAN RIGHTS CODE*
R.S.B.C. 1996, c. 210 (as amended)

AND IN THE MATTER of a complaint before
the British Columbia Human Rights Tribunal

B E T W E E N:

The Patient

COMPLAINANT

A N D:

The Dentist

RESPONDENT

REASONS FOR DECISION

Chair:	Bernd Walter
On his own behalf:	The Patient
Counsel for the Respondent:	Bruce LeRose
Dates of Hearing:	April 26-27, 2013
Location:	Vancouver/Nelson

**** By order dated June 26, 2013, the published version of this decision has been amended to anonymize the Complainant and the Respondent.**

INTRODUCTION AND BACKGROUND

[1] On April 24 and 25, 2013, the Tribunal convened to hear the complaint of The Patient against The Dentist. The Patient alleges discrimination in the provision of services customarily available to the public, on the basis of his mental disability, contrary to s. 8 of the *Human Rights Code*.

[2] In July 2010, The Patient met The Dentist for an initial interview as a dental patient. The Patient attended for dental treatment in August 2010. A subsequent, follow-up appointment was cancelled, and The Dentist declined to treat him further. The Patient alleges that The Dentist knew, or ought to have known, of his mental disability and its influence on his conduct during treatment, and says that it was a factor in The Dentist's refusal to continue to treat him. The Dentist denies discriminating and says that his decision to discontinue treatment was based solely on The Patient's inappropriate, disruptive and upsetting behaviour during his treatment session.

[3] Because of The Patient's personal and health circumstances, the hearing was, with the consent of the parties, conducted under somewhat unusual arrangements. On both days, the proceedings commenced at noon. The Patient attended at the Tribunal's offices in Vancouver, along with myself as presiding member, and the Tribunal's case manager. The Dentist, his counsel and witnesses participated by means of simultaneous video and teleconference link from Nelson, British Columbia. In Vancouver, The Patient and I were able to observe and hear The Dentist and his witnesses. At the Nelson end, The Dentist and his counsel were able to observe and hear The Patient. Although the manner in which this hearing was conducted was a departure from the Tribunal's normal process, I expect that such arrangements will be far more frequent, and even commonplace, in future.

[4] The Patient was unrepresented. He gave evidence on his own behalf, and called no additional witnesses. The Dentist called as witnesses his assistants Ms. S and Ms. M and also testified on his own behalf.

[5] In considering the evidence presented, I have applied the principles in *Faryna v. Chorny*, [1952] 2 D.L.R. 354 (B.C.C.A.), including my assessment of the demeanour, powers of observation, judgment and memory of each witness. In my assessment of the evidence, I have also applied the considerations in *Van Hartevelt v. Grewal*, [2012] B.C.J. No. 906 (QL).

THE PATIENT'S EVIDENCE

[6] The Patient is a small man, fifty-six years of age. He appears somewhat unkempt. His affect is one of constant consternation. He appears anxious, he paces, and his verbal style can, at first blush, be perceived or experienced as confrontive, demanding or complaining. That said, his speech is clear and, in the main, unimpaired.

[7] The Patient says he has suffered from mental illness since his childhood, which, from his description, was tumultuous. He says he had bad parents who caused his Post Traumatic Stress Disorder ("PTSD"). He was admitted to a psychiatric facility at eleven. He says that he left home at thirteen. For the past ten or fifteen years he has been mostly homeless and transient. The Patient's mental disability makes him asocial and he has self-isolated. He says he does not do well around people, and they react strongly to him. His primary relationship appears to be with his dog. He was able to perform some labour jobs for ten years or so as a young person.

[8] The Patient is also poor and says that he has been in receipt of disability benefits ("PWD"), since 2009. The Patient submitted a Ministry of Housing and Social Development application form for PWD, dated September 24, 2009. In response to a series of questions on the form, The Patient discloses that he suffers from a number of mental conditions including "severe depression, anxiety, insomnia, P.T.S.D., hypertension, fatigue and body dysphoria". He says that all of these conditions are constantly interacting and are getting worse as he gets older. Of relevance to the current complaint he says, "My teeth are rotting and my gums bleed. I can't go to the dentist because I'm phobic about dentists". The PWD application does not list this latter diagnosis.

[9] The PWD application also details The Patient's impaired social functioning and problematic communication style. The diagnostic portion of the application form, completed by The Patient's (then) physician, records diagnoses of "Hepatitis "C", Depression, P.T.S.D., and anxiety, dating from the 1960's". The latter three conditions are characterized as mental disorders.

[10] As to the functional implications of The Patient's mental and physical impairments, the PWD application cites lack of self-care skills, lack of motivation, and deficits in executive, memory, emotional, and concentration areas. The Patient says he is terrified for his own safety. His doctor concludes he needs supervision and assistance "to be socially acceptable". The Patient says he is not on any regular regime of prescribed medications currently. He says medication overly sedates him. (Ex. 10)

[11] The Patient also submitted a "referral letter" from Dr. Joel Kailia, of Nelson, British Columbia, dated May 26, 2011, which, from its date, I assume was obtained in contemplation of this proceeding. The note says the doctor is treating The Patient for anxiety, depression, insomnia, PTSD and high blood pressure. The note provides no further details or treatment modalities. It does not say how long The Patient has had these diagnoses or how they originated. Dr. Kailia was not called as an expert witness. The note is in the nature of hearsay and I assign little or no probative value to it. (Ex. 11)

[12] The Patient further submitted a "medical certificate" from Dr. Kathleen Dann, dated March 26, 2013, again obviously in anticipation of this hearing. It indicates The Patient suffers from anxiety with panic, PTSD, and a "specific dental phobia", which can cause him to have a difficult time accomplishing a dental visit. (Ex. 12) This note does not satisfy the definition of an expert report, and The Patient did not deliver a copy to the Respondents or call Dr. Dann as an expert witness, under *Rule* 33 of the Tribunal's *Rules of Practice and Procedure*. I note none of the other documents provided by The Patient in support of his disability identify a specific dental component. The Patient later says he has not seen a dentist since 2000, nor have I been provided evidence about how a "dental phobia" constitutes a mental disability under the *Code*. I find it strains credulity that, absent any contact, The Patient would have latterly, or in the past two or three years,

spontaneously developed a specific disorder related to dentistry. Although I am entitled under the *Code* to admit hearsay evidence, I assign little or no weight to this note.

[13] The Patient says he had no dental care or treatment for a number of years because of his fear of dentistry. His PWD benefits include a limited dollar amount for dental care. Therefore he decided to try to obtain some treatment. The Patient says he needed to go to Nelson once or twice a month to see his doctor. He noticed The Dentist's office and called for an appointment.

July 21, 2010: First Appointment and Diagnosis

[14] When The Patient first met The Dentist on July 21, 2010, in Nelson, he was living rough in a small, ill-equipped trailer or camper near Winlaw, about forth-five minutes to an hour away from Nelson.

[15] The Patient says he made the appointment with The Dentist to first talk to him about his problems, including his physical and mental health issues. He says that at this first visit The Dentist let him take a long time, which The Patient found comforting. He says maybe The Dentist just thought he was scared of dentists.

[16] After their conversation, The Dentist examined The Patient's mouth. The Patient says he was able to tolerate The Dentist's examination which took only about a minute, but he was extremely anxious and "panicked". He says he did not understand he would have an examination and he had thought the dentist just wanted to talk. The Patient says that he disclosed pain in one of his teeth. The Dentist told him the tooth was cracked and half of it needed to be removed. There was also an exposed root and according to The Patient, The Dentist said to put "sensodyne" on it. The Patient says his back teeth were "breaking off" and hurting his tongue. The Patient says The Dentist decided to deal with his painful cracked tooth first. He says because of his nervousness and because he had discussed his fear and anxiety, The Dentist gave him a prescription for some [anti] anxiety medication to calm him. The Patient did not say whether he obtained or used this medication.

[17] The Patient says he told The Dentist to do as "little as possible" and, if x-rays were not needed, not to take them. The Patient says when he asked The Dentist to please try to treat him without x-rays, The Dentist said it might be possible. The Patient says the treatment plan and cost estimate that was formulated and given to him on July 21, 2010, made no mention of, and included no charge or fee in relation to, x-rays. (Ex. 15)

[18] At the conclusion of their first meeting on July 21, 2010, The Patient made an appointment to see The Dentist on August 25, 2010. He says he does not remember making the appointment.

[19] The Patient tendered The Dentist's four-page Patient Intake Form, which he was required to complete at his first appointment. (Ex. 13) The first page is headed "Welcome" and it collects the patient's personal contact information. The patient's self-declared "Medical History" begins in the middle of the first page. In it The Patient says he considers his current health as "poor". He says he smokes two rolled cigarettes a day. He also indicates he is prescribed and consumes "hypertension" medication. The Medical History questionnaire continues on the second page of the Intake Form and requires the patient to answer questions about past treatment for diseases or medical problems by circling a "Y" for Yes, and "N" for No. On this questionnaire The Patient responds:

- "Yes" to Hepatitis/Jaundice;
- "Yes" to Heart Murmur/Rheumatic Fever;
- "Yes" to High/Low Blood Pressure;
- "Yes" to Abnormal Bleeding ("very little, sometimes")
- "No" to psychiatric problems.

[20] The Patient also indicates that he is allergic to Penicillin, Aspirin, Codeine and Acetaminophen, Sulfa Drugs and Novocane (as written). The Patient also writes that he has a very rapid pulse and asks not to be given any drugs which increase heart rate. He declares he is currently in pain or discomfort with his tooth and gums and describes their condition as "poor". He dry brushes his teeth once per day and says he grinds his teeth. He says his last dental visit was in 2000.

[21] Near the bottom of the page, The Patient certifies the accuracy of his answers. He attests that he has had his questions answered to his satisfaction and he consents to treatment. The bottom of the form is signed by both The Patient and The Dentist. (Ex. 13)

[22] When asked why he did not disclose his psychiatric problems on the form, The Patient said he had been told that, because he is not psychotic, hallucinating, or violent, he could not see a psychiatrist. The Patient appears to posit that because he has not been seen by a psychiatrist, he does not have formal psychiatric problems which he in turn needs to disclose. I consider The Patient's response in this respect verging on disingenuous.

[23] The Patient says he was not at The Dentist's office to disclose his mental health problems. He says his mental health problems should be evident on observation.

August 25, 2010: Treatment Session

[24] The Patient says when he attended for treatment, he was very scared in The Dentist's office environment because of all the activity that was going on. The Patient's fear made him agitated. He had trouble sitting down in the waiting room so he walked around. He says he probably had not slept for several nights in anticipation of the appointment. He does not remember how long he waited in the reception area.

[25] The Patient was called into the operatory. He says he expected to get treatment for his broken tooth. The Dental Assistant wanted to take an x-ray before he entered but he objected. He refused because the dentist had said no x-ray would be required. He says he reminded The Dentist that he had said there would be no x-ray and none had been included in his cost quote. The Patient says The Dentist told him he was right and agreed to proceed without the x-ray.

[26] The Dental Assistant applied anesthetic to The Patient's gums. The Dentist started freezing the tooth but had difficulty "numbing" it. The tooth was not frozen enough and was still hurting. The Dentist was having problems numbing the entire spot and had to repeat the process a few times. The Patient says he used the "F-word a few

times". The Patient agrees his behaviour was bad and disruptive. He says he did not know if anyone else heard him, but on cross-examination he remembered seeing a child sitting on a counter.

[27] Once the tooth was sufficiently frozen, The Dentist "split the tooth and removed half". The pain and the cracking noise from his tooth troubled The Patient. He specifically does not recall asking the dentist to try the procedure without more freezing. The Dentist then left the room, leaving behind his Dental Assistant to explain post-operative procedures, such as applying gauze to staunch bleeding. The Patient says he tried to leave the dentist's chair to pick up his hat, which had fallen to the floor. He says the assistant yelled at him to sit. He said "I'm fucking bleeding everywhere". She told him he needed a follow-up appointment to complete his treatment procedures, and to make an appointment in two weeks.

[28] The Patient says he has no recall relating to the amount of time that had passed. He says he was very "freaked out", and left the office before realizing he had not paid for his treatment. He called the next day to pay with his credit card, and also asked for an itemized invoice. He says he also talked about a filling which he did not receive. He says the receptionist agreed with him but got upset. She left the phone to talk to The Dentist. When she returned she said there had been no filling. The Patient paid for his treatment. He says the phone call did not go well.

September 15, 2010: Appointment and Cancellation

[29] On September 15, 2010, The Patient called The Dentist's office and a follow-up appointment was scheduled. Five or ten minutes later The Patient received a voicemail from Ms. M, The Dentist's assistant, cancelling the appointment. The message indicated that The Dentist said the August 25 appointment did not go well, that their communication was poor and that The Patient should see another dentist.

September 16, 2010: Letter of Apology

[30] The Patient says that on September 16, 2010, he wrote The Dentist a letter of apology, "an explanation of his disabilities and issues", and asked The Dentist to see him again:

> DATE: 9/16/2010
> TO: [The Dentist]
> FROM: [The Patient]
>
> Hello [The Dentist]:
>
> I am writing to say that I tried to speak with you at the dental office after my extraction as well as calling you the next day however I was not successful in speaking with you personally. The reason I was trying to speak with you was to thank you and also to apologize for my inappropriate language during the tooth extraction. I noticed a child in the room next to me and when you were done and I realized that I was very wrong to use that language. My fear overcame me and my language was very inappropriate. I'd also like to apologize for any other behaviour that may have offended you or your staff.
>
> I also want to say that your work was outstanding and that dentistry has come a long way since I was young. The freezing wore off quickly without any side effects or pain in the areas where the needle was inserted nor was there any pain in the partial tooth that remains. You are the best dentist I have ever had.
>
> I realize that I am socially very inadequate. I try but at times I still manage to affect people in less than positive ways. This is a result of my several disabilities. Specifically when I am in a new environment or unknown circumstances I realize that my behaviour can be difficult to understand. And again I apologize for that. Once I know what to expect I am fine after the initial exposure.
>
> I am writing to ask you to please reconsider having me as a patient. I guarantee you I will not use inappropriate language again. I will do anything you ask of me in order to be your patient. I also want to apologize for accidentally leaving the office without paying the bill. I realized that I left before paying half way home and by that time it was too late to call. I called the next day and paid over the phone.
>
> Once again please accept my apologies. I hope you will see it in yourself to continue being my Doctor. I am hoping I will get a call reinstating my appointment.
>
> Kindest Regards
>
> [The Patient] (Ex. 8)

[31] The Patient insists that his letter of apology describes or discloses his disabilities. It clearly acknowledges and apologizes for what The Patient called his inappropriate language, which he attributes to his fear. The Patient couches his apology in his social inadequacy. He refers to his "several disabilities". He says his behaviour can be difficult to understand when he is in new or unknown circumstances.

October 6, 2010: The Dentist's Letter

[32] The Patient did not receive a response from The Dentist until October 6, 2010, in the form of a letter confirming the termination of their professional relationship:

> October 6, 2010
>
> [The Patient]
> General Delivery
> Winlaw, B.C. VOG 2JO
>
> Dear [Patient]:
>
> This letter is in response to your letter to our office of Sept. 16, 2010. We do appreciate your apologies for your actions. However, [Dentist] and the staff are still of the strong opinion that we do not wish to continue with our professional relationship with you.
>
> We think it best for everyone if you get your dental treatment at another dental office. We will be happy to forward all x-rays to the other office when they contact us.
>
> We wish you the best in your endeavors.
>
> Regards
> [The Dentist] & Staff (Ex. 9)

[33] The Patient argues that The Dentist's letter acknowledges his letter of apology and therefore The Dentist was aware of his disabilities. The Patient filed his complaint on September 21, 2010, before he had received The Dentists' letter of October 6, 2010. The Dentist's letter of appreciation for The Patient's apologies "for [his] actions" does not acknowledge any disability.

MS. S'S EVIDENCE

[34] Ms. S is a Dental Hygienist. She worked for The Dentist from 2008 until 2011 as a Certified Dental Assistant, a position she had held in four dental offices, working with a number of dentists.

[35] Ms. S testified that when The Patient arrived at The Dentist's office on August 25, 2010, the appointments were running a bit late. She was asked to seat The Patient and to prepare him for x-rays. She says she tried to explain the need for x-rays as part of pre-extraction policy and procedure, but The Patient refused. He said, loud enough to be clearly heard, that he did not want an x-ray. It is unclear to me whether this exchange occurred outside of, or in the operatory.

[36] Once in the operatory, Ms. S applied topical numbing gel to The Patient's mouth as a prelude to The Dentist injecting the area. Ms. S does not recall any problems or anything unworkable with respect to the procedure. She says once The Patient's mouth was numb, after five or ten minutes, The Dentist tested the tooth to determine if the anesthetic had been effective and then began to "elevate" (extract), the tooth. She says that The Patient, in a very loud voice said, "Stop, that fucking hurts". She had not heard a patient swear or appear so agitated in her years as a Dental Assistant.

[37] Ms. S testified that The Dentist stopped and advised that more freezing was needed, but that The Patient said, in a loud voice, "I don't want any more fucking freezing". He asked for some time to calm down. When The Dentist resumed, The Patient said, "Stop, that fucking hurts". She says this sequence of false starts may have been repeated up to ten times. It was an uncomfortable situation because there were lots of other patients and staff in the office, including a small child of eight or nine, in the next room. She did not want the child to be scared. Ms. S says The Patient's procedure took much longer than the normal forty or fifty minutes that had been booked for it. The next scheduled appointment was delayed and patients were kept waiting.

[38] Ms. S testified that throughout the episode, The Dentist remained calm, spoke quietly and tried to keep The Patient calm. He did not raise his voice and always stopped

immediately when The Patient was uncomfortable. Ms. S says The Patient appeared to understand what The Dentist was saying and that he explicitly refused additional anesthetic saying he "had enough fucking freezing".

[39] After the procedure, The Dentist left the room. Ms. S was left with The Patient to provide him with post-operative information to manage his pain and bleeding. Ms. S testified that The Patient wanted to leave but she asked him to remain lying in the dental chair. She says he kept "talking over her" and started to remove the gauze from his mouth. He became agitated about the bleeding and got out of the chair saying, "I'm fucking bleeding everywhere". She sternly told him to sit and he did. She gave him extra gauze, and instructions on how to use it and The Patient left. She says The Patient was rude and grumpy and the most difficult patient she had seen. Ms. S says she had looked at The Patient's medical history before treating him but had no knowledge of any mental disability, and the form did not list any psychiatric problems. She assumed he experienced a lot of pain and had a fear of dentistry.

[40] Ms. S's evidence was clear and straight forward. She was entirely non-defensive in acknowledging any gaps or lapses in her memory of the events due to the passage of time.

MS. M'S EVIDENCE

[41] Ms. M has worked for The Dentist as a Dental Assistant since 2007. Her duties also include front desk reception and maintaining the office.

[42] Ms. M never actually saw or met The Patient. She remembers a disturbance in an adjoining office while she was cleaning a child's teeth. The commotion consisted of inappropriate language, including use of the "F-word", which she clearly heard around five times. Her response was to protect the child by talking to her louder than normal to try to avoid exposing her to The Patient's language. She thinks she decided to complete the cleaning procedure as quickly as possible to get her out of the office and to bring her back on another day so she would not be frightened.

[43] Ms. M says The Dentist told her to inform The Patient they could not treat him due to his communication skills and she recorded this on The Patient's chart.

THE DENTIST'S EVIDENCE

[44] The Dentist has been a dentist for seventeen years. He worked eight years in Cranbrook, spent some time in Saskatchewan and has owned his office in Nelson for nine years.

[45] The Dentist says he has a preference for treating children and finds it rewarding because it poses a challenge and requires time and care. He treats children ranging in age from three to ten or twelve. His method of communicating with them depends on the child's level of understanding.

[46] The Dentist says he has worked with hundreds of people with mental illness, phobias and anxiety. He says knowledge and experience dictates proper treatment planning and the proper treatment of such individuals. He testified that he has never dismissed a mentally ill patient from his practice.

July 21, 2010: First Visit

[47] The Dentist identified his signature on the bottom of the medical and dental history form which The Patient completed on July 20, 2010, (*sic*) and which The Patient also signed along with two additional pages. (Ex. 13) The Dentist testified that these forms are the source of all of his information about a patient and their accuracy is extremely important. The forms disclose a patient's health history and assist the dentist in determining his treatment approach and assessing potential drug interactions. Again, The Dentist reiterated that he had encountered many psychiatric issues. The Patient circled "N" on his form indicating no history of psychiatric problems.

[48] The Dentist introduced a chart excerpt dated July 20, 2010 (*sic*) documenting, in his own handwriting, his first interaction or interview with The Patient. On it he lists a number of dental issues, including:

- Root exposure on Le. L. [left] side of mouth

- Incredibly painful
- Took vit[amin] C
- Very painful sores
- Can't eat
- Rinsing everyday (peroxide)
- Hygiene is an issue
- Patient says he is very high needs
- Patient has anxiety issues – wants teeth fixed and not extracted
- U.R. tooth been bothering for over a year
- Can't eat on R side – hurts – uses peroxide
- Does not want teeth out! He knows he will eventually lose teeth.

The chart contains additional writing which I cannot decipher.

[49] Under the heading of "treatment plan", there is mention of an extraction of the #16L fragment (no other option), reference to #26 buckle composite and "1PA needed for #16". The later phrase, according to The Dentist, refers to the need for an x-ray. (Ex. 17) The Dentist testified that The Patient said he would prefer no x-rays but that if it was necessary he could take them.

[50] The Dentist testified that their conversation occurred before the actual examination of The Patient's mouth. He would then have examined and identified the problems or areas of concern to be treated. He says that The Patient was cooperative and there were no problems or outburst during the examination which lasted one or two minutes. The Dentist says the problem areas were easily identified using a hand-held mirror and explorer or probe.

[51] The Dentist was referred to The Patient's Treatment Plan and Cost Estimate (Ex. 15) It contains no fee attributed to x-rays. He had no explanation for why this item would not have been mentioned or included, but he confirmed that the issue was discussed on July 21, and said that The Patient had said he did not like x-rays because he had heard they were bad for the gums and for the "brain". The Dentist says it is important to educate a patient about the importance of x-rays to diagnosis and treatment and that the procedure is considered a "standard of care". The Dentist testified he told The Patient he would need x-rays but could take them before commencing treatment rather than at the first visit.

[52] The Dentist says that on July 21, he spent forty minutes with The Patient. He says during that time there was no discussion of mental illness, PTSD, depression, or insomnia. He did record The Patient's anxiety on the chart (Ex. 17), but not in any detail.

[53] As he noted in the chart (Ex. 17), The Dentist acknowledged that The Patient was very anxious about his dental treatment but added that "everybody is". He testified he had no suspicion The Patient's anxiety was beyond normal in range. He said that this initial appointment was "quite positive", and he never considered not treating The Patient. He reiterated that he was not aware of any mental illness on The Patient's part.

August 25, 2010: Treatment Session

[54] The Dentist says that when they met on August 25, The Patient was already in the operatory. He administered an injection which was straightforward and he gave the anesthetic time to take effect. He then probed the tissue around the tooth and looked for indications that the anesthetic was working. He noted nothing unusual on tactile or visual examination and commenced treatment. When he started to put pressure on the tooth, The Patient said "that fucking hurts". The Dentist was a bit shocked and inquired if more anesthetic was needed and about the nature of The Patient's pain. He does not remember the exact communication. He says he offered more anesthetic and asked The Patient exactly what he was feeling. He says The Patient refused any more "fucking freezing".

[55] The Dentist says he had never had this sort of experience before. He denies getting angry. He says he tried to reassure and relax The Patient. He spoke to him calmly, asked him not to use that language, and how to make him more comfortable. The Dentist says he interrupted the process to allow the anesthetic to deepen and to try to accommodate The Patient.

[56] The Dentist says he tried to ask The Patient what was bothering him. The Patient did not mention anything about his mental disabilities. The Dentist says he thought The Patient was experiencing normal anxiety. He spent over an hour working on The Patient, during which the procedure was interrupted by five or six stops and starts, but felt with time he could help The Patient understand and treat him but The Patient would not listen.

The Patient was non-compliant to direction and could not describe what he was feeling. Finally the procedure was completed.

[57] The Dentist says The Patient's behaviour was very disruptive because of the volume and his language. He says there were children present. He says he tried to control the situation but was unsuccessful. He had Ms. S, his Dental Assistant, deal with post-operative matters, but heard more screaming and swearing from The Patient, who was not using gauze to stem his bleeding.

[58] The Dentist referred to another chart entry in respect of The Patient, dated 25 August, 2010. The entry, in The Dentist's writing confirms extraction of #16, lingual root. There is also an entry which states "patient does not want x-rays because it's not good for the gums, causes recession or not good for the brain. Decided not to take x-ray". Further on the entry says "very difficult to understand what patient wants. Does not understand implications of procedure. Wants to save tooth but not comprehending pros and cons. Did not listen during post-op" and, "does not want tooth out however I am not sure how to best serve this patient". At the top of the entry are the words "trauma control". At the very top are the words NEVER BOOK AGAIN. The Dentist says he does not know when this notation was added.

[59] The Dentist testified there were six members of his staff and up to fifteen or twenty patients or parents in his office at the time. The Dentist testified that he is obliged to provide his patients with a stress-free treatment environment and this was impossible under the circumstances. He had to terminate a child's treatment early. He says the events have had ongoing effects on his staff. They and parents still talk about and relive this unprecedented situation years later.

[60] The Dentist says later on August 25, 2010, he decided it was in the best interests of his staff, his patients, himself and the public not to treat The Patient in future. He says communication is key, and if he was not able to communicate effectively with The Patient, someone else might be more successful.

[61] The Dentist says The Patient chose to use inappropriate language after he was asked not to and was not respectful of the environment he found himself in. He says he

has previously dealt with extremely high anxiety patients and takes extra time to interact and to establish a trusting therapeutic relationship. He says because of the open design of his office space, another dental office might be better-suited to such a patient. He also said alternative techniques such as intravenous sedation, hospital-based in-patient treatment, or nitrous oxide, which he does not use, might be useful options for treating The Patient. The Dentist says he had already decided not treat him again when he received The Patient's letter of apology. He says the cancellation of The Patient's follow-up appointment was not due to any disabilities. Under cross-examination by The Patient, The Dentist reiterated that he was not aware of The Patient's psychiatric issues.

SUBMISSIONS

THE PATIENT

[62] The Patient submits that The Dentist's version of events and his own are so divergent as to be mind boggling. He asserts that for The Dentist to deny his disclosure of his physical and mental problems, he must be lying.

[63] The Patient says he knows he behaved badly on August 25, 2010, and suggests under the circumstances, The Dentist ought to have known there was something wrong with him.

[64] The Patient says this episode has had a long-term and traumatic effect on him and the experience repeats itself in his head. This is of course not an allegation of discrimination.

[65] The Patient submits that his September 16, 2010 letter of apology clearly discloses his disabilities and The Dentist responded to it in writing. Therefore, The Patient argues that The Dentist ended the relationship because of his behaviour which is the inextricable product of his disability. The Patient says The Dentist had a duty to accommodate his disability by seeing him at least one more time and then referring him to another dentist or seeing him outside of regular office hours. The Patient submits he has established a *prima facie* case of discrimination.

THE DENTIST

[66] The Dentist submits that The Patient's competence and demeanour throughout this hearing indicates he is able to exercise self-control. The Dentist submits The Patient has not established a *prima facie* case of discrimination because his letter of September 16, 2010 does not disclose any mental disability such as PTSD, anxiety or depression. Therefore it does not establish The Dentist was aware of the disability and, moreover, it was written after The Patient was informed The Dentist would not see him again.

[67] The Dentist says that his chart of July 21, 2010 only notes that The Patient is "high needs" and has anxiety. The notes contain no reference to a mental disorder and The Dentist says he would absolutely have recorded such information. Further, the intake document completed by The Patient specifically denies any psychiatric problems or mental disorders. The Patient did not accurately disclose his illness to The Dentist. Alternatively, if The Patient did disclose his mental health issues, The Dentist says if he were inclined to discriminate he simply would not have agreed to treat The Patient on August 25, 2010.

[68] The Dentist submits that The Patient has provided no evidence that his acknowledged bad behaviour on August 25, 2010 was caused by, or related to, a mental disorder or disability.

[69] Therefore, The Dentist argues that The Patient has not established a *prima facie* case, on a balance of probabilities.

THE PATIENT

[70] In reply, The Patient submits The Dentist's duty to accommodate his disability arose, irrespective of when he learned of it. He admits he never disclosed his diagnosis of mental disorder to The Dentist but merely told him he had mental problems and was in receipt of PWD. He says he has a right to his privacy but is unable to hide his disabilities and that it is in fact impossible to do so.

ANALYSIS AND DECISION

[71] The Patient's complaint is brought under s. 8 of the *Code* which provides:

> (1) A person must not, without a bona fide and reasonable justification,
>
> (a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or
> (b) discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public
>
> because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or class of persons.

[72] No party disputes that The Dentist provides a service customarily available to the public.

[73] The onus is on The Patient to establish, on a balance of probabilities, that The Dentist discriminated against him on the basis of his mental disability. He must establish *a prima facie* case, one which covers the allegations made and which, if the allegations are believed, is sufficient to justify a finding in his favour: *Ontario Human Rights Commission and O'Malley v. Simpson-Sears Limited*, [1985] 2 S.C.R. 526.

[74] To establish a *prima facie* case, The Patient must prove that:

a) He has personal characteristic(s) protected under the *Code*;

b) He was adversely treated or experienced adverse impact in relation to a service; and

c) His protected characteristics or group membership were, or it is reasonable to infer they were connected to, or at least factors in, the adverse treatment by the Respondent: *Moore v. British Columbia (Education), 2012 S.C.C. 61*.

[75] If The Patient is successful in establishing a *prima facie* case on these elements, the onus shifts to the Respondents to show, on a balance of probabilities, that they had a *bona fide* reasonable justification for their treatment of him: *British Columbia*

(Superintendent of Motor Vehicles) *v. British Columbia Council of Human Rights* [1997] 3 S.C.R. 868 ("*Grismer*").

[76] The Patient submitted his 2009 PWD forms, completed by his physician, which confirm diagnoses of PTSD, depression, anxiety and insomnia, and their functional implications or sequelae. These forms established his eligibility for financial benefits.

[77] In *Morris v. BC Rail* 2003 BCHRT 14, the Tribunal held:

> …in assessing whether an individual has a physical or mental disability within the meaning of s. 13 of the *Code*, the Tribunal must consider the individual's physical or mental impairment, if any; the functional limitations, if any, which result from that impairment; and the social, legislative or other response to that impairment and/or limitations. The focus is on this third aspect, which is to be assessed in light of the concepts of human dignity, respect and the right to equality… (para. 214).

[78] I find The Patient suffers from mental disabilities which satisfy the first element of a *prima facie* case.

[79] The next element of a *prima facie* case, that of adverse treatment, is not in dispute. It is common ground that, following his conduct in the course of receiving treatment on August 25, 2010, The Dentist decided to withdraw his services from The Patient.

[80] When The Patient made a follow-up appointment on September 15, 2010, it was cancelled within minutes, on the basis of poor communication.

[81] The Patient's September 16, 2010 letter of apology and request to reinstate his cancelled appointment went unanswered until October 6, 2010, when it was declined.

[82] I have no difficulty finding that The Patient was adversely affected by the withdrawal of The Dentist's treatment services. He has satisfied the second element of a *prima facie* case of discrimination.

[83] In order to succeed in his complaint, The Patient must establish a nexus, or connection, between his mental disability and the adverse treatment. He must show that his disability was at least a factor in The Dentist's refusal to treat him further. There

must be evidence that The Dentist knew, or ought to have known of The Patient's disability when he withdrew his services: *Low v. British Columbia Nurses' Union and Sostad*, 2004 BCHRT 358; *Moser v. District of Sechelt*, 2004 BCHRT 72, para. 51. Intent to discriminate is not a requirement under s. 2 of the *Code*.

[84] In his evidence, The Patient admitted he did not, on his patient intake form, disclose a history of psychiatric problems or diagnoses. He did not specifically testify that, in the course of their introductory diagnostic session, he disclosed the nature of any mental disability to The Dentist, beyond saying he was high needs, which could refer to a ten-year gap in dental care, and disclosing his anxiety. The Dentist interpreted The Patient's anxiety within normative bounds. The Patient himself testified that, "maybe The Dentist just thought I was scared of dentists". The rest of their conversation appears entirely devoted to diagnosis and treatment planning and The Dentist prescribed something for The Patient's anxiety. I do not consider The Patient's request to forego x-rays as indicative or disclosive of a mental disability.

[85] At the bottom of the intake form The Patient attests to the accuracy of his disclosures to The Dentist by affixing his signature. I find The Patient did not disclose his disability to The Dentist.

[86] The Patient submits that he was under no obligation to disclose his diagnoses because he had not seen a psychiatrist. I consider this explanation implausible. In closing, he also advanced his personal privacy rights to explain his lack of full disclosure. The issue, of course is whether, not having disclosed it, The Dentist ought reasonably have been aware that The Patient had a mental disability.

[87] The Patient submits his mental disability should be considered self-evident on the basis of his behaviour. His initial visit with The Dentist was routine and uneventful. His testimony in respect of his August 25, 2010 treatment session only describes him declining to be x-rayed, and repeatedly yelling expletives in response to the doctor's evidently painful intrusion into his less-than-fully-anesthetized mouth. I cannot find, on a balance of probabilities, that The Dentist ought reasonably to have concluded that The Patient's protestations of extreme pain, whether or not prefaced or augmented by the "F"

word, were due to an active mental disorder or disability. I am unable to conclude that The Patient's behaviour, despite the degree of disruption and consternation it engendered, would have been perceived as anything but the result of sensitivity to intense unexpected pain, nervousness, and a generalized, though perhaps somewhat extreme, fear of dentistry.

[88] I consider this case analogous to the Tribunal's decision in *Matheson v. School District No. 53 (Okanagan Similkameen) and Collis*, 2009 BCHRT 112. The complainant made allegations of abusive behaviour by her employer. The respondents applied to dismiss the complaint on the basis that she had failed to provide evidence of a mental disability throughout the course of her employment; that they did not know nor ought they to have known that she had a mental disability during the course of her employment; and that they were not under a duty to inquire whether she had a disability during the course of her employment. The complainant admitted she had never disclosed her condition, including not answering "yes" to the question on her application. She explained this on the basis that, in her mind, she does not have a mental illness but has a mental disability. Ms. Matheson also stated her belief that "I do not have to tell my supervisor about any mental disability": para. 10.

[89] In *Matheson*, the Tribunal said that an employee seeking accommodation for a disability is under a duty to disclose sufficient information to her employer to enable it to fulfil its duty to accommodate: *Central Okanagan School District No. 23 v. Renaud* (1992), 16 C.H.R.R. D/425 (S.C.C.). It found that Ms. Matheson alleged a failure by the respondents to accommodate her disability, her refusal to disclose her disability to them was, in the circumstances, fatal to her claim: para. 11.

[90] I cannot, on the evidence, find that The Dentist knew or ought to have known, that The Patient had a mental disability, which, I have noted, he admits he did not disclose. Therefore there is no basis for a finding that The Patient's mental disability was a factor in The Dentist's initial refusal to provide further treatment.

[91] In his letter of apology dated September 16, 2010, asking The Dentist to reconsider his decision to discontinue treating him, The Patient explains that he is

"socially very inadequate" and that his negative effect on people is as "a result of [his] several disabilities". The Patient does not explain or detail his disabilities except to say that his behaviour can be difficult to understand when he is in a "new environment or unknown circumstances". Having determined that The Patient's failure to disclose his disability before or while receiving treatment, persuades me that it was not a factor in The Dentist's initial withdrawal of his services, I must decide whether The Patient's letter provides sufficient information so as to inform or alert The Dentist that his behaviour on August 25, 2010, may have been related to, or the product of, a mental disability requiring The Dentist's accommodation. On the basis of The Patient's letter, was The Dentist aware, or ought he have been aware there was a relationship between The Patient's disability and his behaviour so as to raise a duty to inquire into the possibility of a relationship before finally withdrawing his services?: *Martin v. Carter Chevrolet Oldsmobile*, 2001 BCHRT 37.

[92] The Patient's apology letter and reference to his disabilities is of course not in the nature of medical information or opinion evidence. It does not identify his disabilities or their impact on his conduct. He characterizes his behaviour as "difficult to understand" and attributes it not to a disability but to being in new and unfamiliar circumstances.

[93] In *Drobic v. BC (Ministry of Employment and Income Assistance) and others (No. 2)*, 2008 BCHRT 143, the Tribunal stated:

> The question which arises is whether the information which the respondents did have was sufficient to impose a "duty to inquire" on them.
>
> ...
>
> Although the duty to inquire has arisen primarily in employment-related complaints, it is also applicable to complaints under s. 8 of the *Code*. However, as noted by the Tribunal in *Martin v. 3501736 (c.o.b. "Carter Chevrolet Oldsmobile)*, 2001 BCHRT 31, the duty only arises where the respondent knows, or reasonably ought to have known, of the relationship between the prohibited ground and the need for accommodation: para. 29. (paras. 136 and 138)

[94] A respondent generally has no duty to inquire unless there is a reason to suspect the effect of the disability on the complainant's conduct: *Gardiner v. Ministry of Attorney General*, 2003 BCHRT 41, ("*Gardiner*"). The obligation is normally on the complainant to communicate the nature of the disability to the respondent: *Mager v. Louisiana Pacific Canada Ltd*., [1998] B.C. H.R.T.D. No. 36 (Q.L.) para. 47.

[95] In *Alexander v. Northern Health Authority and others (No. 2)*, 2008 BCHRT 389, the Tribunal dismissed a complaint of discrimination based on mental disability. In that case, similar to The Patient's, one of the complainant's difficulties involved her inappropriate communications with her co-workers and supervisors. The Tribunal referred to cases, including *Gardiner* and concluded that, even though the employer knew that the complainant had previously been off work for two months for anxiety and depression, it had no information from which it should have concluded that her current work and communications problems were related to a disability.

[96] The Patient does not identify or even say he has a mental disability. He does not attribute his inappropriate language in the dentist's office to a mental disability. Based on my review of the jurisprudence, I do not find that his letter and its allusion to unnamed disabilities sufficed to impose on The Dentist a duty to inquire whether The Patient's August 25, 2010 behaviour or verbal outburst were the result of a mental disability.

[97] I am not persuaded The Patient's mental disability was a factor in The Dentist's withdrawal of his services. Therefore, The Patient has failed to establish a *prima facie* case of discrimination. His complaint is dismissed under s. 37(1) of the *Code*.

Bernd Walter, Chair