

SUMMARY OF THE COMPLAINT AND DECISION - DR. JOSHUA PROFITT

Complaint filed against Dr. Joshua Profitt by Parent A on behalf of their son, Patient B

File # PDBNS-2024-27

A panel of the Complaints Committee met on September 8, 2025 and December 2, 2025 via Microsoft Teams to address this complaint.

Documentation

The Committee received reviewed the following documentation for the September 8, 2025 meeting:

- The original complaint submission (the “Complaint”) from Parent A received by on 2024-10-10;
- A response to the Complaint (the “Response”) from Dr. Profitt received on 2025-06-23;
- Parent A’s reply to Dr. Profitt’s response to the complaint received 2025-01-17;
- Dr. Profitt’s follow-up reply (no date provided) to Parent A’s 2025-01-17 correspondence;
- Dental records and related office correspondence provided by Dr. Joshua Profitt;
- Dental records and related office correspondence provided by Endodontist C; and
- Various administrative correspondence related to the complaint.

In addition to documentation considered for the initial meeting, members of the panel reviewed the following materials for the December 2, 2025 meeting:

- Letter from Chair of the Complaints Committee, Dr. Clare Champoux to Dr. Joshua Profitt dated 2025-09-22;
- Response to Dr. Champoux’s letter submitted by Dr. Joshua Profitt dated 2025-10-17.

The Complaint

In the Complaint submitted by Parent A to the Nova Scotia Regulator of Dentistry and Dental Assisting (the “NSRDDA” or the “Regulator”), they allege that Dr. Joshua Profitt violated the expected standard of care in their treatment. Specifically, they describe that their 13-year-old son, Patient B, presented to Dr. Profitt [the clinic] with severe tooth pain which was assessed with a brief examination and x-ray. They state that Dr. Profitt stated “the pain was directly caused by a wisdom tooth that required immediate removal.” They further state that Dr. Profitt’s advice was accepted, the extraction was completed and advice for after-care provided.

According to Parent A, her son's discomfort continued for several days following the extraction and he eventually experienced fever and severe swelling that extended to his eye being "practically swollen shut". On follow up at the clinic, Patient B was seen by another dentist who prescribed antibiotics, antiseptic rinse and various medications to address pain. Parent A states they were advised at a subsequent orthodontic appointment that swelling was still present and to follow up with their regular dentist. It was determined by Patient B's regular dentist that the wisdom tooth had not required removal; rather, a different molar required a root canal. Parent A asserts that, by misdiagnosing and unnecessarily removing the [wisdom] tooth, Dr. Profitt may have violated the standard of care. Parent A further assert that their son experienced unnecessary pain and they were required to pay for unnecessary treatment.

The Response

In his written response to the complaint, Dr. Profitt expresses sympathy for Patient B's postoperative pain and difficulties and regret that he was not made aware of their experience until he received the formal complaint lodged against him.

Dr. Profitt explains that, at the time he saw this patient, he was providing locum services to assist with a variety of dental services at [the clinic]. He reports that he provided a thorough examination of Patient B's complaint of discomfort on the upper right side and found no swelling, redness, fistulas, percussion sensitivity or evidence of abscess or infection in the affected area. Dr. Profitt states they exhibited sensitivity near the impacted tooth 18. Dr. Profitt notes details of the presence of orthodontic bonded attachments, wires and elastics. He states that he presented options to either monitor tooth 18 or proceed with its removal; the parent had opted for the extraction.

Dr. Profitt describes that the extraction was completed without complications and post-operative instructions were provided to manage bleeding, pain and swelling. Dr. Profitt explains that he did not prescribe prophylactic antibiotics stating that he was following current clinical guidelines for routine wisdom tooth extraction in the absence of infection. He acknowledges that it is standard practice to place patients on antibiotics when there is post-operative infection.

Dr. Profitt reiterates:

- At the time of treatment, tooth 18 was symptomatic.
- There were no clinical indications that tooth 16 was contributing to Patient B's discomfort.
- He would have been willing to undertake review and reassessment of Patient B's post-operative condition had he been made aware of the infection.
- He regrets any distress and hardship experienced by Patient B

Decision

After reviewing the available information, interviewing Dr. Profitt, considering past conduct history, and having Dr. Profitt respond to the significance of the past conduct history, the Complaints Committee ordered the following disposition:

- **In accordance with s.84(1)f of the *Regulated Health Professions Act* and with Dr. Profitt's consent, Dr. Profitt be issued a reprimand and that the reprimand be communicated to Dr. Profitt and the complainant;**
- **In accordance with s.84(1)g of the *Regulated Health Professions Act* and with Dr. Profitt's consent, the following conditions be met by Dr. Profitt:**
 - **remedial education in the clinical assessment and diagnosis of odontogenic pain as approved by the Registrar within 12 months following Dr. Profitt's consent to these terms; and**
- **failing a successful resolution, the complaint be referred back to the Complaints Committee for further deliberation.**

Reasons for Decision

Members of the panel determined that the complaint lodged against Dr. Joshua Profitt by Parent A regarding the extraction of Patient B's tooth 18 and his subsequent development of an abscess on tooth 16 is both understandable and regrettable. Panelists empathized with the pain, tooth loss and inconvenience experienced by Patient B.

Panelists reviewed patient care and administrative issues elucidated through Parent A's complaint with ensuing discussion by members of the panel focused on the following key concerns:

- Regarding whether there were deficiencies in Dr. Profitt's standard of care, panelists determined that sparse clinical records and apparent lack of a methodical approach for diagnosis and treatment planning left them with concerns about the thoroughness of Patient B's assessment, particularly regarding the source of his pain. Despite the often subjective and radiating nature of pain, panelists seriously questioned Dr. Profitt's judgement regarding the source of pain on the day they presented. Given Patient B's age and the position of the impacted 18 evident in radiographs, they also questioned the hastiness with which Dr. Profitt recommended and proceeded with a surgical extraction when palliative measures and monitoring presented viable options. It was especially concerning that - even with his own acknowledged uncertainty about whether 16 could have been causing pain on the day this patient presented, Dr. Profitt told the panel he would not have strayed from his recommendation.
- Regarding deficiencies in Dr. Profitt's record-keeping, panelists were somewhat reassured by Dr. Profitt's description of improvements to his documentation since taking

a recent course in Recordkeeping. However, Dr. Profitt’s patient record for Patient B clearly did not meet expectations outlined in the Regulator’s *PDBNS Dental Recordkeeping Guidelines*. Specifically, panelists determined that level of detail and specificity in the documentation of Patient B’s history, diagnostic assessment and findings, differential diagnoses, options for care, and informed consent are seriously lacking.

- Regarding deficiencies for informed consent, panelists determined that, in the absence of sufficient *prima facie* documentation, Dr. Profitt’s process and scope for seeking meaningful informed consent are essentially unknown and he therefore fell short of expectations outlined in the *PDBNS Informed Consent Guidelines*, namely,
 - *In order for consent to be informed, the dentist must provide the patient with certain information: the diagnosis or problem noted, the treatment alternatives available (not just the ones that the dentist provides), the risks and benefits of each treatment, the estimated cost of each option, the nature and purpose of the proposed treatment, and the likely consequences of not having treatment. The dentist should be certain that the patient understands what has been explained and has consented to the procedure(s).*

After careful deliberation, and in accordance with the Regulated Health Professions Act, SNS 2023, c 15 [RHPA], the Committee determined that Dr. Profitt’s conduct constitutes professional misconduct – having regard to all of the circumstances Dr. Profitt’s conduct would reasonably be regarded as unprofessional. Specifically, the Committee determined that Dr. Profitt:

- a) Failed to maintain the standards of practice specific to:
 - assessment and diagnosis of odontogenic pain;
 - recordkeeping (Section II of the *Recordkeeping Guidelines*); and
 - the *Informed Consent Guidelines*.
- b) Failed to adhere to the *Code of Ethics* (specific to Article 8: Informed Choice)

The Committee passed a motion that, with Dr. Profitt’s consent, Dr. Profitt be issued a reprimand and be subject to conditions as set out above in the **Decision** section.

Executed Consent to Reprimand and Conditions

On June 5, 2026 a Consent to Reprimand and Conditions (the “Agreement”) was signed by Dr. Profitt, Dr. Champoux (Complaints Committee Chair), and Dr. Mackey (the Registrar). In the Agreement, Dr. Profitt and the Regulator agree as follows:

- a) The information contained in the Agreement’s Statement of Facts is true and forms part of the agreement;
- b) Dr. Profitt consents to a written reprimand in accordance with Section 84(1)(f) of the *RHPA*;

- c) Dr. Profitt consents to undertake measures for remediation in the clinical assessment and diagnosis of odontogenic pain as approved by the Registrar within twelve (12) months of the execution of this Agreement;
- d) That, failing a successful resolution, the Complaint may be referred back to the Complaints Committee for further deliberation; and
- e) This Agreement constitutes a full disposition of the Complaint.

The Committee is satisfied that its disposition of the complaint fulfills the NSRDDA's objects as set out in Section 3 of the RHPA to:

- protect the public from harm;
- serve and protect the public interest;
- subject to the public interest, preserve the integrity of the profession; and
- maintain public confidence in the ability of the regulatory body to regulate its profession.

Confidentiality

Under provincial legislation, the professional conduct process is confidential.¹ All who obtain information through this process, such as our staff, the respondent, witnesses and committee members), and the complainant are required by law to keep confidential all information they receive or have knowledge of through the professional conduct process, unless the *Regulated Health Professions Act* specifically permits otherwise. This confidentiality applies to, without limitation, the complaint and the decision.

Under provincial legislation, information from the professional conduct process cannot be used in other proceedings, including civil proceedings.²

The Complaints Committee thanks the Complainant for bringing their concerns to the attention of the NSRDDA. The public's participation allows the Regulator to continue to uphold its mandate to protect the public interest and promote quality dental care throughout the province. The Committee also appreciates the dentist's participation in this complaint and in responding to the Complainant's concerns.

Dr. Clare Champoux

Dr. Clare Champoux, Complaints Chair

June 18, 2026

¹ Section 136 (a) through (h) of the [Regulated Health Professions Act](#)

² Section 136 of the [Health Professions Disciplinary Proceedings Protection \(2008\) Act](#) and Section 138 of the [Regulated Health Professions Act](#)