Dentist, Dr B

A Report by the

Acting Health and Disability Commissioner

(Case 09HDC01081)

Overview

This case is about the dental care provided to Mrs A by Dr B between September 2006 and March 2007. Mrs A saw Dr B with a painful tooth and a vague pain behind her front teeth. Following extensive dental treatment by Dr B, Mrs A suffered severe and ongoing discomfort. On 28 May 2008 Dr B refunded $28,805.00 to Mrs A. She has since had her dental work re-done.

This investigation examines the standard of Dr B's dental treatment, whether he gave Mrs A information about all the other dental options available to her, and whether she made an informed choice and gave informed consent to her treatment.

Complaint and investigation

On 6 April 2009, the Health and Disability Commissioner (HDC) received a complaint from Mrs A, forwarded by the Dental Council of New Zealand, concerning the services provided by Dr B. The following issues were identified for investigation:

Whether Dr B provided Mrs A with dental treatment of an appropriate standard.

Whether Dr B provided adequate information to Mrs A.

An investigation was commenced on 12 May 2009.

Information reviewed

Information was obtained from:

Mrs A	Consumer/Complainant
Dr B	Dentist/Provider

Information was also reviewed from:
Dr C
Dr D
Dr E

Also mentioned in this report:

Dr F	Dentist
Dr G	Consumer affairs officer, New Zealand Dental Association

Independent expert advice was obtained from Dentist Dr Tim Little (see **Appendix A**).

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Information gathered during investigation

Background
On 4 September 2006, Mrs A attended an appointment with dentist Dr B for a toothache.

Dr B
Dr B is a shareholder and sole director of a dental company. He shares his premises with another dentist, with whom he operates through a business.

First appointment, 4 September 2006
Mrs A explained that she chose to see Dr B because he had been recommended to her and she did not have to wait before an appointment could be organised. Dr B advised that Mrs A was referred to him by a colleague, Dr F, because Mrs A, who had been receiving treatment for her teeth on a regular basis, "was concerned that each time she went [to the dentist] she had teeth extracted and had been told that it was only a matter of time before she lost all her teeth". Dr B also stated that it had been "reported" to him that Mrs A was experiencing constant pain from her teeth and had sought "many" opinions, both medical and dental, without success. Dr B has not provided a copy of any referral letter, nor is there any reference to a referral in the patient records.

Dr F's children attend the school where Mrs A is a teacher. Dr F recalls Mrs A telling her that she was going to see Dr B for dental treatment, but she does not recall ever making a formal referral to Dr B. She advised that because she was working a few hours a week at the same practice as Dr B, she agreed to review Mrs A's radiographs and notes. Dr F recalls having a discussion with Dr B about Mrs A's case but did not discuss the proposed treatment in any detail. Dr F stated that she has never seen Mrs A in a professional capacity as her dentist.

Dr B advised that during his initial examination he noted that many of Mrs A's teeth had already been extracted and "most of her remaining teeth had been extensively filled, many having little or no sound tooth substance above gum level". In a letter to HDC dated 10 August 2009, Dr B stated that he also considered that she had a "progressive periodontal condition",[1] which she had never been advised of. In a further letter to HDC dated 3 September 2009, Dr B wrote that following his examination he diagnosed Mrs A with "chronic Periodontitis". He explained that periodontitis is the advanced stage of periodontal disease, which is characterised by bone loss or destruction of the periodontal ligament that holds the tooth in place. He explained that this is a process that usually progresses slowly over many decades.

Dr B recalls that he explained to Mrs A what periodontal disease is, showing her pictures and X-rays. He remembers that she was shocked and asked him why nobody had explained this to her before.

In contrast, Mrs A stated that she went to see Dr B because she was experiencing pain in one of her bottom left teeth. However, following his examination Dr B told her that she required immediate extensive dental treatment on all her teeth, or they would fall

[1] A chronic bacterial infection of the gums and bone supporting the teeth.

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out within two years. Mrs A denies telling Dr B during their initial discussions that she had been experiencing a burning sensation behind her front teeth. It was not until he had advised her that she required extensive treatment on her teeth that she commented that she had been experiencing a burning feeling behind her front teeth and on the roof of her mouth. Furthermore, she denies ever seeking treatment for this problem in the past. She advised that she had only ever mentioned it to her general practitioner and never to her previous dentists.

Dr B started Mrs A on antibiotics for a sinus inflammation and planned to review her again the following week to discuss treatment options. Dr B advised that he recommended and discussed the following with Mrs A:

> "a) Treatment and satisfactory resolution of poor oral hygiene and periodontal disease.
>
> b) Restoration of the occlusion by replacement of the missing teeth.
>
> c) Restoration of the decayed and/or defectively filled teeth.
>
> d) To consider the importance or not of any cosmetic implication, i.e. visible denture clasps, shape matching discrepancies between acrylic, porcelain and natural teeth, etc."

The details of this discussion are not documented in the clinical records. The clinical record states:

> "Patient having pain in mouth, burning sensation, sensitive to hot and cold. Has been to Dr and Specialist in past to sort out. Sore tooth 26,[2] [Dr B] adjusted bite and explained that root was pressing on sinus and is inflamed. Which causes tooth to become tender. Patient also has perio disease [Dr B] explain what this was and how to treat. Also needs old [fillings] replaced. [Dr B] said to address perio disease first then fix old [fillings]. …"

Treatment options

Dr B stated that he discussed a number of treatment options with Mrs A. First, in relation to addressing her poor oral hygiene and periodontal disease, he advised her that "lengthy education, root planning[3] and 100% patient motivation and that regular monitoring over a period of several months" was required.

Secondly, in relation to the options available for the replacement and restoration of her decayed and missing teeth, Dr B advised that he would have discussed the use of implants,[4] fixed prosthodontics,[5] removable prosthodontics[6] and precision attachment prosthetics.[7]

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[2] The number refers to a dental notation system, where the tooth number corresponds with a specific tooth.

[3] The process of removing the plaque from the tooth and root.

[4] An artificial root upon which crowns and bridge work can be constructed.

[5] A tooth restoration technique using bridge work and crowns.

[6] The technique where missing teeth are replaced with a removable prothesis (dentures).

[7] The use of a specialist attachment device for securing removable crowns and dentures.

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Dr B said that he discussed all of these options at great length "over a period of several months" with Mrs A. He stated that "[e]very option was fully explained including the advantages and disadvantages of each" and that Mrs A asked numerous questions, leaving him in "no doubt that she was in full possession of all the facts prior to her signing the informed consent for each procedure".

Dr B recalls that Mrs A considered that the option of implants was too expensive. She rejected the option of a combination of restoring the defective and decayed teeth with crowns and fillings and having a removable upper denture, for cosmetic and functional reasons. She also asserted that her mouth was too small for dentures.

Dr B said that his "preferred" option would have been precision attachment prosthodontics, but Mrs A immediately rejected this option, again due to the cost.

At the conclusion of his discussions, Mrs A consented to the option of "full upper and lower arch crown and bridgework".

None of these discussions or treatment plans are documented in the clinical records. Dr B explained that once treatment has been decided, any other alternative plans are automatically removed from the computer charting.

In contrast, Mrs A denies ever discussing any treatment options other than that of fixed bridge work to replace the missing teeth with crowns, and fillings on the other affected teeth. Mrs A recalls suggesting that dentures might be an option, but Dr B advised her that her mouth was too small. She stated that she was "horror-struck and shaken" by Dr B's prognosis that she would lose all of her teeth within two years and, as a result, felt pressured into accepting the proposed treatment.

Dr B saw Mrs A again on 20 and 21 September 2006. On 20 September, Dr B noted that the pain at tooth 26 had gone and the sinus inflammation had settled. He documented that he discussed the estimate for surgery, explained what crowns are, and advised that surgery needed to be completed first, then the fillings would be placed and lastly the crowns would be completed. On 21 September, impressions for the periodontal work were taken.

Consent and treatment

On 9 October 2006, Mrs A signed and completed a "confidential health questionnaire". This form includes a section for consent for the proposed surgical/dental procedure. In the space where it specifies the procedure being consented for, it states "perio + general". Mrs A also signed a "patient consent form for sedation" on the same date. This form states that the procedure has been explained to the patient and consent has been given for the procedure. There is no information about what the procedure is.

On 26 October 2006, Mrs A signed and completed another "confidential health questionnaire". However, in the consent section, the space that specifies the procedure being consented to has been left blank. Mrs A also signed a "patient consent form for sedation" on the same date.

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According to the clinical records, Dr B saw Mrs A a number of times in October and November, during which time he carried out treatment on, and provided education about, Mrs A's periodontal disease.[8] He also extracted tooth 27 because of the extent of the periodontal disease.

On 29 November, Dr B noted that Mrs A's teeth were "looking good". He then talked about the next step in her treatment and discussed her options, including "[d]o nothing and in future have dentures" or "crown and bridging all teeth". The records also note that Dr B "explained both options at length".

On 20 December, it is noted that Mrs A was complaining of sore gums. Following review, Dr B noted that they were a bit inflamed but looked "fine".

On 4 January and 12 February 2007, Mrs A signed two more "patient consent form for sedation" forms. On 12 February, she also completed and signed a "confidential health questionnaire". However, nothing has been written in the consent section of this form to specify what procedure was being consented to. Mrs A also completed another "confidential health questionnaire", which in the consent section states that she consented to the procedure of "crown prep". However, Mrs A has dated it with her own birth date, rather than the date she signed the form.

In his initial response to HDC, Dr B provided the following description of the treatment he performed:

> "In accordance with [Mrs A's] wishes I provided 2 fixed bridges at the upper left and right quadrant as well as single crowns at 21 and 22. Some 4 weeks later I provided two fixed bridges at the lower left and right quadrants as well as 4 single crowns at 31, 32, 41 and 42."

In more detailed explanation (although he advised that this explanation was based on his records as he did not have access to the models and X-rays) Dr B stated:

> "a) The upper right bridge replaced 17 and 16 by means of 1 cantilevered, free end, pontic supported from abutments at 15, 14, 13, 12, and 11.[9]
>
> b) The upper left bridge replaced 26 and 27 with abutments at 23, 24, 25, and 28.
>
> c) The lower left bridge replaced 35 (½ unit mesial to 36 and ½ unit distal) by over sizing of abutments at 37, 36, 34, and 33.
>
> d) The lower right bridge replaced 44 and 45, with abutments at 47, 46, and 43."

Dr B outlined the "accepted formula" for securing bridge work, stating that "the combined root areas of the abutment teeth in any fixed bridge should be, at least, 1.5 times as great as the combined root areas of the teeth being replaced".

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[8] Dr B saw Mrs A on 9, 10, 17, 26, and 27 October, and 2 and 29 November 2006.

[9] The teeth where the bridge is attached.

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Dr B explained that "[t]his formula assumes there is no periodontal disease, no bone loss to the abutment teeth, no root canal treatments present in the abutment teeth and that there is a fair amount (40%) of sound supported tooth substance above gum level".

Dr B advised that, because teeth 21, 22, 31, 32, 41 and 42 did not require functional bridge work, Mrs A asked about the colour match between these teeth and those replaced by the bridges because she wanted the bridges to be whiter than her natural colour. Dr B explained to her that the bridges would either need to be her natural colour or she would need to bleach her teeth after the bridge work was complete. Alternatively, she could crown the remaining teeth for "purely cosmetic consideration". Dr B advised that Mrs A decided on the option of crowning her remaining teeth.

Mrs A said that she did agree for her remaining teeth to be crowned, as all the rest were being done, but again Dr B did not point out any detrimental effects. She advised that her decision to undergo the treatment was for health, not cosmetic reasons. Mrs A recalls making this clear to Dr B during one of her first appointments.

On 26 January 2007, Dr B completed the upper bridge.

On 7 February, a telephone conversation is documented in Mrs A's patient records which states:

"1. Excess saliva at night causing her to dribble !!!!!!
2. Has a stinging pain in the roof of her mouth.
3. [Dr B] has made a mistake on his quote as she has had more crowns on the top.
4. Does not want to go ahead with bottom jaw next week if she is going to have all the above."

The records then state that an emergency appointment was made with Dr B later that day to discuss these issues and that following the discussion Mrs A was "happy".

From the clinical records it appears that the lower bridge work was completed on 12 February. Dr B then saw Mrs A again on 19 February, and 2, 5, 15 and 27 March to complete the insertion of the crowns, and to review and adjust her bite. On 27 March, the clinical records state "adjusted bite. Review and scale in 3 months".

Ongoing pain

On 17 May, Mrs A presented to Dr B complaining of "[s]ore gums and jaw". The records document that Dr B discussed her temporomandibular joint (jaw joint) and showed her some exercises. He also discussed making her a nightguard if the pain did not improve, explaining that this was normal in patients who have had "full arche (sic) restorations" due to the patient's bite being changed. The records also note that Mrs A was complaining that her gums were "stinging" and that she had been using interdentals[10] three times a day. Dr B explained that using interdentals so often was

[10] Small brushes used to clean between the teeth.

HDC

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irritating the gums and recommended that she use them only once a day. Dr B then checked her bite and planned to review her again in July.

On 19 July, Dr B noted that Mrs A had very inflamed gums. He adjusted her bite, explaining that it "wasn't right" and that she was "protruding and is biting front teeth". He noted that this could be the reason why her gums were inflamed. He also discussed the possibility of her gums "rejecting crowns". Dr B prescribed her metronidazole (an antibiotic) and gave her Savol mouthwash.

On 23 July, Dr B noted that Mrs A's gums were "no better". He reviewed her technique using interdentals and advised her to use the small size. He then documented that gums were "50% better".

On 26 July, Dr B noted that the gums looked "a lot better". An appointment was made for the following week for a nightguard and, on 8 August, teeth impressions were taken. During this appointment Mrs A advised that she was still experiencing a burning sensation in her gums. Dr B discussed the possible causes for this and advised her that he was "happy to take off bridge and see if gums settle". Dr B then discussed burning mouth syndrome with Mrs A and recommended multivitamins for "levelling out nutrition". He suggested that she have blood tests and consider the possibility of starting antidepressant medication for "balancing out nerves, changing taste in mouth, chemical release etc".

On 6 December, Mrs A wrote to Dr B, stating:

> "I decided I'd persevere positively until the end of the year with my sore mouth, but I'm afraid I really can't put up with it for much longer. I feel I've been given a life sentence, when what was intended was the opposite.
>
> When I first went back to you I accepted lots of possible explanations with an open mind.
>
> - Infected mouth so put on strong antibiotics. Absolutely no difference.
> - Cleaning my teeth too much and therefore irritating gums. (I am very careful.)
> - Then told not to clean so much, everything got so much worse.
> - Finally it was suggested burning mouth syndrome.
>
> Hence I'm back to cleaning three times a day which is the only way I can get a bit of relief and I have some bonjela which I put on both sides of gums top and bottom.
>
> The symptoms:
>
> Can't open mouth properly as my left [hand] jaw makes a huge crack and I don't have to open it very far for this to happen.
>
> It feels terrible especially after eating unless I just suck food and swallow it. Most foods seem to all get stuck in back teeth top and bottom. It does help if I instantly

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rinse and go through a whole procedure, which is difficult as I have to run off to bathroom all the time and sometimes there isn't a bathroom. It seems to be where my teeth go into my gums and it's pinching, grabbing, pulling and stinging. Sometimes it feels if it's all my bottom teeth and I think at least it's only my bottom and then it moves to the top. Also it's difficult to read aloud and sing which is part of my job. My tongue seems to hit just above my two front teeth and irritate this area.

I can put up with it being difficult to chew properly but not the other.

This distress has changed my lifestyle. In particular I have to eat in large quantities and get it over and done with and make sure I'm near a bathroom. It also takes time. Socially I like to share food over a period of time and eat between meals. This is not a pleasant experience anymore, in fact it's fearful. Sharing food to me is everything and this is not the case anymore.

I feel I've given all your suggestions a go including health pills, blood tests, and antidepressants and nothing has changed.

I look forward to a possible solution."

On 24 December, Dr B responded stating that he was "disappointed" that she was still experiencing pain. He suggested that they now try removing some or all of the bridges to see if that helped.

On 16 January 2008, Mrs A saw Dr B and discussed "what to try next". Dr B noted that he still considered that Mrs A had burning mouth syndrome, that her gums looked healthy and she was not reporting toothache, but that he was happy to take off a section of the bridge to see if that made any difference. They also discussed the possibility of allergies to the bonding metal, but Dr B noted that he had never experienced this before and would have expected widespread areas of reaction, which Mrs A was not experiencing.

On 1 February, Dr B sent Mrs A information on burning mouth syndrome. He also commented that the owner of the laboratory where the bridge work and crowns were made had advised him that they had no history of allergies to bonding metal, but agreed that replacing the bridge work with titanium or free alloy metal was advisable to eliminate this possibility.

On 4 February, Mrs A wrote to Dr B advising that she was reluctant to have the bridges removed because she was "anxious of the outcome". She also commented that she was surprised that he wanted to remove the crowns to eliminate the possibility of an allergy to a non-precious metal, as it was her understanding that hers were made of gold. She also expressed her concern "as whether or not my treatment was the right procedure for the initial problem".

On 15 February, Dr B responded to Mrs A's letter, reiterating his recommendation to remove a section of the bridge work to eliminate allergy as a cause of the pain. Dr B also commented that after all the "suffering" she had experienced "it is easy to forget

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that the only other initial treatment option would have been dentures and I still do not believe that would have been the best alternative".

On 27 February, Dr B saw Mrs A again to discuss her options. He recommended that he take off her bottom crowns and replace them with temporary crowns. Mrs A said that she would consider this option.

Mrs A paid approximately $28,000 for the treatment Dr B provided. She completed her payments on 5 March 2007.

Second opinion

In January 2008, Mrs A sought a second opinion from dentist Dr C. Following his assessment, Dr C noted that large numbers of Mrs A's teeth were joined together in the bridge work and that her bite was incorrect. He also queried whether Mrs A's pain might be associated with nickel sensitivity, the fact that a large number of her teeth were joined together, or food aggregation.

Dr C encouraged Mrs A to seek further opinions from another dentist, Dr D, and prosthodontist Dr E.

Third opinion

On 25 January 2008, Mrs A saw Dr D. Dr D advised that he took Mrs A's history and carried out a cursory oral examination. He noted a problem with Mrs A's bite on the left side, but no obvious periodontal issues, with "[g]ood to excellent oral hygiene". He also noted a low-grade inflammation of Mrs A's gums.

At the completion of his examination, Dr D considered whether Mrs A's pain might have been associated with a metal sensitivity.

Fourth opinion

On 17 September 2008, Mrs A saw Dr E. Dr E noted that Mrs A had been tested for nickel sensitivity with negative results, and that a non-precious alloy with nickel content had been used. At the completion of his assessment, Dr E recorded that Mrs A had a poor occlusion and "purple, boggy" gums. He considered that, despite the sensitivity test, Mrs A might have a possible nickel allergy. He recommended that her bridge work be re-done.

Apology and reimbursement

In March 2008 Mrs A contacted Dr G, a consumer affairs officer from the New Zealand Dental Association, to assist her in resolving her concerns with Dr B.

Dr B recalls being contacted by Dr G in March or April 2008 and discussing the treatment provided and the possible causes of Mrs A's pain. Dr B advised Dr G that he recommended removal of the bridges in order to correct the occlusion and eliminate the possibility of a metal allergy.

Dr G told Dr B that Mrs A had lost confidence in him and wanted to have her further treatment completed elsewhere. Dr B suggested that if the new dentist used the same laboratory they would not charge for the new work and he would be prepared to cover

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the cost of the surgeon's fees. However, Dr G told Dr B that Mrs A was unlikely to be happy with this arrangement and confirmed that she wanted a full refund. Dr B said he reluctantly agreed to provide Mrs A with a full refund. Dr B stated:

> "I was reluctant to agree to this as I felt I had provided excellent clinical and emotional support to [Mrs A] and whilst I accepted the bite was incorrect, felt that it was a genuine and (with hindsight) unavoidable error, given that the treatment was carried out under sedation when the patient was unable to give the required bite readings. I had accepted my responsibility and was prepared and confident of putting it right."

On 24 April 2008, Dr G sent a letter to Dr B advising that Mrs A had decided to accept his offer of a full reimbursement of $31,239.50.

On 16 May 2008, Dr B responded advising that his records showed that Mrs A had paid a total of $28,805 for her crown and bridge work, which he offered to repay.

On 23 May 2008, Dr B repaid Mrs A $28,805, with an apology for "the pain and suffering, both physical and emotional, that [she] has gone through".

Comment from Mrs A

Mrs A advised that since having the work done by Dr B she has suffered constant pain and feels angry about the care he provided. Having subsequently seen three other dentists in relation to her ongoing problems it is her belief that the work carried out by Dr B was both unnecessary and unprofessional. She believed that the crown and bridge work was manufactured with a gold component, not nickel as she has since found out.

Comment from Dr B

In Dr B's view, there are two aspects to Mrs A's pain. The first is related to her soft tissues, and he considers the pain to be caused by burning mouth syndrome. Dr B considered this to be her main problem. The second cause stems from an incorrect occlusion, which Dr B considers was an "unavoidable error" as a result of the surgery being carried out under general anaesthetic sedation and thus being unable to obtain bite readings. He comments that he recognised this early on and made a number of attempts to correct the occlusion.

Dr B stated that when requesting crowns from the laboratory he has always asked for "VMK" crowns, which is a generic prescription for porcelain fused to metal. He advised that he has never questioned the constituent elements of the metal. He also advised that he was unaware of any reported cases of nickel allergy and remains unconvinced that "this condition exists". He stated that nickel is still used in 70% of crowns worldwide. However, he now uses titanium as his main bonding metal in crown and bridge work.

Dr B stated that since receiving this complaint he has reviewed his complaints process and introduced a more comprehensive informed consent form. He also takes more oral photographs at each stage of the restorative process.

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Response to provisional opinion
Mrs A advised that although a significant time has lapsed since her dental treatment was completed, it is important to point out that there has been no change for the better and she has had to take leave from teaching until the end of the year.

In response to my provisional opinion, Dr B said that although he respected my opinion, he did not agree with it nor with any of the opinions or conclusions arrived at by my advisor. He provided no new information.

Opinion: Breach — Dr B

Information and informed consent
Mrs A went to see Dr B because she was experiencing pain in one of her teeth. Dr B was recommended to her by one of his colleagues, Dr F, who had children at the school where Mrs A worked. Because she could get an appointment immediately, Mrs A arranged to see him.

Following his examination, Dr B assessed Mrs A as having an "advanced periodontal condition". He discussed the need for treatment and outlined his recommendations, including treatment of the periodontal disease and extensive surgical restoration of her missing and decayed teeth.

Dr B had a duty to explain to Mrs A all of the options available, and the risks, benefits and costs of each. This was particularly important given the extent and the potential impact of the proposed treatment. This is in accordance with the Dental Council of New Zealand *Code of Practice: Informed Consent (2005)*, which states: "Information to be given … All relevant management options/alternatives with their probable effects and outcomes."

In his responses to HDC (dated 10 August and 3 September 2009) Dr B provided an account of the information he provided to Mrs A in relation to her treatment options. In particular, Dr B recalls that he provided Mrs A with a detailed explanation about her options to replace or restore her missing or decayed teeth, which included implants, fixed prosthodontics, removable prosthodontics or precision attachment prosthetics.

In contrast, Mrs A recalls being told only that she had periodontal disease and that she required crowns and bridging of all her teeth or they would fall out within two years. Mrs A recalls raising the possibility of dentures, but was told that her mouth was too small.

I note that the clinical records from 29 November state: "… Dr B gave options. (A) Do nothing and in future have dentures (B) crown and bridging all teeth. …" Furthermore, I note Dr B's statement in his letter dated 15 February 2008 to Mrs A in which he states that "it is easy to forget that the only other initial treatment option

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would have been dentures and I still do not believe that would have been the best alternative".

I accept that Dr B did discuss the option of dentures with Mrs A. However, his written statement detailing what was discussed with Mrs A was provided some three years after the discussions took place. When considering this, coupled with what was documented in the clinical records, I prefer Mrs A's account that he did not provide her with any other options other than full bridge and crown work or dentures, despite other options clearly being available to Dr B. I note that my expert advisor, Dr Tim Little, commented that he was surprised that no other options were discussed.

Dr B also had a duty to obtain Mrs A's informed consent before commencing treatment. The requirements for informed consent are set out in the Dental Council of New Zealand *Code of Practice: Informed Consent (2005)*, which states: "Where the person giving the consent is conscious and does not object, oral consent is sufficient for minor procedures, which include most services carried out by general practitioner surgeons." It goes on to state: "When in doubt about whether a procedure is major or minor, get written consent. In all situations keep careful, clear, written records."

While there is evidence that Dr B discussed some aspects of the proposed treatment with Mrs A, there is insufficient documentation that she provided informed consent for the treatment.

None of the "patient consent form for sedation" or "confidential health questionnaire" forms signed by Mrs A specify what the treatment was, with the exception of the one for "perio + general" dated 9 October 2006 and one for "crown prep". However, this form is not correctly dated.

Standard of care
Following his initial review, which included an oral examination and X-rays, Dr B concluded that Mrs A had advanced periodontal disease. He advised that he observed loss of bone and attachment around all of Mrs A's teeth, as well as large calculus (hardened plaque) deposits on most of the exposed roots. It was on this basis that Dr B recommended treatment.

Mrs A advised that while she had received dental treatment in the past she had never been advised that she had advanced periodontal disease.

Although Dr B has provided a detailed account of his examination findings in his response to HDC, they are not recorded in the clinical records. Given that Dr B's description comes some three years after his assessment, I question the accuracy of his recollection (I will comment further about the adequacy of his documentation).

Dr Little's opinion, following review of the existing X-rays taken at the start of treatment, was that generally Mrs A's bone loss (a feature of periodontal disease) was at the early stages with the exception of only a few teeth. Although Dr Little acknowledges that his opinion is made without the benefit of having reviewed any

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charting of pockets[11] or photos, his view is consistent with the view of Dr D, who had carried out a recent oral examination.

I note Dr Little's advice that the current protocol for periodontal treatment would normally involve deep scaling with root planning, followed by a comparison of pocketing and oral hygiene with initial charting. Surgery would then be considered for unresolved areas.

Given the lack of documentation, coupled with Dr Little's opinion and Dr D's more recent assessment findings, it appears that much of the treatment completed by Dr B may have been unnecessary.

Even if I accept that the treatment Dr B completed was indicated, I note that Dr Little has questioned the extent and quality of the work carried out. Dr Little disagrees with the formula Dr B used to conclude the number of abutments required, which he considers has placed the other teeth at risk of either periodontal problems or loss in the case of a bridge failing.

Furthermore, Dr Little questioned the necessity of the number of the crowns carried out. While Dr B advised that Mrs A made a decision to have all her remaining teeth crowned for cosmetic reasons (a point disputed by Mrs A, who says it was for health reasons), Dr Little considers that if this were the case, bleaching would have been a better option.

There is no dispute that as a result of Dr B's treatment Mrs A now has an incorrect occlusion. Dr B agrees that this is one aspect of her ongoing pain issues. The clinical records show that Dr B made attempts to adjust Mrs A's bite on 19 February 2007 and then again on 15 and 27 March. When Mrs A continued to experience problems, he gave her exercises for her jaw and made her a nightguard. He later recommended removing the bridge work.

As Dr B was clearly aware of Mrs A's malocclusion at the completion of treatment, he should have taken steps to address this before it became an issue. Dr B considered that the malocclusion was the result of an "unavoidable error" which was the result of the surgery being carried out under sedation and therefore being unable to obtain Mrs A's bite readings. However, carrying out this type of surgery under sedation is not an unusual situation. I note Dr Little's advice that the use of a facebow[12] would have helped the technician ensure good canine guidance and an accurate and balanced bite. I also note Dr Little's view that this malocclusion should have been dealt with much earlier. I am of the view that it should have been considered at the preliminary planning stage.

It appears that it is relatively rare for patients to experience allergies to non-precious metals used in crowns. Certainly Dr B cannot be held responsible if Mrs A developed a rare allergy. However, I would expect him to be aware of what metals were used in

[11] Charting of the amount of bone and tissue loss around the tooth.

[12] A facebow is a device used to measure the positions of the temporomandibular joints of a patient relative to the maxillary (upper) teeth.

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the materials he was using. That the laboratory form did not specify the constituents of the crown is not an excuse, particularly given how common the use of non-precious metals in porcelain fused to metal crowns appears to be (according to Dr B, in approximately 70% of crowns worldwide).

Documentation

Health professionals are required to keep accurate, clear, legible and contemporaneous clinical records. They are a record of the care provided to the patient and clinical decisions made, and enable other health professionals to provide coordinated care. Furthermore, as demonstrated in this case, records are important in verifying facts once a complaint has been made. I note Dr Little's view that Dr B's records are somewhat limited.

Baragwanath J stated in his decision in *Patient A v Nelson–Marlborough District Health Board*[13] that it is through the medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). In my view, this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Furthermore, the failure to keep adequate records is poor practice, affects continuity of care, and puts patients at real risk of harm.

Similarly, the Dental Council's *New Zealand Code of Practice: Patient Information and Records (2006)* also outlines the importance of recording a patient's treatment. It states:

> "1.1 The patient's treatment record is legally regarded as 'health information' and is an integral part of the provision of dental care. A record of each encounter with a patient will improve diagnosis and treatment planning and will also assist with efficient, safe and complete delivery of care considering the often chronic nature of dental disease. The treatment record will also assist another clinician in assuming that patient's care.
>
> 1.2 The treatment record may also form the basis of self protection in the event of a dispute associated with any treatment provided and it may also form the basis for some types of self monitoring or audit systems used in quality review systems."

Dr B's records are brief and, as mentioned earlier, do not record details of the various treatment options or discussions that he claims took place. Dr B has explained that other treatment plans were deleted once Mrs A had made a decision about which option she would take.

I find this hard to believe, particularly as Dr B clearly stated in his record of 29 November 2006 that he explained "both options at length". He does not mention discussion of any of the other options. In any case, even if I were to accept his

[13] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV-2003-204-14, 15 March 2005).

explanation, in my view deleting information from a patient's records is very poor practice and contrary to the relevant professional standards set out in the Dental Council's *Code of Practice: Patient information and records (2006).*[14] Furthermore, Dr B failed to obtain adequate written consent for surgery.

Conclusion

While Dr B maintains that he provided Mrs A with information about all the options available to her, there is no documentation to support this. Nor is there evidence that Dr B obtained adequate consent prior to treatment. As mentioned above, the Dental Council of New Zealand *Code of Practice: Informed consent* states that oral consent is sufficient for minor procedures only and "in all situations keep careful, clear, written records". I do not consider the procedures carried out on Mrs A were minor. Accordingly, I conclude that Dr B breached Rights 6(1)(b)[15] and 7(1)[16] of the Code of Health and Disability Services Consumers' Rights (the Code).

While it is difficult to make an accurate assessment of the state of Mrs A's teeth prior to treatment, the advice I have received suggests that the extent of the treatment performed was unnecessary. Even if I accept that such extensive treatment was indicated, it is clear that Dr B failed to carry out an adequate preliminary assessment, and the treatment that was performed was of a poor standard, which has resulted in ongoing problems for Mrs A due to a severe malocclusion. In conclusion, by failing to exercise reasonable care and skill in his assessment and treatment of Mrs A, Dr B breached Right 4(1)[17] of the Code.

In failing to maintain adequate documentation and deleting his proposed treatment plans, Dr B failed to comply with the relevant professional standards and also breached Right 4(2)[18] of the Code.

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[14] Standard 2.11 states: "Dentists or their staff **must** not alter or delete information recorded at an earlier date."

[15] "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including – … An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option."

[16] "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent …"

[17] "Every consumer has the right to have services provided with reasonable care and skill."

[18] "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Follow-up actions

- A copy of this report will be sent to the Dental Council of New Zealand, with a recommendation that it consider whether any further action is warranted.[19]

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the DHB, and it will be advised of Dr B's name.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the New Zealand Dental Association and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[19] The Dental Council is already aware of this complaint and has considered it in accordance with section 39 of the Health Practitioners Competence Assurance Act 2003.

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Appendix A: Independent dentistry advice to Commissioner

The following expert advice was obtained from dentist Dr Tim Little:

> "On reviewing the information presented to me which included reports from [Dr C], [Dr D], and [Dr E]. Also x-rays and models from [Dr C] and [Dr B's] notes and reports to Health and Disability [Commissioner].
>
> I note that there are two parts to the treatment that [Dr B] has undertaken on [Mrs A].
>
> 1. Periodontal
>
> Existing x-rays would imply that general bone levels at the start of [Dr B's] treatment were generally at an earlier stage of bone loss, with only a few advanced periodontal issues, mainly on 27 with moderate bone loss and on a few of the other posterior teeth. Not having any clinical charting of pockets prior to periodontal treatment and not having any photos makes it is hard to assess what the presenting situation was like. However I would find it hard to assess that [Mrs A] was going to lose all her teeth within 2 years due to this condition. Certainly assessment by other dentists, of [Mrs A's] oral hygiene and periodontal condition shows it to be fair. There is no periodontal charting at the end of the periodontal treatment to show what was achieved.
>
> The current protocol for periodontal treatment would normally involve deep scaling with root planning. This would be followed up comparing pocketing and oral hygiene with initial charting. Surgery may then be necessary for unresolved areas. Once again without charting it is very hard to assess the extent of the initial condition.
>
> 2. Crown and bridge work
>
> I found that the clinical notes differ considerably with [Dr B's] later comments as to what went on in treatment and that often these clinical notes are closer to what [Mrs A] remembers of treatment.
>
> 29/11/06 — [Dr B] discussed at length two options only with [Mrs A].
>
> Either leave her teeth and end up with dentures or crown or bridging of all teeth.
>
> — The notes say [Dr B] explained both options at length.
>
> — I was surprised other options were not given as 1 option implies that if nothing is done that [Mrs A] will lose all teeth.
>
> — There is no mention in the notes of wax ups being done.
>
> — In the clinical notes only one core build-up is mentioned for the 36 — does that mean all other teeth have original filling work under the crown or bridge

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work? It is difficult to ascertain this from the x-rays or notes. — There are no vitality tests for any of the teeth nor clear assessment of the root canal on 13 (no PA or comment on it) — very difficult to tell from panoramic x-ray, though it appears ok.

— It is hard to assess from the models what the current situation with the bite is, as they are not articulated. Going by the clinical assessment of the other dentists who assessed [Mrs A], there is obviously some serious problems, with heavy contact on the left hand side, no canine guidance nor contact on the right hand side.

— For such a big case I see no mention of a face bow being used to help with setting up the case so that the technician could provide good canine guidance and an accurate and balanced bite.

— The incorrect bite could cause considerable pain and induced extra stress on one or both of her TMJ [temporomandibular — jaw] joints.

— I would have expected this malocclusion to be dealt with much earlier when adjusting and reviewing in March 2007. The lack of contact or occlusion on the right hand side certainly would explain why [Mrs A] could not bite on the right hand side and probably why food stuck there.

During my practising life I have only had a very few patients who have possibly had a reaction to metals used in crown and bridge work. I have discussed this particular occurrence (reaction to metals in crowns) with other colleagues and they have had similar low numbers of problems. [Dr B] may have been wise, due to [Mrs A's] past history to ensure that precious metals were being used, but this sounds as though it has been a very unfortunate reaction to the metal. It does look more like an allergy than BMS. [The] lab sheet would have given the option of precious or non precious metals and [Dr B] should have known what was being used. The joining of many teeth together, to try and gain support offers many more problems than it solves. With large gaps to fill, there are better options such as implants or possibly a denture.

I would disagree with [Dr B's] formula for root areas of a bridge. What is very important is the state of the periodontal tissues of the abutments and the extent of the restorations existing on those teeth.

The extent of the bridging offers a number of potential problems.

— Eg The cantilever of one pontic to replace 16 (not 17 as charted) with abutments on 15, 14, 13, 12 and 11. I would choose no pontic and separate crowns if they were necessary. The cantilever could easily unseat one or more of the anterior crowns without the patient's knowledge and lead to a potential disaster.

— Margins not prepared with enough room to build up adequate porcelain without being bulky.

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- Failure of just one part eg: root canal in 13 (no post or core) may result in the loss of the whole bridge, and there is also potential for even greater loss of teeth.

- For a perio patient the cleaning of such bridges could lead to potential for disaster.

It is very difficult without photos to know what the lower incisors were like prior to being crowned, but normally they would be the last teeth to do full coverage VMK crowns. If colour was the main issue then bleaching would be a much better option and vastly less invasive (basic incisal length still the same). Veneers would have been an option if composite restorations had not been appropriate.

Both 36 and 37 look as though they could have been crowned separately leaving both 34 and 33 not needing preparations (don't know the mobility of 36, 37, 47 and 46).

Likewise with the gap of 45 and 44 only being approx 1/2 premolar in size a bridge 46–43 would have been more than adequate with a separate crown on 47 if necessary.

The quote for the treatment would be very difficult to work out exactly what was going to be done (eg: long span bridging) and for a lay person has no other written explanation of treatment options, outcomes and possible complications (eg: pain, root canal treatment, loss of teeth).

In conclusion it appears that [Dr B] had not given much or any information on the other treatment options … [and] the information given on the treatment done was limited.

[Dr B's] notes are somewhat limited in information compared to his later written statement where he remembers facts from up to 2 years previously. The extent of the bridgework coverage would seem excessive and I feel that it would put these teeth in real danger of either periodontal problems or loss due to failure of the bridges.

The incorrect occlusion is probably due to lack of preliminary planning (wax up) and in not using a face bow or like in the taking of the bite. This incorrect bite which hadn't been resolved over a period of time is almost certain to have caused a reasonable amount of [Mrs A's] after pain and discomfort.

The combination of these would leave me to believe that [Dr B] has not provided [Mrs A] with an appropriate standard of care, and this level of care is well below what you would expect."

Dr Little explained that, in his opinion, the standard of [Dr B's] dental treatment was moderately to severely below that expected by the profession.

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