Dental Service

Dentist, Dr B

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC00103)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This case concerns the information about orthodontic treatment provided to a consumer by her dentist. The woman sought treatment to correct the alignment of her teeth, which were "wonky" and off-centre because she was naturally missing her top right incisor (tooth 12).

2. The woman underwent treatment with braces and an upper fixed growth guiding appliance (FGA). After six months of treatment, a gap opened where tooth 12 was meant to be. The woman was not informed by her dentist that this gap would be opened or the options to fill it (a dental implant, a Maryland bridge, or cosmetic shaping of the adjacent tooth). She stated: "[H]ad I known the full extent of the treatment, and the cost involved in having an implant installed, I would never have proceeded with the treatment."

Findings

3. The Deputy Commissioner found that the dentist did not provide the woman with information about the fact that a gap would be opened by the FGA at the tooth 12 space, and the options and costs of a Maryland bridge or an implant to fill the space. The Deputy Commissioner considered that this was information that should have been provided prior to commencing treatment. Accordingly, the Deputy Commissioner found the dentist in breach of Right 6(1)(b) of the Code.

4. The Deputy Commissioner also found the dentist in breach of Right 7(1) of the Code, as without this information, the woman was not in a position to make informed choices about her orthodontic treatment.

5. The Deputy Commissioner considered that the dental service did not breach the Code.

Recommendations

6. The Deputy Commissioner recommended that the dentist apologise to the woman, provide evidence of a system for documenting treatment options clearly in letters to consumers, reflect on how the letters could be written using more plain English, and review the Dental Council of New Zealand's Informed Consent Practice Standard.

7. The Deputy Commissioner recommended that the dental service use this case as a basis for a staff education session, and provide evidence to HDC of the steps it is taking to ensure that treatment options and costs are laid out clearly in its letters to consumers.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by the dental service and dentist Dr B.[1] The following issues were identified for investigation:

- *Whether the dental service provided Ms A with an appropriate standard of care in 2018–2019.*
- *Whether Dr B provided Ms A with an appropriate standard of care in 2018–2019.*

9. This report is the opinion of Deputy Commissioner Deborah James, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dental service	Provider/dental clinic
Dr B	Provider/dentist

Also mentioned in this report:

Ms C	Practice treatment coordinator

11. Independent expert advice was obtained from Dr Donald Schwass (Appendix A).

Information gathered during investigation

Background

12. On 17 September 2018, Ms A presented to Dr B at the dental service[2] for an orthodontic evaluation. Ms A told HDC that she is missing her top right incisor (tooth 12) naturally, which has caused her teeth to move over and fill that space, resulting in "very wonky top teeth". Ms A was seeking orthodontic treatment to centre the midline of her teeth and match her top and bottom bite.

13. A plan was made for Ms A to undergo a course of orthodontics using an upper fixed growth guiding appliance (FGA) and upper and lower orthodontic appliances (bands and brackets).[3]

[1] Dr B has undertaken further training in the area of orthodontics to offer orthodontic services.
[2] The clinic is operated by the dental service. Dr B is a contractor to the dental service via a company of which she is the sole director. The contract between the company and the dental service specifies that the contractor will "comply with the Code of Health and Disability Services Consumers' Rights" and "carry out the responsibilities for the provision of the services … in a timely, efficient, honest, and diligent manner consistent with good professional practices and standards".
[3] Commonly referred to as "braces".

14. On 1 November 2018, Ms A was sent an information pack including a post record consultation (PRC) letter from Dr B outlining the above plan. Ms A was quoted $7,670.00 for the total treatment plan, "inclusive of all appointments, retainers, 1 year follow-up to retention, all adjunctive training tools and devices as well as GST".

15. Ms A signed a treatment agreement form, which confirmed the above cost and documented the treatment as being "orthodontic and myofunctional treatment". Ms A also signed a generic informed consent form and retention agreement form, and was provided with an information sheet setting out the policy for orthodontics. This information sheet states: "[T]here should be no other expenses unless the patient should break an arch wire or a band."

16. The dental service explained that the PRC letter is the source of specific individualised information for each patient (rather than the informed consent form/retention agreement form). It stated that the letter is put together by the treating dentist after the initial consultation.

17. The orthodontic treatment commenced on 7 December 2018. After six months of treatment, Ms A's teeth had moved and a gap had developed where her missing tooth 12 was meant to be. She asked Dr B how the gap in her teeth would be addressed, and was advised that she would require a fake tooth.

18. Ms A told HDC:

> "I proceeded to have a meeting with [the treatment coordinator at the dental service] and told her that I hadn't been ever informed of this plan and that it had not been discussed with me or included in my overall treatment plan booklet. She told me that this was 'a f*** up on their part' and that she had 'miscounted my teeth'. She then told me she would meet with [Dr B] and look into my options and their cost."

19. Ms A had a further meeting with the treatment coordinator at the dental service, and was advised that her options were to have no dental implant inserted but cosmetic bonding/shaping of the teeth; a semi-permanent implant (a Maryland Bridge) that would cost $3,000 but would be discounted to $726.50 by the dental service; or a permanent dental implant, which would cost $8,000.

20. Ms A told HDC:

> "In my mind the best option was obviously the permanent implant. I am addressing my teeth now and didn't want to have to keep paying thousands of dollars for a temporary solution, but an additional $8k (on top of the $7600 braces) is something that I would have needed time to consider before signing and agreeing to go with the dental service."

21. Ms A said: "[H]ad I known the full extent of the treatment, and the cost involved in having an implant installed, I would never have proceeded with the treatment."

Recollections of what was discussed

22. Ms A told HDC that during the initial consultation on 17 September 2018, Dr B never discussed with her that the outcome of correcting the alignment of her teeth would involve an implant or a fake tooth. Ms A said that she was "shocked" when she was told this six months into treatment.

23. In Dr B's first response to HDC, she stated that during the initial consultation she discussed with Ms A her missing tooth as well as "some treatment options available" for the management of this as per her clinical notes (which I note do not mention the possibility of a bridge or an implant). However, Dr B acknowledged that she neglected to present that part of the information they discussed into the written treatment plan (the PRC).

24. In Dr B's second response to HDC, she stated that at the initial consultation, a brief discussion took place regarding options for keeping the canine tooth in place with cosmetic bonding (where resin is applied to teeth to change their shape), or orthodontically opening the space and replacing tooth 12 with either a Maryland bridge or an implant. She said that at that time, no detailed discussion took place around implant treatment, as that was best discussed with an oral surgeon.

25. In Dr B's third response to HDC, she stated:

> "The discussion covered an implant as a means of replacing the missing tooth, or protracting the other teeth towards the central incisor tooth in order to close the space … As the discussions seemed to follow the path of a lower maintenance treatment option, the orthodontic treatment plan presented before the start of treatment did not include formal implant information or diagnostics, with the assumption that the protraction method was going to be used."

Documentation

26. The clinical notes for the initial consultation mention a "[c]ongenitally missing tooth 12" and note the proposed treatment plan as FGA, brackets and bands, as well as whitening and conservative bonding to change the shape of tooth 13. These notes do not mention the possibility of an implant being needed in order to fill the gap where tooth 12 would usually be.

27. The PRC letter outlined the findings of the consultation, identified the factors with Ms A's teeth that fell outside the range of "what would be considered normal", and noted the recommended treatment as an FGA and upper and lower brackets. The letter does not mention Ms A's missing tooth or any options for treatment of this. Ms A highlighted that nowhere in the PRC did it explain that a gap would be created in her mouth with the FGA, and that an implant or a fake tooth would be required.

28. The dental service told HDC that it would have expected the treatment options to have been discussed formally with Ms A and the options set out in her individualised PRC letter.

29. The records from 5 April 2019, when Ms A raised her concerns about needing an implant with the treatment coordinator, state:

> "[Ms A] expressed her surprise and somewhat disappointment … the news of opening the [tooth 12] space and filling it was a shock. [Dr B] did an excellent job explain[ing] this and the benefits of doing this; however, it is a big error this was missed in the PRC report and presentation."

30. With respect to discounting the price of the Maryland bridge for Ms A, the records of 5 April 2019 state, "[Dr B] has agreed we wear this [one]," and explain that the dental service could offer the bridge at cost price.

Subsequent events

31. An appointment for 4 July 2019 with another dentist at the dental service who works alongside an oral surgeon was arranged for Ms A. The purpose of the appointment was to discuss Ms A's preferred option of a permanent implant.

32. On 5 July 2019, Dr B signed a Dental Injury Claim form for ACC, which was submitted by Ms A. The form recorded what happened as "Miscommunication/misinformed by dentist about work happening to my teeth." However, ACC did not accept the claim, as it did not relate to a physical injury as a result of an accident.

33. Dr B stated that as an implant replacement was discussed informally at the outset, but not formally written into a restorative treatment plan, she offered "to discount the implant crown for Ms A in good faith, and also apologised for the misunderstanding, as the information regarding an implant was not intentionally omitted".

Further comment

34. Ms A told HDC: "I have been left in a very stressful and tough situation where my teeth are progressing, and I have no idea who is responsible for this oversight and cost to come …"

Responses to provisional report

35. Ms A, Dr B, and the dental service were given the opportunity to comment on relevant sections of the provisional report. None of the parties had any comments to make.

Opinion: Dr B — breach

Provision of information and informed consent

36. Dr B and Ms A have presented different versions of what was discussed about Ms A's treatment options at the initial consultation on 17 September 2018.

37. Ms A told HDC that during the initial consultation, Dr B never discussed with her that the outcome of correcting the alignment of her teeth would involve an implant or a fake tooth. Dr B maintains that there was a brief discussion of the options for the tooth 12 space, but said that at that time no detailed discussion took place around implant treatment.

38. The clinical records for the initial consultation do not record that there was any discussion about the possible options other than conservative bonding. The subsequent PRC letter does not mention Ms A's missing tooth or any options or costs for treatment of this, and it does not explain that a gap would be created with the FGA for an implant or a fake tooth. Ms A proceeded with treatment at an expected total cost of $7,670.

39. Six months into the treatment with the FGA, it is recorded in the dental service clinical notes that "the news of opening the [tooth 12] space and filling it was a shock" to Ms A. It is documented that this was "a big error this was missed in the PRC report and presentation". Ms A told HDC that if she had known the full extent of the treatment and the costs involved, she never would have proceeded.

40. I have considered the different versions of events as well as the written records available both at the outset and once Ms A queried the gap in her teeth. It is my view that it is more likely than not that the fact that a gap would be opened by the FGA at the tooth 12 space, and the options and costs of a Maryland bridge or an implant to fill that space, were not discussed with Ms A at the initial consultation with Dr B.

41. Dr B has provided three slightly different recollections of what was discussed, and the PRC letter clearly does not record any options or potential further costs related to the tooth 12 space and the options to fill it. Further, the subsequent records (both the dental service clinical records and the ACC dental injury claim form) show acknowledgement that there had been an oversight in presenting the treatment options to Ms A. I also note the advice of my expert advisor, Dr Donald Schwass, that it would have been reasonable to have expected Dr B to inform the treatment coordinator of Ms A's treatment if it involved space management, and yet there is no evidence that such a discussion occurred. Similarly, there is no evidence of any planning for an implant.

42. I further note that Ms A's recollection of events has been clear and consistent.

43. In my view, the evidence overwhelmingly supports Ms A's account that she was not adequately informed.

44. Dr Schwass advised that it is common for presenting dental problems to be able to be addressed through a range of options. He stated:

> "Considering that for the most part, dentistry in New Zealand is paid for privately, it is important that informed consent for dental procedures should always involve a full and frank discussion of the costs for the various options, so that the patient can be guided to make an informed decision about which treatment direction to take."

45. Dr Schwass noted that decisions regarding treatment direction are best made without pressure before treatment commences. I agree with this, and I consider that by the time Ms A was aware of her options, she felt obliged to continue with the treatment because it was already well underway.

46. Regarding the information that should have been provided to Ms A at the outset, Dr Schwass stated:

> "As a registered general dental practitioner, and as someone offering orthodontic treatment, it would have been reasonable to expect that [Dr B] should have been able to at least speak in general terms about the risks and considerations for implant therapy, along with providing at least a ballpark guide to the range of expected costs associated with implant treatment."

47. Dr Schwass commented on the complexities of placing implants in the upper lateral incisor space and stated that in Ms A's case, placing an implant there would require careful planning and thought before confirming whether this was possible. He stated:

> "Ideally information about the potential complexity of implant placement should have been provided to [Ms A] at the outset, along with conducting as much preliminary planning as possible to estimate the likelihood of success … [I]t is apparent that almost certainly the matter of implant placement was not considered to the detail appropriate to the complexity of the case."

48. Dr Schwass advised that if an implant at the tooth 12 site was not discussed at all with Ms A at the start of treatment, this would clearly represent an oversight, departing from what might be considered a reasonable standard of care. He advised that in this situation:

> "Considering that the patient was not fully informed until already committed to treatment and part way through delivery of care, and that the financial implications of this oversight are large (in part due to the patient's desire to seek a more permanent solution), such a departure should be considered as being in the moderate to severe category, departing well away from an acceptable standard of care."

49. I accept Dr Schwass's advice. As I have set out above, I find it more likely than not that at the outset, Dr B did not provide Ms A with information about the fact that a gap would be opened by the FGA at the tooth 12 space, and the options and costs of a Maryland bridge or an implant to fill that space. In my view, this is information that Dr B should have provided to Ms A.

50. Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights (the Code) states that "[e]very 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 the costs of each option". In my view, Dr B did not provide information that a consumer in Ms A's circumstances would expect to receive before commencing treatment, and therefore I find that Dr B breached Right 6(1)(b) of the Code.

51. It follows that Dr B also breached Right 7(1) of the Code, which states that "[s]ervices may be provided to a consumer only if that consumer makes an informed choice and gives informed consent". By failing to give Ms A an explanation of the options available and their costs, Ms A was not in a position to make informed choices about her orthodontic treatment.

Language used in PRC letter

52. Dr Schwass commented that some of the dental clinical findings and information provided to Ms A at the beginning of her treatment used "distinctly specialist dental terminology which a lay person could typically not be expected to understand". I agree with Dr Schwass's view that this would not be helpful for ensuring effective communication.

53. I have asked Dr B to reflect on this comment and consider how she may present her PRC letters using more plain English in future.

Opinion: Dental service — no breach

54. As a healthcare provider, the dental service is responsible for providing services that comply with the Code. In this case, I consider that Dr B's errors were individual failures on her part, and do not indicate broader systems or organisational issues at the dental service. I therefore do not consider that the dental service breached the Code.

Changes made since events

55. The dental service has made some updates to its generic informed consent form, and it now provides only the "wear and tear" instructions that are relevant to the individual treatment.

56. The dental service told HDC that it will take more care in discussing risks and uncertainties in regard to implants. It stated that if a patient would like to investigate the option of implants further, it will recommend consultations with an oral surgeon before treatment commences.

57. The dental service said that it will ensure that treatment options are laid out clearly in the PRC letters.

Recommendations

58. I recommend that Dr B:

a) Provide a written apology to Ms A for the issues set out in this report. The apology should be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

b) Provide evidence to HDC, within three months of the date of this report, that she has in place a system for ensuring that all treatment options and costs are discussed with patients and set out clearly in the PRC letter. In this regard, Dr B should consider Dr

Schwass's comment that a clinician should have in place "a process for double checking to ensure that they have covered off everything of importance requiring consideration that will in any way impact on the patient".

c) Reflect on how her PRC letters could be written using more plain English, taking into account Dr Schwass's comment that a lay person could not be expected to understand complex dental terminology in the PRC letter. Confirmation that this reflection has been undertaken should be provided to HDC within three months of the date of this report.

d) Review the Dental Council of New Zealand's Informed Consent Practice Standard,[4] and confirm to HDC that she has done this, within three months of the date of this report.

59. I recommend that the dental service:

a) Use this case as the basis for a staff training session on the importance of ensuring that all treatment options and any further costs are discussed with patients and set out clearly in the PRC letter as part of the informed consent process. Confirmation that this training has occurred should be provided to HDC within three months of the date of this report.

b) Provide evidence to HDC, within three months of the date of this report, of the steps it is taking to ensure that treatment options and costs are laid out clearly in the PRC letter (as referenced in paragraph 57).

Follow-up actions

60. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Dental Council of New Zealand, and it will be advised of Dr B's name in covering correspondence.

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

[4] Accessible at: https://dcnz.org.nz/assets/Uploads/Consultations/2017/Informed-consent-practice-standard-consultation/Informed-consent-practice-standard-May18.pdf

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from Dr Donald Schwass:

"I have been asked to advise the commissioner whether [Ms A] received an appropriate standard of care from [Dr B].

I have read and agree to follow the Commissioner's guidelines for Independent Advisors.

I am the Clinical Director for the Faculty of Dentistry, University of Otago. I hold specialist registration with the Dental Council of New Zealand as a Prosthodontist. My qualifications are BSc, BDS (with distinction) DClinDent (Prosthodontics).

I have had 17 years of general dental practice experience (for 14 years I owned and operated a group practice employing other dentists and hygienists) and 1 year of hospital dental practice. Following completion of a clinical doctorate in 2009, for the last eleven years I have been employed as a specialist Prosthodontist at the Faculty of Dentistry, University of Otago.

I am a consultant for the Dental Council of New Zealand, past Faculty coordinator for Dental Council competence assessment and retraining for practitioners, and an examiner for the NZDREX examinations since 2002. Historically I was a complaints assessor for the Dental Council prior to establishment of the current competence framework. I am also a consultant for the Accident Compensation Commission (ACC) and the Faculty ACC liaison officer.

Information reviewed

1. Letter of complaint dated 13 January 2020
2. [Dr B's] response dated 7 February 2020
3. Clinical records from [the dental service] covering the period September 2018 to January 2020

[Dr B] (General Dental Practitioner) from [the dental service] provided dental care for [Ms A]. [The dental service] where this treatment was provided offers patients orthodontic treatment as well as general dentistry. Orthodontics is not considered part of the core scope of dentistry as it is not part of the Bachelor of Dental Surgery curriculum, but it is considered acceptable for practitioners who have received appropriate training in Orthodontics to offer Orthodontic services for their patients. General dental practitioners who elect to provide such specialist services could be expected to comply to similar standards of care as would be expected within the scope of a specialist orthodontist or prosthodontist where relevant, providing similar services.

Initially [Ms A] attended [Dr B] as she was interested in improving her smile. At time of presentation [Ms A] had a congenitally missing upper right lateral incisor tooth 12 and crowded lower anterior teeth.

Following initial consultation when [Ms A] signed up to proceed with treatment, [Ms A] was presented with what appear to have been a series of standardized generic information and consent forms, which [Ms A] duly signed. Signed forms included:

A General Information Sheet which explained about payment expectations, timing of what the practice delivers, appointment scheduling, and expectations during and following orthodontic treatment.

An 'Informed Consent' form offered information regarding the risks and limitations of orthopaedic, orthodontic and myofunctional treatment.

A 'Retention Agreement' discussed expectations regarding wearing of retaining appliances following orthodontic treatment to minimize relapse.

A 'Treatment Agreement' which laid out the full cost of proposed treatment $7670, with a minimum deposit of $1000 required, and 18 monthly payments of $371. The treatment agreement appeared to be customised and restricted to the provision of orthodontic treatment, specifically mentioning that the fee estimated did not include 'the cost of original records taken, any general dentistry, fillings, crowns, veneers, implants, root canals, cleanings, radiographs, extractions, or examinations for cavities etc.'

[Ms A] was provided with a booklet containing detailed measurements of her mouth, findings, and details about what treatment was proposed, along with a copy of the quote for orthodontics and payment plan.

The treatment [Ms A] subsequently underwent involved a course of orthodontics using an upper fixed growth guiding appliance (FGA) and lower fixed orthodontic brackets commencing on 7th December 2018, followed by upper fixed orthodontic bracket appliances in March 2019 to correct her malocclusion.

[Ms A] alleges that she was not fully informed about the impact of undergoing orthodontics to straighten her teeth and realign her upper teeth to restore her midline. After 5–6 months of wearing the fixed growth appliance [Ms A] noticed a lot of space opening up on both sides of her upper jaw, which caused her to ask [Dr B] about how these spaces were to be managed. [Ms A] was told that they were making a space for her missing lateral incisor and that a 'dummy tooth' would be connected to the braces once they were finished with moving her front teeth, and that on completion of orthodontic treatment a 'dummy tooth' would be put on her retainer until she got an implant put in.

[Ms A] claims that she had not realised that this was what they were doing with the space, so she asked [Dr B] how much an implant would cost and was referred to a person called [Ms C].

[Ms A] proceeded to meet with [Ms C], when she was told that the practice had overlooked including implant treatment as part of the overall care plan for [Ms A]. [Ms C] indicated that she would meet with [Dr B] to consider options and costings for [Ms A].

[Ms A] returned on another occasion for a further meeting with [Ms C] where she was informed of her options which included:

> A Maryland bridge, considered a 'temporary option' with a lifespan of about 10 years, costing $3000, discounted to $726.50 in view of the admitted error made by [the dental service].
>
> An Implant crown, considered a more permanent solution, costing $400–500 for diagnostic tests, $5000 for surgery to place an implant fixture, and $2500 for implant crown placement, reaching a grand total of $8000.

[Ms A] maintains that she was never made aware of these additional expenses at the time she signed up for treatment, and that had she been aware of the full extent of costs she would not have signed up to commence treatment at all. However, by the time [Ms A] found out she had already paid a deposit for the orthodontics and was already more than 5 months into treatment with spaces created.

[Ms A] understood that an implant was the better option for space management, so asked whether [the dental service] could offer her a discount. [Ms C] advised any discount would be limited to the prosthetic part of treatment such that the implant would still cost at least $6000 as surgical costs are incurred with another provider.

After being directed by the Citizens Advice Bureau to the New Zealand Dental Association, [Ms A] was advised to lodge an ACC claim. [The dental service] subsequently lodged an ACC claim on [Ms A's] behalf seeking compensation for the implant treatment, but [Ms A's] claim was declined due to insufficient information provided. ACC recommended resubmission with a more detailed explanation but to date [the dental service] have failed to progress this.

Reviewing the electronic treatment notes entered on 5/4/19 by [Ms C] and 30/4/19 by […] at the practice, it is clear that [Ms C] and [Dr B] felt terrible and apologetic about the situation of overlooking explaining to [Ms A] about management of the 12 edentulous space.

In contrast to this, in her letter to HDC regarding this matter, [Dr B] maintains that she had discussed the missing tooth 12 and options for restoring at time of original consultation, although it is not clear that implants were discussed fully until March 2019 when [Ms A] enquired about managing the gap. However, nothing referring to implant treatment, the cost or the potential complexities of implant treatment was provided to [Ms A] in writing at time of consultation initially.

For implant placement the proposed site for fixture placement must have adequate bone height, width and volume in order for a predictable solution to be achieved. This is normally confirmed by conducting a 3-dimensional CBCT (cone beam computer tomography) scan of the proposed site. For best success, implant placement should be prosthetically driven. In other words, the desired coronal restoration position and shape determines where the fixture needs to be placed.

In situations where teeth are congenitally missing and space is subsequently made for a prosthetic solution, it is not uncommon for bone to be deficient in the proposed site. When teeth are congenitally missing the alveolar bone fails to develop to the same extent as where alveolar bone is normally associated with the eruption of teeth. In some cases, this can be managed by considering an autogenous bone graft from a donor site elsewhere in the body, however, implants placed into grafted bone sites can sometimes be associated with lower survival and success rates. In situations where bone height is missing, generally this cannot be predictably replaced by grafting due to subsequent high risk of resorption and re-modelling.

Upper lateral incisors are the smallest tooth in the upper arch, such that the mesio-distal (front to back) space width for implant placement is sometimes compromised, requiring placement of smaller than ideal implant sizes with respect to the forces that implants can be exposed to. In order to successfully place an implant fixture into any space that has been opened up by orthodontics, it is important to ensure that the roots are angulated at least vertically, or away from the edentulous space to ensure sufficient space for the implant fixture allowing a safe distance in all directions away from root surfaces.

These considerations inform that implant placement in [Ms A's] case requires careful planning and thought, before confirming whether possible. This was recognized by Dr […] when [Dr B] consulted him on 1/5/19 when he was quoted in the patient record as stating that 'there is a bit to consider as certain teeth are better candidates for implants due to load and space. He would need to assess the case'.

Ideally information about the potential complexity of implant placement should have been provided to [Ms A] at the outset, along with conducting as much preliminary planning as possible to estimate the likelihood of success.

Although it seems to be a matter of conjecture as to whether implants were discussed as a solution for replacing the congenitally missing upper right incisor tooth 12 when [Ms A] first engaged in a course of care, it is apparent that almost certainly the matter of implant placement was not considered to the detail appropriate to the complexity of the case.

[Dr B] and staff at [the dental service] did attempt to remediate the situation that unfolded somewhat 'after the effect' but this could not make up for not fully informing the patient initially.

It is common for presenting dental problems to be able to be addressed through a range of options. Considering that for the most part, dentistry in New Zealand is paid for privately, it is important that informed consent for dental procedures should always involve a full and frank discussion of the costs for the various options, so that the patient can be guided to make an informed decision about which treatment direction to take. Best practice typically involves backing this information up by confirming it in writing. I note that [the dental service] follows a detailed informed consent process when providing Orthodontic treatment, but in [Ms A's] case this did not appear to extend to

prosthetic management of the edentulous space re-created by treatment despite the very significant costs associated with the various options. It is thus no surprise that [Ms A] was unhappy and surprised when part-way through treatment she was advised of overlooked details. For informed consent to be valid, the proposed procedures should be explained in a way that the patient understands, which often informs the need to provide customised information specific to that patient case rather than a generic one size fits all solution. Although informed consent provided for [Ms A] regarding orthodontic treatment was comprehensive, some of the clinical findings and information provided to her in the booklet she was presented with used distinctly specialist dental terminology which a lay person could typically not be expected to understand. This certainly would not be helpful for ensuring effective communication. It is not clear from the material provided whether or not the orthodontic consenting information is customised in any way or part of a standard generic format.

Summary

Based on these findings I am led to draw the following conclusions:

If we were to assume that an implant at the 12 site was discussed with the patient at the start of treatment, there is no written evidence to support that this occurred, or that the complexity of implant placement into sites where teeth have been congenitally missing has been considered or discussed. Such lack of documentation would likely lead to communication problems where the patient feels insufficiently informed of the risks and issues. **Such a situation could be considered a minor departure from accepted practice**.

If, on the other hand, we were to assume that an implant at the 12 site was not discussed with the patient at the start of treatment at all, this would clearly represent an oversight departing from what might be considered a reasonable standard of care. It is likely this was an accidental omission, perhaps influenced by the complex orthodontic component of care also being offered. Considering that the patient was not fully informed until already committed to treatment and part way through delivery of care, and that the financial implications of this oversight are large (in part due to the patient's desire to seek a more permanent solution), **such a departure should be considered as being in the moderate to severe category, departing well away from an acceptable standard of care**.

Where general dental practitioners become involved in providing treatment which falls into what might be considered specialist scopes, it would be reasonable to expect that the clinician's work would be assessed by specialist peers at the level of specialist standards. Omitting to provide details associated with a complex and significant part of treatment would likely be frowned upon by specialist peers.

In order to prevent a similar occurrence occurring again, the practitioner involved is encouraged to take a more holistic approach to the patient's treatment needs, considering the full range of presenting patient problems, rather than primarily focusing on a particular specialist part of care, namely orthodontics. Before presenting options to their patients, the dental clinician is encouraged to have a process for double

checking to ensure that they have covered off everything of importance requiring consideration that will in any way impact on the patient.

The practitioner should be encouraged to develop informed consent information that is specifically customized to the patient's individual spectrum of presenting conditions and needs, supported in writing with an itemised estimate of options. Decisions regarding treatment direction are best made without pressure before treatment commences, whereas in this situation the patient felt cornered because treatment was already well underway.

Dr Don Schwass
Specialist Prosthodontist"

The following further advice was received from Dr Schwass:

"I have reviewed the following additional material provided:

1. Letter addressed to [HDC] from [Dr B] (undated) providing further requested information
2. Letter addressed to [HDC] from [Ms C] dated 23/11/20
3. Letter written by [Ms A] (undated) responding to [Dr B's] position statement
4. Letter addressed to [HDC] from [the Directors of the dental service]
5. ACC Dental Treatment Injury Claim form
6. Letter written by [Dr B], dated 30/01/20
7. Patient information material
8. Email sent to [HDC] by [Dr B].

It is clear that there is disagreement between [Ms A] (patient) and [Dr B] (Treatment provider) about whether informed consent was obtained with respect to management of [Ms A's] congenitally missing upper right lateral incisor tooth 12.

[Dr B] maintains that she discussed this aspect of treatment with [Ms A], including options to either close the space held by this tooth, or to open it up and replace the missing tooth with a bridge or implant. However, no formal record of this discussion was made in [Ms A's] treatment records to back this up.

On the other hand, [Ms A] is adamant that placement of an implant was never discussed with her at the outset when proposing treatment to correct her malocclusion. [Ms A] indicated expressing confusion part way through treatment when she began to notice a space opening up where the missing 12 would have been, and that this is when she can recall tooth replacement for 12 first being mentioned. Given [Ms A's] shocked reaction to the additional $8000 cost estimated for an implant ([Ms A's] preference for replacement) which was over and above the $7670 estimated cost for orthodontics, it seems unlikely that the cost was adequately discussed at the time when treatment costs were originally estimated. For informed consent to be valid, necessarily the patient

must have a good appreciation of the options available to them and the associated costs agreed to.

According to [Ms A], at the time when she became aware of additional costs, [Ms C] (Practice treatment coordinator) was very apologetic, stating with coarse-language that it was an error on the practice's behalf and that they had 'miscounted my teeth'. It is reasonable to expect that the treating clinician, [Dr B] would have informed the practice treatment coordinator of [Ms A's] treatment if involving space management (bridge or implant) from the outset. Clearly this was not the case.

The Directors of [the dental service] have indicated that changes have been made to patient consent processes in the practice which should reduce the likelihood of a similar event occurring again for another patient. This includes recommending patients have a consultation with an oral surgeon before orthodontic treatment starts to discuss implant options if they are envisaged, including mention of risks and uncertainties which often surround implant therapy.

Further the practice has offered [Dr B] some assistance by allowing her to reimburse the practice slowly for the cost of implant or bridgework provided to remedy the situation for [Ms A].

The Directors mention that [Dr B] has been very apologetic for her mistake of failing to document discussions with the patient by way of including in the treatment confirmation letter given to the patient. However, this was not reflected in the letter that [Dr B] provided where no mention was made of any error.

[Dr B] said that although the option of an implant was mentioned for the 12 space, detailed discussion of implant treatment did not take place because it was an orthodontic consultation and that the complexities of implant treatment would best be discussed with an Oral Surgeon because this was not her area of expertise. However, referral to an Oral Surgeon for consultation was not facilitated at this stage. Nevertheless, as a registered general dental practitioner, and as someone offering orthodontic treatment, it would have been reasonable to expect that [Dr B] should have been able to at least speak in general terms about the risks and considerations for implant therapy, along with providing at least a ballpark guide to the range of expected costs associated with implant treatment.

Overall, I find that the additional information provided has not materially changed my findings or opinion.

As previously stated, **if we were to assume that an implant at the 12 site was discussed with the patient at the start of treatment**, there is no written evidence to support that this occurred, or that the complexity of implant placement into sites where teeth have been congenitally missing has been considered or discussed. Such lack of documentation would likely lead to communication problems where the patient feels insufficiently informed of the risks and issues. **Such a situation could be considered a minor departure from accepted practice.**

If, on the other hand, we were to assume that an implant at the 12 site was not discussed with the patient at the start of treatment at all, this would clearly represent an oversight departing from what might be considered a reasonable standard of care. It is likely this was an accidental omission, perhaps influenced by the complex orthodontic component of care also being offered. Considering that the patient was not fully informed until already committed to treatment and part way through delivery of care, and that the financial implications of this oversight are large (in part due to the patient's desire to seek a more permanent solution), **such a departure should be considered as being in the moderate to severe category, departing well away from an acceptable standard of care**.

Yours sincerely

Dr Don Schwass
Specialist Prosthodontist"