Dr B, Dentist

A Report by the

Health and Disability Commissioner

(Case 03HDC14244)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider/Dentist
Dr C	Dentist
Ms D	Dr B's chair-side assistant

Complaint

On 24 September 2003 the Commissioner received a complaint from Mrs A about the dental services provided to her by Dr B. The following issue was identified for investigation:

Whether Dr B provided services of an appropriate standard to Mrs A on 25 August 2003. In particular:

- *whether the information Dr B provided to Mrs A, prior to treatment, was adequate and appropriate;*
- *whether Dr B obtained Mrs A's consent to the intended procedure, prior to initiating treatment;*
- *whether the extraction Dr B performed was appropriate;*
- *whether Dr B acted appropriately in response to Mrs A's request that he discontinue treatment; and*
- *whether the information Dr B provided to Mrs A about the consumption of alcohol while using the medication he had prescribed was appropriate.*

An investigation was commenced on 14 November 2003.

Information reviewed

- Information from Mrs A
- Information from Dr B, including
  - post dental treatment instructions
  - Dr B's clinical notes
- Information from Dr C, including
  - an X-ray of tooth 25, taken in September 2002
- Information from Ms D

Independent expert advice was obtained from Dr Andrea Cayford, dentist.

Information gathered during investigation

Appointment and examination
On 25 August 2003, Mrs A sought treatment from her dentist, Dr C, for a broken upper left premolar, tooth 25. Dr C had restored this root-filled tooth with two pins and amalgam a month previously. Mrs A said that after the tooth broke, on 22 August, she could see the top of the gum, with a little bit of tooth showing from the gum and the pin sticking out. The pin dug into her cheek at night.

As Dr C was on leave and unavailable for a dental consultation until 1 September 2003, Mrs A was booked for an emergency appointment on 25 August with Dr B. Dr B shares a surgery with Dr C. Dr B was assisted by Ms D, his chair-side assistant. The consultation took one hour and 20 minutes.

Mrs A said that Dr B did not introduce himself to her. Dr B stated that he greeted her pleasantly. Mrs A showed Dr B her fractured tooth, and explained that it was causing her discomfort. She also mentioned that she had a hole in tooth 13 but said that she told him that treatment on that tooth could wait.

On examination, Dr B found that a large portion of the crown in tooth 25 had fractured, and that the root had broken below the gum line. He also found that tooth 13 (an upper right canine) had lost a large filling. His assessment of tooth 13 was that its sharp edges were causing irritation to Mrs A's tongue.

Information and consent
Mrs A and Dr B have sharply differing recollections of what occurred during the consultation and treatment, including the sequence of events. Mrs A says that after undertaking the assessment Dr B commenced treatment by giving her two injections into her left molar gum and then an injection into her top right gum, without explaining what treatment he proposed or seeking her consent. She said that he specifically did not discuss with her repairing tooth 13.

Dr B, on the other hand, says that he discussed his treatment plan for tooth 13 and tooth 25 with Mrs A before commencing treatment. In relation to tooth 13 he said that he considered that it would be cheaper and faster for Mrs A to have a permanent filling done at the consultation than a temporary filling. He thought that Mrs A had given him consent to proceed with the treatment he recommended. If she had said no, he would never have gone ahead with the treatment.

Given the conflict between these two accounts of the consultation I sought the recollection of Ms D, who was present at the consultation as Dr B's assistant. She provided me with the following information in relation to tooth 25:

> "[Dr B] … gave her [Mrs A] various options, he said the tooth would probably need extraction as a filling was not possible as the tooth had broken away below the gum level. He offered to put in a temporary filling if she would prefer to wait and see [Dr C]

> for extraction. [Dr B] made it clear that he thought in the end the only option would be extraction, and if left it would become infected and probably abscess. [Dr B] said it would be easier to extract then to relieve any irritation she had … [Mrs A] then nodded and said okay, and at no stage did she say stop or appear unhappy for [Dr B] to proceed."

Ms D did not provide me with any specific information about the discussion in relation to tooth 13 – other than to say that in accordance with the plan Dr B injected Mrs A, on both sides of her mouth, in preparation for what she considered to be two standard procedures – and that Mrs A appeared to be in agreement for the work to proceed.

Treatment
Dr B undertook the following treatment:

(a) a pinned composite filling in the broken tooth 13; and
(b) extraction of tooth 25.

Dr B said that he repaired tooth 13 first, while waiting for the local anaesthetic to completely anaesthetise tooth 25, and then commenced work on tooth 25. While trying to rotate the spiky piece of the crown that remained on tooth 25, the crown splintered and fractured below the gum level. After obtaining further instruments[1] he removed the alveolar bone around the tooth, elevated the root remnants and placed two sutures. Dr B noted that because tooth 25 splintered while he was trying to extract it, he had no option but to surgically extract it, which is a more uncomfortable procedure and takes more time to heal.

Mrs A stated that Dr B worked on tooth 25 first, then worked on tooth 13, after he had broken tooth 25. She said that the work on tooth 13 was done while Dr B was waiting for extra injections around tooth 25 to work.

Mrs A stated that at the point when Dr B gave her an injection in her right gum she instructed him to undertake no further work on her teeth. Dr B agrees that Mrs A did at one stage ask him not to do any more treatment – but that it was later in the appointment, at the stage he was finishing the composite filling on tooth 13. He said that in the context of the emergency consultation he took her to mean not to undertake any work that was non-emergency, as opposed to the planned emergency work on tooth 25, still to be done. Ms D's recollection is that at no stage did Mrs A appear unhappy to proceed and she did not hear Mrs A ask Dr B to stop. She said that Dr B checked with Mrs A regularly during the treatment to see if she "was doing OK" and Mrs A never indicated she wasn't or that she wanted the treatment to stop.

Mrs A has reviewed Dr B's and Ms D's recollections of the consultation and remains adamant that before treatment was commenced no information was given to her by Dr B,

[1] Dr B placed these instruments on Mrs A's bib. This is relevant to an issue raised by my independent advisor – but Mrs A is clear that she had no objection to where the instruments were placed.

nor were the options discussed. She says that although Dr B may have had a treatment plan in his head, he did not speak to her about it and she does not consider that she consented to the treatment.

Everyone present agrees that during the course of treating Mrs A, Dr B regularly enquired whether she was "OK". Mrs A noted that each enquiry coincided with Dr B tapping her on the forehead and that Dr B continued tapping until he received a nod from her – something Mrs A found unpleasant.

Mrs A was also concerned that while working on her mouth Dr B dropped an X-ray of her tooth, which he was referring to, onto the floor and did not wash his hands or change his gloves after retrieving it. The X-ray in question was taken by Dr C in September 2002.

Dr B responded to this aspect of Mrs A's complaint as follows:

> "[Mrs A] was supine at the time – had she been upright she would have noticed that the glove never touched the floor as one pinches the acetate sheet with the X-ray attached with thumb and forefinger to lift it up without contacting the floor and normally gets the assistant to pick up."

He also advised that since Mrs A's complaint he has changed his procedure to ensure that his assistant picks up a dropped X-ray or he changes his gloves if he picks it up.

Postoperative care

Dr B prescribed Mrs A 500mg tablets of amoxycillin; 200mg tablets of metronidazole; and 50mg tablets of Voltaren postoperatively. He advised Mrs A that the antibiotics were in case of infection. Dr B says that he told Mrs A that analgesics such as Disprin, Panadol and Nurofen could be used in conjunction with the prescribed medications. Mrs A disputes this.

In relation to the provision of antibiotics, Dr B said that before treatment Mrs A's "gum" was infected, exhibiting marginal gingivitis, and that he prescribed antibiotics as he routinely does after a surgical extraction, to prevent infection of the surrounding pre-molar alveolar bone, socket and soft tissue. His experience is that metronidazole helps anaerobics and fungus control, particularly the prevention of thrush in female patients (often caused by taking amoxycillin alone). Mrs A says that Dr B never mentioned gingivitis to her.

Dr B said he advised Mrs A to rinse her mouth with salt and water after 48 hours and not to disturb the extraction site with her tongue. He also told her to take the prescribed medications with food – to have "a greasy feed". Dr B said he told Mrs A that such a meal would assist with the absorption of the medications. He suggested that she eat on the side of her mouth opposite the extraction site, and demonstrated how to do so. Mrs A disputes the amount of information Dr B gave her.

What is not disputed is that Dr B advised Mrs A to have a drink of alcohol when she went home. Mrs A's recollection is that Dr B said:

> "When you go home, have a good glass of whisky or brandy – if wine is your preference, then that will be fine."

Dr B admits that he suggested Mrs A have a drink but states that it was never his intention that she consume alcohol and take antibiotics. He has apologised for the misunderstanding and given the following explanation:

> "Because [Mrs A], like anyone, was uptight after a surgical extraction I suggested just a 'tipple' of whatever she likes may help to relax her way before she started taking the drugs. But I did stress that you cannot take alcohol while you are taking the course of drugs I have prescribed or you'll be sick and they won't work effectively … Also alcohol increases the risk of prolonged bleeding from the socket … Note too the pharmacist always prints on tablet bottles – NO ALCOHOL so there is no problem there."

Ms D says she gave Mrs A the prescription, with an envelope of cotton rolls and a post-extraction instruction sheet, as is her routine. Mrs A says she was not given a post-extraction instruction sheet or the cotton rolls. Dr B provided a copy of the standard instruction sheet that is routinely given to his patients. It sets out information on issues such as rinsing, types of food, what to do if bleeding occurs, and pain relief (including the use of pain relief such as Nurofen).

Ms D's recollection of Dr B's postoperative instructions is as follows:

> "[Dr B] gave her verbal instructions on what to do and what not to do and … made it clear as he does with all extraction patients that they cannot take alcohol with the antibiotics, in fact he always tells his patients who require an extraction to arrange their appointment when they aren't planning to consume alcohol for 4-5 days after."

Mrs A says that Ms D was not in the consulting room at the time Dr B gave her the postoperative instructions.

Dr B informed Mrs A that she would have to attend his surgery for removal of the sutures placed over the extraction site of tooth 25. Mrs A states that the period Dr B specified was between two and seven days post-extraction. Dr B says he specified a period of between five and seven days post-extraction. Mrs A had the sutures removed by Dr C seven days post-extraction.

Independent advice to Commissioner

The following expert advice was obtained from Dr Andrea Cayford, dentist:

"**Introduction**

I have been asked to provide an opinion to the Health and Disability Commissioner on case number 03/14244. I have read and agree to follow the Commissioner's guidelines for Independent Advisors.

I am a general dental surgeon practicing in a large group practice performing a wide range of general dentistry to the public. I have been in private practice for 19 years and have also spent a year as a dental house surgeon.

Expert advice required

Did [Dr B] provide [Mrs A] with all the options available for treating her condition?

Was [Dr B's] treatment plan appropriate in the circumstances? In particular, please comment on:

(a) His decision to extract tooth 25; and
(b) His decision to place a pinned composite in tooth 13.

Were [Dr B's] postoperative instructions, to [Mrs A], appropriate? In particular, please comment on:

(a) whether [Dr B] should have advised [Mrs A] to drink alcohol; and
(b) whether [Dr B] should have advised [Mrs A] to eat a large meal prior to taking the medications he prescribed.

On the evidence provided, did [Dr B] provide [Mrs A] with dental services of an appropriate standard?

In your opinion, did [Dr B] obtain [Mrs A's] consent to the treatment prior to commencement?

Are there any aspects of the care provided by [Dr B] that you consider warrants either:

(a) *Further exploration by an investigator?*
(b) *Additional comment?*

Information reviewed

Letter of complaint, from [Mrs A], dated 5 September 2003. (p1-4)
Letter of notification, to [Mrs A], dated 14 November 2003. (p5-6)

Letter of response, from [Dr B], dated 12 January 2004 (p7-13). Including:
- post dental treatment instructions (p12)
- [Dr B's] clinical notes (p13).

Action note detailing [Dr B's] recollections, dated 20 January 2004. (p14)
Response to a request for information, from [Dr C], dated 17 December 2003 (p-15). Including:
- X-rays of [Mrs A's] teeth, taken in September 2002.

Response to a request for information, from [Dr C], dated 10 December 2003 (p17).

Summary of case

On 25th August 2003, [Mrs A] attended the surgery of [Dr B] for an emergency dental appointment. [Mrs A] was a patient of another dentist in the same practice and had an appointment with him after his holiday.

[Mrs A] had a premolar tooth (tooth 25) which had broken and was causing discomfort because of the sharp edges on her tongue. Tooth 25 was root filled. A large pinned filling had been placed on this tooth a month previously.

[Dr B] found that tooth 25 had fractured below the gum line. [Dr B] decided that the best option for the tooth was an extraction.

[Dr B] also found that tooth 13 had lost a large filling. He decided the best treatment would include a filling on this tooth.

According to [Mrs A], [Dr B] extracted tooth 25 and filled tooth 13 without obtaining her consent or explaining treatment options. [Dr B] disputes this and says that [Mrs A] was informed about treatment options and did consent to treatment.

Treatment plan

[Mrs A's] primary concern was tooth 25 and the rough edges on her tongue. Dentists treat this situation as an emergency as at times it can be as debilitating as toothache.

Teeth which have previously been root filled are much more brittle than vital teeth. When filling these teeth dentists try to design a filling which will prevent the tooth breaking but it is not always successful. In particular it is very common to have an upper premolar tooth (eg tooth 25) break at the gum line.

There are a variety of options in treating such a tooth. As an emergency measure it is acceptable to place a temporary filling on the tooth. This provides comfort to the tongue and allows time to make long term decisions, or for the patient to see her own dentist. A comment is made by [Dr B] that the gum was infected, but [he] later dismisses this by saying 'We'll give you antibiotics to prevent infection'. The tooth wasn't giving [Mrs A] any pain (root filled teeth usually don't) so the temporary filling would have eased the discomfort.

If the patient wanted a definitive treatment at this time and the dentist had the time, the options are to extract the tooth or do a filling or crown. If the tooth had broken below the gum line as [Dr B] stated, then the option of extracting the tooth is appropriate. I have not been provided with a preoperative x-ray of the broken tooth to confirm this, it appears that an x-ray was not taken. Dentists can only successfully fill a tooth where the edges of the filling will be above or very near the gum line. It is possible to keep a tooth which has broken below the gum line. However this would require surgery to remove gum tissue and expose the gum line. This would often be done by a periodontal specialist. After the surgery a filling can be placed or more commonly a post and crown. This last option is expensive and is limited to patients with excellent oral hygiene and a well maintained dentition. Both [Mrs A] and [Dr B] state that her mouth isn't the best. Therefore a tooth fractured below the gum in [Mrs A's] case would require an extraction. Nevertheless the reason for this needs to be explained and although there may appear to be options, realistically there is only one.

Tooth 13 had lost a large filling. The appropriate treatment choice is to repair it with a composite filling. However it would appear from [Mrs A's] letter that it wasn't her primary concern and therefore it may have been appropriate to leave this, or place a temporary filling. Temporary fillings can be placed in a couple of minutes. This may well have allowed more time for the treatment on tooth 25.

Dentists don't often have too long to 'slot in' an emergency patient. It is appropriate to limit the treatment to what is necessary to bide time until a longer appointment is available. It appears that [Dr B] did have a reasonable length of time to spend with [Mrs A] although the nurse was 'running late' afterwards according to notes from a phone call between [Dr B] and [the investigator].

Regardless of whether or not [Dr B] did fully inform [Mrs A] of treatment options, from the information given, it would appear she received appropriate treatment.

Treatment options

According to [Mrs A's] letter no options were given about the treatment plan for teeth 13 and 25. She did not know what he was going to do until after he had started the extraction.

According to [Dr B's] letter he says he gave her the options and treatment plan prior to starting.

It takes some time to explain to a patient the options for a tooth such as this. Even if it is obvious to the dentist that a tooth has to come out, it may not be to the patient (especially as she'd had the tooth filled recently).

The options given to the patient should be noted on the card.

The chairside assistant would be the only person who witnessed this conversation. It may be appropriate to contact her if further information is required.

Postoperative instructions

[Dr B] spent some time going through postoperative extraction instructions with [Mrs A] and gave her an appropriate information handout.

The advice given to [Mrs A] about having an alcoholic drink was not appropriate. Alcohol may increase the chance of the wound bleeding. Alcohol also interacts with some drugs. Metronidazole (which was prescribed) is well known to interact with alcohol. Alcohol stays in the body for some time. Therefore it would not be advisable to have a drink and soon after start the antibiotics.

It may not have been necessary for [Mrs A] to have antibiotics. Although it was a surgical extraction, there was no infection and may have healed on its own. There is no post operative x-ray to establish if there was any infection at the end of the root. At times antibiotics may be given to prevent infection, especially if the patient had medical problems, was generally slow to heal, or the procedure was very difficult. If an antibiotic was considered necessary then just amoxicillin on its own may well have been sufficient.

The advice and prescription for pain relief was appropriate.

Most pain killers and antibiotics are best taken with food. This is usually written on the prescription label. This is one of the reasons most antibiotics are given three times a day so they coincide with main meals. The amount of food taken isn't critical. A glass of milk would be sufficient.

Sutures are normally removed after 5-7 days.

Standard of care

The choice of treatment [Dr B] provided for [Mrs A] seems realistic and appropriate for her with the exception that temporary fillings could have been offered.

However, even though the choice may have been obvious to [Dr B] it wasn't to the patient. [Mrs A] needed the treatment plan and options explained.

Patients should be treated with respect. Even though the patient had been told by the receptionist who she was to be seeing that day, it is polite for the dentist to introduce him/herself. Patients have the right to be called by their full or preferred name. It is not appropriate to tap a patient on his/her head. Dentistry in itself is an invasion of personal space and as far as possible dentists should try not to touch them in other areas of their body. What seems a perfectly innocent action to the professional can be intimidating to the patient. Tapping the patient's head while performing dentistry promotes the risk of cross infection.

It is inappropriate to place objects on a patient's chest. This is covered in the New Zealand Dental Association Code of Sexual Boundaries.

It is inappropriate to pick something off the floor and continue to refer to it without wiping it down with some kind of disinfectant. I have mentioned previously in this report the fact that there is no preoperative periapical x-ray (this x-ray shows the whole of the tooth including the root). It would appear that the x-ray [Dr B] was referring to was the x-ray I have sighted which was taken on 09-02. This x-ray would have been of little use during the surgical procedure and therefore he didn't need to refer to it at all. Prior to extracting a tooth, it is advisable to have a current periapical x-ray of the tooth. This is important for diagnosis and treatment planning, assessing the difficulty of the extraction and as a record of what the tooth was like in case of any dispute. We are taught to take such an x-ray for any tooth prior to extraction, even when the situation is obvious and the extraction looks 'easy'.

The antibiotic prescription has been mentioned. We try to keep the use of antibiotics to a minimum due to the global trend towards antibiotic resistance. [Dr B's] use and choice of antibiotics for [Mrs A] are at the upper limit of what is acceptable.

Consent

[Mrs A] states that she did not know what [Dr B] was planning to do on tooth 25 until he had started. She may not have wanted tooth 13 treated that day, as she said 'no more work please' after a local anaesthetic was placed for that tooth. [Dr B] assumed she meant no more than treating tooth 13 and tooth 25 that day.

[Dr B] says he presented [Mrs A] with the necessary information, options, treatment plan and obtained her consent prior to commencing.

A witness (staff member) would be the only person to confirm what was said and agreed to. The information I have been provided with isn't enough to decide whether or not [Mrs A] consented to the treatment.

Other aspects

Clinical notes. The clinical notes are brief and difficult to read with the nurse's printing surrounded by the dentist's notes. The notes could include the options given for tooth 25, the patient's presenting complaint and the material used to restore tooth 13.

There are no notes regarding the patient's medical history on the card. It is customary to write 'N.A.D. 2003', (nothing abnormal detected), when the medical history is clear. Then it is clearly recorded that the patient has been asked and when it was last updated.

Conclusions

With the information given I find it difficult to assess whether or not [Mrs A] was given adequate information regarding treatment options and whether or not [Dr B] obtained her consent for the treatment he carried out on tooth 13 and tooth 25.

From the information given it appears she received the correct treatment for each tooth. She could have been offered a more temporary solution and there is some doubt as to whether tooth 13 needed to be treated at this emergency appointment.

An up to date and relevant x-ray may have been useful and should have been considered.

The choice and use of antibiotics may not be justified.

Touching a patient inappropriately is not acceptable.

Picking an x-ray off the floor and continuing to handle it without making an attempt to disinfect it is not acceptable.

Acceptable manners in our society include introducing yourself and calling someone by their given name.

Alcohol consumption while taking antibiotics is not recommended. Antibiotics and painkillers are best taken with food of any sort.

The clinical notes are minimal."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

Right 4

Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

Right 6

Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*

   a) an explanation of his or her condition; and

   b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and cost of each option; …

Right 7

Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Opinion: Breach

Right 4 of the Code affirms a patient's right to receive services of an appropriate standard. In particular, Right 4(1) of the Code affirms a patient's right to have services provided with reasonable care and skill.

Treatment
Dr Andrea Cayford, my independent advisor, advised that Dr B's choice of treatment provided for Mrs A's teeth was realistic and appropriate, although greater emphasis could have been placed on the possibility of temporary fillings given the emergency nature of the appointment.

However, aspects of Dr B's dental care were not of an appropriate standard.

Up-to-date periapical X-ray
Dr B did not take a periapical X-ray of tooth 25 before starting treatment, instead relying on an X-ray taken by Dr C almost a year before. Dr Cayford commented that "[t]his X-ray would have been of little use during the surgical procedure and therefore he [Dr B] didn't need to refer to it at all."

It is advisable to have a current periapical X-ray of any tooth prior to extracting it, even in circumstances where an extraction appears "easy". X-rays of this type are important for diagnostic purposes, treatment planning, record-keeping, and determining the difficulty of extraction.

In response to Dr Cayford's advice, Dr B said that he did not consider that a current periapical X-ray was required. The X-ray he had was relevant and of good quality and showed him that the tooth was root-filled. He therefore knew, given Mrs A's age, that the tooth would be brittle. It also showed him the length of the root and that there was no cementation of the root to the bone. He considered that with this information it was not necessary to subject Mrs A to further radiation.

Notwithstanding Dr B's response, Dr Cayford remained of the opinion that the appropriate standard is to take a periapical X-ray prior to extraction.

Dropped X-ray
While reviewing the X-ray, Dr B dropped it onto the ground and retrieved it and continued his work on Mrs A's mouth without taking steps to ensure that contamination did not occur. Dr Cayford described this as "not acceptable", an assessment with which I agree.

Advice on alcohol
Dr Cayford described Dr B's advice that Mrs A have a "tipple" after her treatment as "not appropriate". Alcohol consumption is not recommended while taking antibiotics. Alcohol lingers in the body for some time, and it is well known to interact with metronidazole, one of the medications Dr B prescribed for Mrs A. I do not accept Dr B's view that the warnings printed on pharmaceutical bottles absolve him of his professional duty to provide accurate advice about the medications he prescribes.

In my opinion, by electing not to take an X-ray of Mrs A's tooth before commencing treatment, relying on an out-of-date X-ray, not taking appropriate hygiene precautions after dropping the X-ray, and suggesting Mrs A drink alcohol after prescribing antibiotics, Dr B did not provide services to Mrs A with reasonable care and skill. Accordingly, he breached Right 4(1) of the Code.

Opinion: No breach

Other postoperative instructions
Although there is differing evidence from Mrs A, Dr B and Ms D on the extent of the postoperative instructions given to Mrs A, I am reasonably satisfied that, the alcohol issue aside, Mrs A was given appropriate instructions about what to do postoperatively – including when the sutures should be removed. Dr Cayford's advice is that sutures are typically removed between five to seven days post-extraction. Dr B said that he advised removal five to seven days post-extraction. Mrs A recollects Dr B saying that she should present for suture removal two to seven days post-extraction, but she presented to Dr C for removal of her sutures seven days post-extraction.

Opinion: No further action

Communication and informed consent
There is a sharp conflict of evidence between Mrs A's recollection of events and that of Dr B and his employee, Ms D. Dr B suggests that perhaps the fact that the consultation did not go in accordance with Mrs A's previous experience of extractions – tooth 25 required surgical extraction when it splintered, resulting in a longer and more uncomfortable procedure than initially expected – has coloured her recollections. I am not convinced by this explanation.

Mrs A complained very shortly after her experience and has been steadfast and compelling in her description of events. However, both Dr B and his assistant state that he did provide explanations and options before starting treatment and then checked regularly with Mrs A during treatment. Given the conflict of evidence I am unable to determine precisely what occurred and do not consider that further investigation will assist me to draw a conclusion.

Under Right 6 of the Code a patient is entitled to receive the information that a reasonable patient, in that patient's circumstances, would expect to receive. This includes a full explanation of the patient's condition and the available treatment options. My independent advisor noted the importance of dentists ensuring that the treatment plan and options are carefully explained before treatment is commenced, so that a patient understands and is able to give informed consent. I recommend that Dr B carefully review his information disclosure practice.

Discontinuing treatment
Mrs A says she asked Dr B not to do any further treatment. Dr B agrees that she did – but took this to mean no treatment other than the emergency treatment. There is disagreement about the stage of the consultation when this discussion occurred. Ms D did not hear Mrs A ask Dr B not to do any further treatment and at no stage did she think Mrs A's behaviour indicated that she wanted the treatment to be discontinued. All agree that Dr B asked Mrs A at intervals if she was OK – and Mrs A indicated she was. Faced with the conflicting evidence I am unable to conclude what transpired between Mrs A and Dr B in relation to this issue and have decided that further investigation is not warranted.

Other comments

Boundaries and personal space
Dr Cayford advised me that placing objects on a patient's chest is not appropriate practice. Nor does she consider it appropriate to tap a patient on the forehead. She observed:

> "Dentistry in itself is an invasion of personal space and as far as possible dentists should try not to touch them in other areas of their body. What seems a perfectly innocent action to the professional can be intimidating to the patient."

These issues did not form part of Mrs A's complaint and she is quite clear that the placement of the instruments was not of concern to her. Nevertheless, I draw Dr Cayford's comments to Dr B's attention.

Record-keeping
Dr Cayford considered Dr B's clinical notes brief and difficult to read with the nurse's printing surrounded by the dentist's notes. The notes could include the options given for tooth 25, the patient's presenting complaint and the material used to restore tooth 13. There are no notes on the card regarding the patient's medical history. It is customary to

write "N.A.D. 2003" (no abnormality detected), when the medical history is clear. This records that the patient has been asked and when the records were updated.

Record-keeping is an important part of a dentist's practice. Accurate, contemporaneous clinical notes are essential for ensuring continuity of care, and notes must be able to be interpreted by a fellow practitioner. Dr Cayford considered Dr B's notes minimal and had difficulty interpreting them. I draw this matter to Dr B's attention.

Recommendations

I recommend that Dr B take the following actions:

- Apologise to Mrs A for his breaches of the Code. This apology is to be sent to the Commissioner and will be forwarded to Mrs A.

- Review his practice in light of this report.

Follow-up actions

- A copy of my final report will be sent to the Dental Council of New Zealand with a recommendation that it consider whether a review of Dr B's competence is warranted.

- A copy of this report, with details identifying the parties removed, 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.