Dr C, Dentist

A Dental Practice

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00437)

Table of Contents

Executive summary....................1

Complaint and investigation....................2

Information gathered during investigation....................3

Relevant standards....................7

Opinion: Dr C....................9

Opinion: Breach — The dental practice....................12

Recommendations....................13

Follow-up actions....................13

Addendum....................13

Appendix A — Independent advice to the Commissioner....................14

Executive summary

1. Mr A, aged 16–17 years old at the time of these events, enrolled with a dental practice on 22 December 2006 for dental treatment under the Dental Benefit Scheme.[1]

2. On 21 February 2007, Mr A was first seen by Dr D for a routine check-up.

3. On 1 August 2007, Mr A was assessed as having a fracture in a filling in one of his teeth, tooth 46, which was repaired by Dr D.

4. On 3 July 2008, Mr A was assessed by Dr C as having chronic irreversible pulpitis in tooth 46, and a root canal was commenced. This was completed on 14 July 2008 by Dr C and, during the treatment, Dr C became aware that one of the fine instruments used had separated or broken off in Mr A's root canal. Dr C did not tell Mr A about the separated instrument, nor did he document this in the clinical records.

5. On 2 August 2010, Dr C undertook re-treatment of the root canal. Mr A continued to experience pain, and further treatment was carried out on 16 August and 15 September. Dr C did not tell Mr A about the reason for the re-treatment, the options available, or the risks associated with each option, including his skill in this area. Dr C advised HDC that the re-treatment consisted of the attempted removal or bypassing of the separated instrument. However, this is not documented in the patient records. Dr C reviewed the re-treatment of the root canal on 13 December.

6. In May 2011, part of Mr A's tooth 46 broke away. In light of this, Mr A sought a second opinion from another dentist, Dr E. Following his assessment, Dr E advised Mr A that an instrument had broken off in the root canal, and that the root had been widened and damaged. Dr E referred Mr A to an endodontist, Dr F.

7. Dr F saw Mr A on 30 May 2011. Dr F confirmed Dr E's assessment and discussed the options for treatment with Mr A, recommending that the tooth be removed and an implant retained crown be placed. Dr F then referred Mr A to a prosthodontist, Dr G, for an implant consultation which occurred on 15 July 2011.

Decision

8. Dr C breached Right 6(1)(g) of the Code of Health and Disability Services Consumers' Rights (the Code)[2] for failing to disclose that an instrument had separated during the root canal treatment on 14 July 2008. Dr C breached Right 6(1)(b) of the Code[3] for failing to fully inform Mr A about the reasons for his re-treatment, the treatment options available to him, and the risks, side effects, benefits and costs of

[1] The Dental Benefit Scheme is a government funded scheme providing free dental care for adolescents.

[2] Right 6(1)(g) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — the results of procedures."

[3] Right 6(1)(b) of the Code states: "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 …"

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

those options, including Dr C's skills in the area. Without this information, Mr A was not in a position to make an informed choice and provide informed consent for the re-treatment. Accordingly, Dr C also breached Right 7(1) of the Code[4] for failing to obtain Mr A's informed consent for the re-treatment.

9. For failing to comply with his professional responsibility to keep proper records, Dr C breached Right 4(2) of the Code.[5]

10. Criticism has been made regarding Dr C's decision to complete only a partial cover restoration of Mr A's tooth.

11. Dr C has been referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

12. The dental practice did not have specific written policies in relation to informed consent, and is vicariously liable for Dr C's breaches of the Code.

Complaint and investigation

13. The Commissioner received a complaint from Mr B about the services provided to his son, Mr A. The complaint was supported by Mr A. The following issues were identified for investigation:

- *Whether Dr C provided Mr A with adequate information about his condition, treatment and options, and whether Dr C obtained Mr A's informed consent prior to proceeding with treatment.*

- *The appropriateness of the care provided to Mr A by Dr C between July 2008 and December 2010.*

- *The appropriateness of the care provided to Mr A by the dental practice between 2007 and 2010.*

14. An investigation was commenced on 27 March 2013.

15. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

[4] Right 7(1) of the Code states: "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."
[5] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

16. The parties directly involved in the investigation were:

Mr A	Consumer
Mr B	Complainant and consumer's father
Dr C	Provider, dentist
The dental practice	Provider

Also mentioned in this report:

Dr D	Dentist
Dr E	Dentist
Dr F	Endodontist
Dr G	Prosthodontist

17. Independent expert advice was obtained from dentist Dr Mary Towers (**Appendix A**).

Information gathered during investigation

Background

18. Mr A, aged 16 years, enrolled with a dental practice on 22 December 2006 for dental treatment under the Dental Benefit Scheme.

Consultation — 21 February 2007

19. On 21 February 2007, Mr A attended the dental practice and was seen by Dr D for a routine check-up. At this time a full examination was carried out. Posterior bite wing X-rays and an X-ray of tooth 23[6] were taken. Dr D noted that tooth 23 was erupting,[7] and tooth 36 and tooth 46 were noted to have decay.

Consultation — 1 August 2007

20. On 1 August 2007, Mr A (then aged 17 years) returned to the dental practice complaining of toothache, and said that he believed that a filling had fallen out. Mr A was again seen by Dr D, who assessed Mr A as having a fracture to the filling on tooth 46. Dr D subsequently repaired the filling.

Root canal to tooth 46

21. On 3 July 2008, Mr A presented to the dental practice and was seen by Dr C.[8] Dr C advised HDC that Mr A was complaining of a dull ache from tooth 46; however, this is not documented in the clinical record. Dr C took posterior bitewing X-rays and diagnosed Mr A with chronic irreversible pulpitis in tooth 46.[9] Following his assessment, Dr C informed Mr A that he required a root canal and, subsequently, opened up the tooth, removed the nerve, and "dressed" the tooth in preparation for

---

[6] The number refers to a dental notation system, where the tooth number corresponds with a specific tooth.
[7] This refers to the developing tooth becoming visible in the gum.
[8] Dr C is employed as a dentist with a general scope of practice.
[9] Chronic inflammation of the dental pulp.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

completing the root canal. Mr A accepts that he was told that he needed a root canal and agreed to the treatment.

22. There is no documentation in relation to what, if any, information Mr A was provided in relation to this treatment.

23. On 14 July 2008, Dr C completed the root canal, which involved the tooth being cleaned and the roots sealed with rubber based material and cement. Dr C subsequently advised HDC that during the treatment on 14 July he became aware that one of the fine instruments used had separated or broken off, and was left in the root canal. Dr C did not tell Mr A about the separated instrument, nor did he record in the clinical records that this had occurred.

Annual check-up

24. On 27 July 2010, Mr A attended the dental practice for an annual check-up. Mr A was seen by Dr C, who carried out an examination including X-rays. He also scaled and polished all of Mr A's teeth. No issues were identified during this appointment.

Re-treatment to tooth 46

25. On 2 August 2010, Mr A presented to the dental practice and was seen by Dr C. "Emergency dressings" were applied to tooth 46, but there is no documentation in the clinical records of the reason for this re-treatment. However, in a statement to HDC, Dr C advised that re-treatment was required because Mr A was complaining of dull pain from tooth 46. The records of the procedure document that on examination the pulp chamber was noted to be large, and that the roots were cleaned and the tooth dressed. The records document that verbal postoperative instructions were given to Mr A, but the details of these are not documented. On 16 August 2010, Mr A returned for further "emergency dressings" to be applied to tooth 46 because of ongoing pain. Dr C stated that this appointment consisted of "[f]urther cleaning of the roots and attempted removal/bypassing of the separated instrument. Tooth redressed for infection to be cleaned." However, there is no mention of the separated instrument or Dr C's management of it in the records, nor is there any evidence that Dr C advised Mr A of the separated instrument at this appointment.

26. Mr A told HDC that, even when he questioned Dr C directly about the reason for his ongoing pain, Dr C told him that there was just some infection that needed to be cleared out. Mr A said that at no time did Dr C tell him that an instrument had broken off or separated in his tooth.

27. Dr C advised HDC that the separation of fine instruments used in the root canal procedure is one of the complications of the procedure when the roots are curved, and this is what occurred during the original treatment of Mr A's root canal. Further to this, Dr C advised that during his subsequent treatment of Mr A's tooth he attempted to remove or bypass the piece of instrument but, because the roots were narrow, the root was perforated in the process. Dr C stated:

> "It was further hoped that we can remove the separated piece of the instrument or at least bypass it. Again seeing the thin nature of roots small perforation of root

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

happened and this according to recommended guideline was managed with a cement sealer."

28. On 15 September 2010, Dr C completed the re-treatment of tooth 46. It is documented in the clinical records that tooth 46 root canal was filled, and "mta"[10] placed in the "rest of canal and perforation area", and that a temporary filling was put in place with the plan to review the filling in three months' time for a permanent restoration. It is also documented that Mr A was advised that an extraction was likely, in the event of any further problems.

29. On 13 December 2010, Dr C reviewed the re-treatment and placed a restoration on the front half of the tooth. In a statement to HDC, Dr C advised that Mr A had experienced no further problems with the tooth at that time, although that is not documented in the records.

Pain relief

30. Mr A advised HDC that during some of the procedures he complained to Dr C that the treatment was painful, and requested pain relief, but that this was declined. Mr A said that Dr C told him that it was normal to experience pain.

31. Dr C advised HDC that prior to drilling into the tooth it was dressed with "a very potent analgesic (pain killer)", and that it is his usual practice to advise patients undergoing a root canal to use Neurofen or Panadol for pain relief after the treatment, although in this case the advice is not documented.

32. There is no record of what pain relief was administered during the initial root canal treatment on 3 and 14 July 2008. The records relating to the re-treatment on 2 August 2010 record that Mr A was administered articaine, a local anaesthetic, "to achieve satisfactory local anaesthesia results for tooth 46".

Concerns raised by Mr A's parents

33. Mr B advised HDC that he and his wife became concerned about the reasons for Mr A requiring such extensive dental treatment. When they questioned their son about this, he was unsure why he was having ongoing treatment.

34. Mr B advised that both he and his wife went to the dental practice on separate occasions to question why their son was requiring so much treatment. Mr B believes that these meetings with Dr C occurred some time after the second re-treatment appointment (16 August 2010). Mr B stated that on both occasions they were told by Dr C that nothing was wrong, and that he was just "trying to clear out some infection".

35. Mr B told HDC that Dr C did not tell them about the separated instrument, nor did he advise them that the root had been perforated.

36. Dr C advised HDC that he recalls meeting Mr and Mrs B in the reception area of the dental practice on one occasion. Dr C believes that this was on either 15 September or

[10] "Mta" is a dental material used in root canal treatments.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

13 December 2010, at the end of one of Mr A's appointments, as they were waiting in the reception area to pick him up. Dr C advised that Mr and Mrs B queried Mr A's frequent dental appointments, and that he provided them with an explanation in "layman terms" that he was "trying to clear infection from the tooth". Dr C advised HDC that he failed to fully inform Mr and Mrs B of the situation. Dr C stated:

> "I accept failing to advice (sic) of the real circumstances we were facing and should have tried briefing openly about the ongoing treatment."

37. Dr C advised that the "real circumstances" refers to the separated instrument.

Ongoing problems

38. Mr B advised that during the course of the treatment, Mr A's tooth went black.

39. In May 2011, part of Mr A's tooth broke away, so Mr A obtained a second opinion from another dentist, Dr E. Following Dr E's assessment, which included X-rays, Dr E found that an instrument had broken off in the root canal, and that the root had been widened and damaged. Dr E then referred Mr A to an endodontist, Dr F.

Dr F

40. On 30 May 2011, Dr F saw Mr A.

41. Dr F advised HDC that he assessed Mr A and made the following observations:

> "There is a fractured instrument in the mesial root which the [previous] dentist has attempted to remove and has resulted in the loss of a great deal of the tooth structure and possibly also leading to a strip perforation. The restoration is fractured and the tooth is blue most likely from an inter-appointment dressing of Ledermix paste."[11]

42. Dr F discussed the options for treatment with Mr A and Mr B, including re-treatment or apical surgery followed by a cast crown. However, Dr F advised HDC that the prognosis of both these options was poor and might not have resolved the problem. He therefore recommended that the tooth be removed and an implant retained crown be placed. Dr F then referred Mr A to a prosthodontist, Dr G, for an implant consultation, which occurred on 15 July 2011.

Comment from Dr C

43. In relation to his decision to carry out the additional treatment on Mr A's tooth when it was noted that there was a problem with the root canal, rather than referring him to a specialist, Dr C stated:

> "The remoteness of the practice and the limited funding availability under free adolescent care scheme coupled with parents (sic) own incomplete dental treatment due to low socioeconomic status influenced retreatment. The retreatment of root canals is possible and undertaken by general dental practitioners with

[11] Ledermix paste is a steroid and antibiotic compound used for the treatment of pain associated with inflammation of the tooth.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

sufficient experience and who have a special interest in Endodontics. I am not an Endodontist but have keen interest in the practice of endodontics."

44. In response to the provisional opinion Dr C reiterated the fact that the separation of an instrument is a known complication and that he had no reason to hide the fact that it had happened in Mr A's case. However, he stated:

"I thought that a solution could be reached by observing the healing, completing the further treatment, clearing the infection that had developed and all without causing upset to the patient and his family. That said, I entirely accept I ought to have told [Mr A] and for this failure and my lapse of judgement I apologise unreservedly to him and his family."

Changes made by Dr C

45. Dr C advised that an auto checklist has now been introduced at the dental practice to assist in the assessment of the difficulty of endodontic cases. In addition, the dental practice's informed consent form for endodontic treatment has been reviewed to include information about the possible complications of root canal treatment, including the risk of separation of root canal instruments during treatment.

Relevant standards

46. The Dental Council of New Zealand *Code of Practice: Patient information and records* (2006) states:

"2.6 The patient's treatment record **must** contain a record of any and all treatment or service provided within a dental practice, whether it is provided by the dentist or any other health practitioner or other employee of the dentist.

2.7 This record **must** include:

…

(f) Detail of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon;

(g) A concise description of any and all treatment or services provided; …

2.8 The record **should**, in the interests of best practice, also include:

(i) A description of any procedure, including any materials used, variation from any standard or usual technique, and any general comments on the procedure undertaken. The detail of the description should reflect the complexity of the treatment or the seriousness of the potential outcomes; …

(k) Consents obtained for treatment;

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

(l) Advice given to the patient on any pre- and postoperative instructions and any likely treatment outcomes and/or complications; …[emphasis in original]"

47. The Dental Council of New Zealand *Code of Practice: Informed Consent* (2004) states:

"**Treatment fees and costs**
Prior to providing treatment, the Dentist should ensure — via the informed consent process — that the consumer understands the costs (fees) involved in providing their dental treatment.

It is unwise for a dentist to prejudge a patient's ability to afford a particular treatment and the value the patient puts on the treatment. The dentist must discuss the cost and determine the fee level that the patient will be comfortable with in relation to the treatment options — all of which must be outlined. This means the relative value of the proposed treatment to that patient requires the dentist to contribute to the patient's understanding of the delicate balance between cost, affordability and value.

Information to be given

1. An explanation of the patient's condition (Right 6[1,a]), information about the costs of each option (Right 6[1,b]), and advice of the estimated time within which the service will be provided (Right 6[1,c]).
2. The nature, status (whether it is orthodox or developmental) and purpose of the treatment or procedure, including its expected benefits.
3. The likelihood of achieving that purpose: the prognosis.

…

4. All significant known risks, including general risks associated with procedures such as anesthesia, the degree of that risk and the probability of its occurrence.

…

8. All relevant management options/alternatives with their probable effects and outcomes.
9. The name and status of the person who will carry out the procedure.

…

Some examples of areas which need special care in communication

…

Endodontics

- Options available
- Success rates
- Compromise versus definitive procedures.
- Separated instruments as a risk during treatment."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Dr C

Consent to perform a root canal — No breach

48. When Mr A presented on 3 July 2008, Dr C appropriately assessed tooth 46, noting chronic irreversible pulpitis, and recommended a root canal.

49. Although there is no documentation in relation to the information Mr A was given regarding the need for a root canal, there is no dispute that Mr A was informed of the need for a root canal, and he consented to the procedure.

Appropriateness of decision to perform a root canal — No breach

50. My expert, Dr Mary Towers, advised that the acceptable treatment for irreversible pulpitis is a root canal. In relation to Dr C's management of Mr A to this point, Dr Towers advised:

> "This sequence of events is normal and with a young vital pulp, and the extent of restoration already present in this tooth, it is not surprising that the pulp became inflamed and required pulp removal and root canal treatment. Molar root canal treatment is considered a regular dental treatment and comes under the list of treatments not requiring prior approval from the Dental Benefit Scheme administration."

51. Accordingly, I am satisfied that Dr C's decision to perform a root canal was reasonable in the circumstances and within Dr C's scope of practice.

Decision to re-treat and quality of re-treatment — No breach

52. During the original root canal treatment, one of the fine instruments used to clean out the canal broke off or separated in the root canal. Dr Towers advised that this is a known complication of the root canal procedure, and is generally of no consequence if the canal is clean and the separation occurs in the "right place".

53. When Mr A began to experience pain in the tooth, Dr C made the decision to re-treat the tooth and attempt to retrieve the separated instrument himself. Dr Towers advised that the re-treatment of a root canal and retrieval of a separated instrument is a difficult procedure and, while it is within the scope of practice of a general dentist, it requires a high level of skill and is "in the realm of specialist skill level and equipment level". Dr Towers explained that it was particularly important in Mr A's case because he did not have a third molar on his lower right-hand side, and therefore tooth 46 was very important for his biting.

54. Dr Towers advised that the X-ray of the tooth following re-treatment shows that the canals have been cleaned out very well, but that in attempting to remove the separated instrument, Dr C has removed a lot of the tooth and perforated the root.

55. In relation to his decision to proceed with re-treatment of Mr A's tooth, Dr C advised:

> "The remoteness of the practice and the limited funding availability under free adolescent care scheme coupled with parents (sic) own incomplete dental

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

treatment due to low socioeconomic status influenced retreatment. The retreatment of root canals is possible and undertaken by general dental practitioners with sufficient experience and who have a special interest in Endodontics. I am not an Endodontist but have keen interest in the practice of endodontics."

56. I accept that the work completed by Dr C was within his scope of practice. The fact that the re-treatment of Mr A's tooth was unsuccessful is not in itself evidence of a lack of care and skill.

Informing about the separated instrument — Breach

57. When Dr C became aware of the separated instrument during the appointment on 14 July 2010, he had a responsibility to disclose this to Mr A. Failing to disclose the fact that an instrument had separated meant that Mr A was unable to properly consider his options and the risks of those options.

58. Failing to explain to Mr A what had happened regarding the separation of the instrument during the original treatment was a serious departure from acceptable standards.

59. Mr A advised that when he asked Dr C about the reasons for his ongoing pain, Dr C responded that an infection needed cleaning out. Mr B also said that when he questioned Dr C directly he was told that "nothing was wrong … they were just 'trying to clear out some infection'".

60. I am very concerned that even when Dr C was asked directly about why so much re-treatment was needed, he did not disclose to Mr A or his parents that an instrument had separated in Mr A's root canal. In his statement to HDC, Dr C confirmed that he explained that the need for ongoing treatment was in order to "clear infection from the tooth". He accepts that he did not provide Mr A or his parents with adequate information about why the further treatment was needed. I note Dr C's comments:

> "I accept failing to advice (sic) of the real circumstances we were facing and should have tried briefing openly about the ongoing treatment."

61. Dr C advised that his failure to advise Mr A of the separated instrument was a lapse of judgement.

62. It was not until Mr A sought treatment elsewhere that he was advised of the separated instrument.

63. Dr C advised HDC that he was aware that the instrument separation occurred on 14 July 2008, at the completion of the root canal. This means that there were at least four occasions on which Dr C could have told Mr A what had happened. In my opinion, Dr C should have disclosed to Mr A that the instrument had separated immediately after it occurred. Failing that, Mr A should have been told when he presented with pain in the tooth on 2 August 2010 and Dr C made the decision to re-treat the tooth and attempt removal of the instrument.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Consent for re-treatment — Breach

64. Prior to Dr C commencing the re-treatment, Mr A should have been told the reasons for the re-treatment and the available options, and also about Dr C's skills and experience in carrying out such re-treatment. Mr A may have been willing to travel and pay for treatment by a specialist if he had been told about the reason for the re-treatment and the available options.

65. There is no documentation in relation to the information Dr C provided Mr A. As the Commissioner has previously noted: "[I]n the absence of an adequate record, I am not satisfied that this information was provided to [the patient]."[12]

66. In my view, in the circumstances, Dr C failed to provide Mr A with information that a reasonable consumer would require in his situation, that is, adequate information about the proposed treatment and the reasons why it was necessary. This was particularly important given the complexity of the situation. In particular, Mr A had the right to be fully informed of the available options, risks, side effects, benefits, and costs of those options, and also Dr C's skills and experience in carrying out the proposed re-treatment. In addition, Dr C should have informed Mr A about the separated instrument, the related risks and options, and that he intended to attempt to remove the instrument.

67. The New Zealand Dental Association Code of Practice on informed consent (2004) requires information about the options and the costs and risks of each option to be provided to the patient. It states that it is "unwise for a dentist to prejudge a patient's ability to afford a particular treatment …" In addition, it requires that information about the status of the person performing the treatment be provided. It also specifically identifies "separated instruments as a risk during treatment" as an issue that needs "special care in communication".

Restoration of tooth crown after root canal — Adverse comment

68. At the completion of the treatment, Dr Towers advised that Dr C completed only a sealed cover on the front of tooth 46. She explained that carrying out a partial cover, rather than a full cover restoration of the tooth, reduces the strength and compromises the seal of the root, resulting in an increased risk of the tooth fracturing, which is what occurred in this case. Dr Towers advised that the "standard restoration for a root fill tooth, is a full cover restoration". I am therefore critical of Dr C's decision not to undertake a full cover restoration of the tooth.

Documentation — Breach

69. Dr C's clinical records are brief and do not contain any detail of the information that was discussed with Mr A, or the full details of the treatment carried out on each occasion. Clinical records must be full, accurate, and legible so that they can be accessed by the patient, and by other health professionals who may subsequently treat the patient. The failure to maintain adequate records was a departure from professional standards.

[12] See opinion 10HDC00509.

Conclusion

70. Overall, I am satisfied that the initial treatment and root canal on 3 July 2008 was appropriate. Furthermore, I accept that the re-treatment of Mr A's tooth on 2 August 2010 was within Dr C's scope of practice.

71. Dr C has admitted that he failed to disclose to Mr A that a separated piece of equipment had been retained in his root canal at the time the separation occurred, and subsequently when asked by Mr A and his parents about the reason for the re-treatment. Accordingly, by failing to provide Mr A with information about the results of the procedure by failing to disclose the reason for the re-treatment, Dr C breached Right 6(1)(g) of the Code.

72. Mr A had the right to be fully informed of Dr C's plan to re-treat the tooth and the reasons for the re-treatment. Dr C should also have informed Mr A about the options available, including the risks, side effects, benefits, and costs of each option, and Dr C's skills and experience in carrying out such treatment. Mr A should also have been told about the separated instrument and its potential impact on the re-treatment. In failing to fully inform Mr A of those matters, Dr C breached Right 6(1)(b) of the Code. Without this information, Mr A was not in a position to make an informed choice and provide informed consent for the re-treatment. It follows that Dr C breached Right 7(1) of the Code for failing to obtain Mr A's informed consent for the re-treatment.

73. For failing to comply with his professional responsibility to keep adequate records, Dr C breached Right 4(2) of the Code.

74. I am critical of Dr C's decision to complete only a partial cover restoration of Mr A's tooth. I note the advice of Dr Towers that in the circumstances it would have been more appropriate to complete a full cover restoration.

Opinion: Breach — The dental practice

75. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions by an employee.

76. As Dr C is an employee of the dental practice, consideration must be given as to whether it is vicariously liable for his breaches of the Code. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

77. At the time of these events, the dental practice did not have specific written policies in relation to informed consent. Therefore, in my view, the dental practice is also liable for the failures in this area. While Dr C had an individual professional responsibility in this case, the dental practice also had a responsibility to ensure that its staff were adequately supported and guided. I conclude that the dental practice is vicariously liable for Dr C's breaches of Right 6(1) and 7(1) of the Code.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

78. I note that the dental practice has since introduced an assessment tool and informed consent information sheet for patients undergoing a root canal.

Recommendations

79. I recommend that Dr C:

- undergo a competence review by the Dental Council of New Zealand; and
- provide a letter of apology for Mr A, to be sent to this Office by **21 February 2014**, for forwarding to Mr A.

80. Dr C has agreed to undertake further training with regard to communication with patients. Dr C should provide evidence to this Office within three months of the release of the final opinion confirming his attendance or enrolment at the relevant upcoming workshop or training seminar.

81. I recommend that the dental practice organise for an independent documentation audit to be completed, focusing particularly on the documentation of discussions relating to treatment options and records of informed consent. The dental practice should advise HDC of the outcome of this audit within three months of the date of release of the final opinion.

Follow-up actions

82.
- Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of the final 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 they will be advised of Dr C's name.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

83. The Director of Proceedings decided to institute a proceeding, which is pending.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A — Independent advice to the Commissioner

The following expert advice, dated 9 December 2012, was obtained from Dr Mary Towers:

"To provide independent preliminary advice about:

1. Should [Dr C] have performed root canal treatment on [Mr A's] tooth number 46, and subsequent procedures?
2. Should [Dr C] have informed [Mr A] and his parents about the separated instrument, in the root canal?
3. Should [Dr C] have administered pain relief to [Mr A] when requested?

I wish to state that I have read and agree to follow the Independent Advisors Guidelines.

I graduated from the Otago Dental School in Dunedin in 1978 with a Bachelor of Dental Surgery.

I am registered with the NZ Dental Council to practise in NZ.

I am a current member of the New Zealand Dental Association, the NZ Society for Anaesthesiology and Sedation, NZ Endodontic Society and NZ Periodontal Society, and Nelson/Marlborough Branch of the NZDA.

I have a current Certificate of Continuing Postgraduate Education.

I have worked in general Dental Practice in New Zealand for the last thirty years, and also in Kew Hospital and currently own my own private Dental Practice and have a Senior Dental Surgeon position at the Nelson Marlborough DHB.

I have no conflict of interest in this case as I do not know either [Dr C] or [Mr A] and I have no prior knowledge of this case.

The Commissioner's Office has asked me to comment on the standard of care provided by [Dr C] for [Mr A] in terms of the Code of Health and Disability Services Consumers' Rights law.

[At this point Dr Towers listed all the documents she was provided with and a summary of the facts. This has been removed for brevity.]

The facts and assumptions, on which my opinion is based, come from my working knowledge and experience of general dentistry and accepted normal procedures in the area of diagnosis, restoration and endodontics in general private dental practice and within the Dental Benefit Contract scheme. This includes Guidelines from our district health board Adolescent Schedule and Endodontic Guidelines recommended by current registered endodontists who teach endodontic courses for both undergraduates and general dentists; also from the NZDA Code of Ethics and from evidence based international Dental publications. Also the NZDA guidelines on informed consent and the Health and Disability Commissioners Act 1994 and Code of Health and Disability Services Consumers' Rights 1996.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Advice for the Commissioner

1. Should [Dr C] have performed root canal treatment and subsequent procedures?

According to the Dental records I have reviewed, [Mr A] presented to [Dr C's] practice, with a tooth, 46, already filled with a deep restoration. When he presented in pain on 01/08/2007, the notes state there was a fractured restoration and this was replaced with a composite restoration.

The next visit was 03/07/2008 when the notes state C.I.P. meaning chronic irreversible pulpitis. Acceptable treatment for irreversible pulpitis is removal of the inflamed nerve which is what was done at this appointment.

It is normal procedure in general dental practice, to perform root canal treatment. General dentists are trained to do this.

In the Operational Guidelines for the service Agreement for the provision of Oral Health Services for Adolescents, standard oral health services include: *7.2.8 Pulp and root canal treatment:*

'Best clinical practice for pulpal/y involved permanent teeth suggests that management by root canal therapy is the preferred option'.

So, yes, this procedure should have been carried out.

But subsequent procedures, ie, the RETREATMENT of a failed root treated 46?

I have spoken to our local specialist endodontist many times about retreatment of permanent molars and his opinion is usually that, in a specialist's hands the average success rate is about 60% for retreatment. When asked his opinion for retrieval of a separated instrument, his opinion is this should not be done unless under an endodontic microscope, in the hands of an endodontist.

In this case of [Mr A's] tooth; he does not have a third molar on his lower right hand side, so the first lower right permanent molar is strategically a very important tooth for his biting ability and the occlusion of his arch.

My opinion is that [Dr C] should not have tried to retreat this tooth but should have sought out a specialist endodontist's help and referred [Mr A].

2. Should [Dr C] have informed [Mr A] and his parents about the separated instrument?

Yes.

'*Every consumer has the right to be fully informed — an explanation of his or her condition and of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option'* from HDC Code.

'*For endodontics (root fillings) options available, success rates, compromise versus definitive procedures, separated instruments as a risk during treatment*' from NZDA guidelines of informed consent.

Although the NZDA guidelines for the age of consent is 18 years, legally 16 years is the age for medical procedures. Regardless of the variability of the actual age,

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

in this case neither [Mr A] nor his parents were informed of the separated instrument or it appears, the retreatment and risks or time frame or options.

3. Should [Dr C] have administered pain relief to [Mr A] when requested?

Yes.

The dental records indicate that verbal post operative care was discussed but the records are not complete. According to [Dr C's] letter to [the family], he had advised [Mr A] to use panadol and neurofen which is readily available without a prescription.

Pain is subjective and every person has individual requirements. Dentists deal with pain every day and are usually expert on advising on the use of analgesics. I think the indication that [Mr A] had ongoing pain could have been indicative of the seriousness of the procedure and may have been dealt with better if the discussion about what was going on had taken place.

Having said that, good analgesics are available to purchase. [Dr C] maybe would have been better to have consulted with either of [Mr A's] parents who would have more experience with pain and know their son's pain threshold, and discussed suitability of various choices.

Discussion

Having read the documents provided including case notes, radiographs, specialists opinions, treatment plans and ACC correspondence and also [Dr C's] letter to [Mr A] and his parents, my opinion is:

[Mr A] presented for regular treatment in 2007 with some existing dental conditions, ie, a deeply restored 46. In the following year he presented with a breakdown of this restoration and/or some dental caries in this tooth creating discomfort and requiring active treatment. There is evidence from the radiographs that tooth 46 had been deeply restored and subsequently was restored with a composite restoration.

This sequence of events is normal and with a young vital pulp, and the extent of restoration already present in this tooth, it is not surprising that the pulp became inflamed and required pulp removal and root canal treatment. Molar root canal treatment is considered a regular dental treatment and comes under the list of treatments not requiring prior approval from the Dental Benefit Scheme administration.

I understand that [Mr A] was informed he needed the root canal treatment and this was carried out. This is a normal daily part of a general dentist's tasks.

However, this particular root canal treatment did not go according to plan and at some stage of the proceedings (not recorded in the clinical notes) a fine instrument used to clean out the canals, had become separated and was in the root. The separation of these fine instruments is a known hazard and risk of root canal treatment and is often of no consequence if it has happened in a clean canal and is in the right place. However, it seems that in this case, either the instrument was in the wrong place or there was still debris in the canal and the tooth did not settle. It appears that [Dr C] did not inform the patient or his parents at this stage.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

When [Mr A] developed pain in this tooth the following year, [Dr C] decided to try and 'fix' the problem by going back into the same tooth and trying to retrieve the instrument and redo the root canal treatment. This is a difficult procedure to perform and is in the realm of specialist skill level and equipment level. Certainly the radiographic evidence after this procedure does show he has improved the root filling in the distal canal but, unfortunately, in his attempt to retrieve the separated instrument he has removed a lot of tooth hard tissue and also perforated the root (mentioned in the clinical notes). He went on to repair the perforation with the correct material (MTA) which has been successful but has resulted in a discolourisation of the tooth and a weakened structure.

[Dr C] verbally gave post operative care instructions and advised over the counter medications for pain relief. This is acceptable.

BUT, even though [Mr A's] parents had asked about the ongoing treatment and were aware that something more was going on, [Dr C] did not actually sit down with them and explain what had happened and that he was trying to rectify the problem. Nor did he offer them any other option for treatment, for example, a specialist referral.

This is a serious departure from the acceptable standards of informed consent.

There is no definite age for legal consent for medical or dental treatment; anyone over the age of sixteen is considered a legal adult, but the acceptable standard of care would involve a full and frank discussion about the mishap and risks, consequences and options of each case.

[Dr C] has admitted to failing to 'advise of the real circumstances' in his letter to [the family] dated October 10, 2011.

In conclusion, although [Dr C] had been diligent in his treatment initially, an endodontic instrument did accidentally fracture and remain in the mesial canal of [Mr A's] tooth.

At that point in time accepted standards suggest he should have stopped and had the discussion with [Mr A] at least about the incident and options. This would then have allowed [Mr A] and his family to make an informed choice for further treatment. It may not necessarily have altered the long term outcome of this tooth, due to its compromised state, but their pathway would have been clearer and the decisions would have been in their hands."

Further expert advice from Mary Towers — 19 August 2013

"I have read the original documents from the initial report and also a copy of [Dr C's] letter response dated 22/3/2013, enclosing a copy of the updated policies and consent forms.

1. [Dr C] has advised HDC that 'the retreatment of root canals is possible and undertaken by general dental practitioners with sufficient experience and who have a special interest in Endodontics'.

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

a. Retreatment of the root canal and retrieval of a separated instrument is **within the scope of practice of a general dentist**.

b. [Dr C's] decision to retreat the tooth was **not** a departure from expected standards. However, the decision to retreat the root canal should have been made in conjunction with the patient and other alternative treatments discussed.

2. The retreatment of the tooth (46) was unsuccessful The purpose of the retreatment was to attempt to retrieve the separated instrument, re-clean each canal and seal with appropriate endodontic sealers, and restore the tooth to a sound, usable restoration.

This was not achieved and in the retreatment procedure, the root was perforated and much sound tooth tissue removed resulting in a weakened hard tissue structure for future restoration. Also the separated instrument was not removed. It is not always necessary to remove a separated instrument from a root canal so long as the cleaning of the canals is still technically able to be done around or beyond the instrument. This does require a high level of skill and excellent equipment, usually only found in the hands of a specialist endodontist, But not always. [Dr C] has attempted to retreat [Mr A's] tooth, 46, in the interests of his patient. Under the New Zealand Government Dental Benefit Scheme, there is no funding for treatment by Dental Specialists, ie, endodontists. Also, there were no endodontists in the immediate area so a referral would have required the patient to travel some distance for treatment. Dentists in smaller towns without specialists close by, often do more of the difficult treatment options than those in a city practice.

[Dr C], therefore assumed that he was doing his best for [Mr A] by putting in a huge effort to try to salvage the tooth he had already treated, by retreatment. According to the opinions of the endodontist, [Dr F], and the prosthodontist, [Dr G], the tooth in question, 46, is not going to be worth restoring for the future. The case has already been accepted by ACC for restoration with an implant after tooth removal.

So was the care/treatment provided, of an appropriate standard?

No.

There is always a percentage of failure for root canal treatment, even in the hands of a specialist. This failure rate is higher in retreatment. For success in root canal treatment, there must be complete cleaning of canals thereby removal of infection and complete sealing of canals and full restoration of the tooth, therefore, a seal of the restored canals.

In this case, the canals appear to have been cleaned out in some areas, very well. The attempt to remove the separated instrument has left a weakened tooth which does mean a reduced long term prognosis for its mechanical strength. Also, the final full cover sealed restoration of the tooth crown, was not done. From [Dr C's] notes, he placed a restoration in the front half of the tooth (mob), not a full cover restoration. Sometimes, a partial restoration, like this, is done as a temporary cover but there is always a risk of the tooth fracturing mechanically and

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

compromising the seal of the root canal restoration. For [Mr A], this subsequently led to breakage of the already weakened tooth.

One of [Mr A's] complaints is that the tooth felt weak and the filling in it had broken. This was because the standard restoration for a root fill tooth is a full cover restoration — so the whole crown of the tooth is sealed and protected from fracture — this was not done at this stage.

3. The appropriateness of the changes made by [the dental practice] following this incident:

I have sited the paper, 'Informed Consent for root canal Treatment' and the paper, 'Root Canal Treatment'. I am presuming the changes that have been made are the introduction of these two papers to the practice and that they are now being discussed and offered to patients requiring root therapy. There is no indication if these two papers were already in place at the time of this case or not. **The informed consent is an excellent start to discussion**.

The copy of the 'AAE Endodontic Case Difficulty Assessment Form' seems a recent addition to the practice and appears to be a useful tool which may help in the future to identify some clues as to the level of expertise required in each case; at least it will be a paper (or computer) trail if there are problems; a learning tool."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.