Totalhealthdentistry Limited
Dentist, Dr F

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00777)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report discusses the dental services provided to a woman by a dentist and Totalhealthdentistry Limited, from 2016 to 2018 inclusive. The woman complained that over the three years the dentist treated her, she "endured unbearable physical and psychological suffering and hardships", and that the outcome of the dentist's treatment was worse than the original condition of her teeth.

Findings

2. The Deputy Commissioner found that the dentist breached Rights 1(1), 4(1), 4(2), 4(4), and 6(4) of the Code. The breaches related to failing to treat the woman with respect, failing to provide services to her with reasonable care and skill and in a manner that minimised potential harm, and for clinical record-keeping that did not comply with professional standards.

3. In addition, the Deputy Commissioner found that the dentist breached Rights 10(1) and 10(3) of the Code for not accepting the woman's verbal and written complaints about the care he provided, and for failing to facilitate a fair, simple, speedy, and efficient resolution of the woman's complaint.

Recommendations

4. The Deputy Commissioner made a number of recommendations, including that the dentist comply with any and all restrictions and supervision of his practice as advised by the Dental Council, and that he report to HDC on the audit/progress reports of any such measures at least six monthly for two years. The Deputy Commissioner also recommended that the dentist apologise in writing to the woman for the breaches of care identified in this report.

5. It was further recommended that Totalhealthdentistry Limited consider providing a refund to the woman for the treatment provided to her between 2016 and 2018, and report to HDC on the outcome; that it develop policies relating to payment for services, and provide these to HDC; and that it arrange for an inspection of its clinic by an independent evaluator, and provide the report to HDC.

6. The Deputy Commissioner also decided to refer the dentist to the Director of Proceedings owing to the care provided to the woman having been severely below the appropriate standard, and for inappropriately altering the woman's clinical records.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her by Dr F. The following issues were identified for investigation:

- *Whether Dr F provided Mrs A with an appropriate standard of care from 2016 to 2018 (inclusive).*
- *Whether TOTALHEALTHDENTISTRY Limited provided Mrs A with an appropriate standard of care from 2016 to 2018 (inclusive).*

8. This report is the opinion of Deputy Commissioner Vanessa Caldwell and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Consumer's husband
Dental implant & periodontics clinic	Provider
Dr B	Provider/periodontist
Dr C	Provider/dentist
Dr D	Provider/dentist
Ms E	Provider/dental hygienist
Dr F	Provider/dentist

10. Further information was received from the Dental Council of New Zealand.

11. Independent advice was obtained from a dentist, Dr Jeffrey Annan (Appendix A).

Information gathered during investigation

Introduction

12. This report relates to the dental care Dr F and Totalhealthdentistry Limited provided to Mrs A, involving the extraction of teeth, placement of implants, and the purchase of dentures. Mrs A told HDC that she paid Dr F more than $16,000 to treat problems with her teeth, but the outcome of his treatment was worse than the original condition of her teeth. Mrs A complained that over the three years during which Dr F treated her, she "endured unbearable physical and psychological suffering and hardships". Mrs A alleges that Dr F was the clinical leader in relation to her treatment.

13. Mrs A told HDC that the clinic had no receptionist, so the clinic door was closed, and nobody was in attendance. Mrs A stated:

> "When they were treating patients, they spent lots of time looking for tools and materials … patients had to leave a message on [Dr F's] mobile phone, and then he would make an appointment to see the patient."

14. Mrs A told HDC that about 80% of her appointments were changed, and the location was a garret,[1] which had only one room that was used as an office, reception, storage, hygiene area, X-Ray area, surgery area and patient waiting area. Mrs A stated that she did not think it was suitable as a dental clinic.

15. Dr F denied that he was the "clinical leader" in relation to Mrs A's treatment. He stated that his only involvement in Mrs A's treatment was the placement of the implants, and dentists Dr D and Dr C worked on Mrs A independently.

Dentures and implants

16. A denture is a removable replacement for missing teeth and surrounding tissues. Two types of dentures are available — complete and partial dentures. Complete dentures are used when all the teeth are missing, while partial dentures are used when some natural teeth remain.

17. Complete dentures can be either "conventional" or "immediate". A conventional denture is made after the teeth have been removed and the gum tissue has begun to heal, and is ready for placement in the mouth about 8 to 12 weeks after the teeth have been removed.

18. Unlike conventional dentures, immediate dentures are made in advance and can be positioned as soon as the teeth are removed. As a result, the wearer does not have to be without teeth during the healing period. However, the bones and gums shrink over time, especially during the healing period following tooth removal. Therefore, a disadvantage of immediate dentures compared with conventional dentures is that they require more adjustments to fit properly during the healing process, and generally are considered only a temporary solution until conventional dentures can be made.

19. A dental implant is a piece of titanium or other material that looks like a screw. It is put into the jaw where the roots of a missing tooth had been. Over time, bone grows around the implant, which helps to hold it in place. An artificial tooth, or crown, is then attached to the metal to fill in the gap left by the missing tooth. Dental implants can also be used to hold a dental bridge[2] or dentures in place.

Dr F's qualifications

20. Dr F is registered in the general dental scope of practice. He told HDC that he has a postgraduate certificate in periodontics[3] and, although he is not registered as a specialist

[1] An attic.
[2] A bridge is a fixed dental restoration used to replace one or more missing teeth by joining an artificial tooth or teeth to adjacent teeth or dental implants.
[3] Periodontics is a dental specialty that focuses exclusively on the inflammatory disease that destroys the gums and other supporting structures around the teeth. A periodontist is a dentist who specialises in the prevention, diagnosis, and treatment of periodontal disease and in the placement of dental implants.

periodontist in New Zealand, his claim to "speciality in periodontology is reasonable". In his responses to HDC, Dr F repeatedly referred to himself as an experienced periodontist.

21. The Dental Council informed HDC that "periodontist" is a legally protected title for practitioners who are registered in the periodontic specialist scope of practice. The Dental Council said that Dr F is not a registered periodontist as he is registered only in the general dental scope of practice and, therefore, he must not claim to be a periodontist or otherwise suggest that he practises as a periodontist.

22. The Dental Council told HDC that in 2013 and 2014 it cautioned Dr F not to promote himself as a periodontist. The Council said that while the practice of general dentistry does include diagnosis and treatment of periodontal (gum) disease — including tooth replacement with dental implants — Dr F is not entitled to claim specialist standing.

23. The Dental Council said that it would appear that aspects of the services Dr F provided to Mrs A were within the general dental scope of practice. The Council noted that there are two aspects to implant treatment:

a) Placing implants, with or without bone augmentation. This aspect is considered within "diagnosis and treatment of diseases or abnormalities of the supporting tissues of the teeth or their substitutes", and it is within the periodontic specialist scope of practice. The Dental Council said that a practitioner who is registered in the general dental scope of practice only is permitted to place implants if they have the knowledge, experience, and skills to do so competently. In the event of a complaint, notification, or adverse outcome, the general dentist may be asked to demonstrate to the Dental Council that they have the required knowledge, experience, skills, and competence to place implants.

b) The restoration, or prosthesis, placed on the implants. This includes the design of the restoration, guidance as to placement of implants, and the restoration. This aspect of implant treatment is not specifically referred to in the scope of practice of a periodontic specialist. It is within the scope of practice of a general dentist, provided the dentist is practising within their level of knowledge, training, and experience.

Mrs A

24. At the time of her first consultation with Dr F (on 12 January 2016), Mrs A was accompanied by her husband, Mr A. Mrs A told HDC that English is her second language, and "listening was quite difficult" for her.

25. Dr F told HDC that he was satisfied that Mrs A could speak and understand English sufficiently to be able to participate in discussions regarding her periodontal treatment.

Consultation 12 January 2016

26. On 12 January 2016, Dr F performed a "screening" assessment of Mrs A's dental condition. Mrs A told HDC that she informed Dr F that she had lost teeth previously because she had a history of periodontitis.

27. Mrs A's concerns are noted in her treatment chart progress notes (the records) as being "periodontal disease and cosmetics". The records note that she had moderate to severe periodontal disease, and a treatment plan was recorded consisting of plaque (a sticky film that coats teeth and contains bacteria) control, "Perio/Hygiene" visits with a dental hygienist, Ms E, and re-evaluation. The records state: "Informed consent given and confirmed by [Mrs A] and her husband [Mr A] who is fluent in English."

28. Dr F told HDC that he spent approximately one hour with Mr and Mrs A discussing the condition of her teeth, her periodontal structures and soft tissue, as well as taking comprehensive radiographs. Dr F said that Mrs A's periodontal condition and disease was moderate to severe. He stated that he had discussions with Mrs A, Mr A and Ms E regarding contraindications, precautions and risks — in particular that dental implants are generally 98% successful but not all of them work, and that the clinic offers to replace a failing implant at no charge. Dr F said that the biggest risk of implant failure is where the patient's oral hygiene is inadequate and inconsistent, and vigilant oral hygiene is something that the clinic "emphasises and insists upon".

29. Mrs A told HDC that after Dr F took an X-ray, he told her that she would have a "good result" following her treatment and be happy in the end. Mrs A said that she asked him several times whether implants would be suitable for her, and his answer was always positive, so she decided to proceed with them. A pre-treatment OPG X-ray[4] provided to HDC by Dr F showed bone loss between all of Mrs A's teeth, and that she was missing all four lateral incisors, as well as teeth 16, 18, 26, 27, 28 and 33.

30. Dr F prescribed Mrs A with the following:

- Vitamin C 1500mg
- Calcium 283mg
- Magnesium
- Vitamin D
- Augmentin 625mg
- Metronidazole 400mg

31. The records do not contain a reason for the prescriptions.

Hygiene treatment

32. Hygienist Ms E told HDC that she saw Mrs A because Dr F had recommended that Mrs A undertake the Periodontal Disinfection Programme hygiene treatment prior to any surgical treatment. Ms E said that Mrs A had commenced taking antibiotics as prescribed by Dr F, and she emphasised to Mrs A the importance of home care for plaque control and regular continuing care.

[4] An OPG is a panoramic or wide view X-ray of the lower face, which displays all the teeth of the upper and lower jaw on a single film. It demonstrates the number, position and growth of all the teeth, including those that have not surfaced or erupted.

33. Ms E's records for 14 January 2016 refer to "5mm pockets[5] [being present] through [the] lower [mandible] (jaw)".

34. Ms E told HDC that there was no finalised treatment plan at that stage, but Mrs A understood that the best option was the extraction of all her teeth from her upper jaw, to be replaced with an implant-supported denture, and extraction of tooth 46 (on the lower right-hand side). Ms E said that she explained her role to Mrs A and told her that her treatment would entail multiple appointments to remove damaged tissue and to "fine scale" her mouth (remove all the plaque and tartar above and below the gumline), supported by applying iodine beneath the gums and between the gums and the bases of the crowns of the teeth.

35. On 21 January 2016, Ms E documented in Mrs A's records that Mrs A's oral hygiene was good. The notes for that day state: "Please ask [Mrs A] about her medical history when in today — cannot understand what she has written on her [health questionnaire]."

Dr D

36. Dentist Dr D told HDC that he developed a specialty in implant prosthodontics (the replacement of missing teeth and/or associated structures by restorations that are attached to dental implants). He stated that he performed prosthodontic work frequently for Totalhealthdentistry Limited.

37. Dr D stated that in January 2016 he attended a meeting with Dr F, Mr A and Mrs A to discuss treatment plans for Mrs A.

38. Dr D said that the periodontal condition of Mrs A's remaining upper teeth left them unsalvageable. He said that they were all mobile with periapical infection (bacterial invasion of the dental pulp) around many of the roots, and the only treatment was a full upper clearance (extraction of all the upper teeth).

39. Dr D stated that following the extraction of Mrs A's teeth, Dr F presented Mr and Mrs A with several treatment options. Dr D told HDC that the treatment plan to which Mr and Mrs A agreed included the removal of the remaining upper teeth and provision of an immediate denture. Dr D explained that once the implants were placed in Mrs A's mouth, the denture was then to be modified and retained with locators, or a new upper denture would be constructed if this modification was not feasible.

40. Dr D stated that Mrs A requested that following the locator retention phase, the denture be made in a "horseshoe" style, without a "pallet".

41. Dr D told HDC that his involvement was to arrange for the making of the denture prior to the extractions. He stated that this work was contracted to a clinical technician at another dental service. Dr D explained that the clinical technician was very experienced in the requirements of dentures.

[5] Space between the gums and teeth.

Consultation 29 January 2016

42. The records from a consultation Mrs A had with Dr F on 29 January 2016 state that Mrs A disliked the look of her upper front teeth. Mrs A saw her mouth as "ugly" and "wanted to smile again". The records state: "Plan implant and extraction procedures." There is no reference to Dr D being present.

43. The records state that Dr F showed Mr and Mrs A videos of full dentures and implant-supported dentures, and they decided not to proceed with a full denture without support. The records note that the cost of a locator denture[6] was $15,000–$16,000, whereas an "all on four" (in which four dental implants support a new full set of teeth) was $40,000, and Mrs A chose the locator-retained denture with the possibility of going to a screw-retained "all on four" denture in the future.

44. The plan was to extract Mrs A's upper teeth and place two implants in the upper posterior areas, and place two anterior implants later.

Consultation 13 June 2016

45. The records for this consultation state that Mrs A discussed with Dr F the options with implants, and also horseshoe dentures. The records state: "[W]as told lower tooth was hopeless and needs [oral surgery] tooth 35 abscess? [tooth] 46 painful and needs to come out."

Appointment with Ms E 20 June 2016

46. Ms E saw Mrs A on 20 June 2016 for a review appointment. Ms E told HDC that she reviewed Mrs A's oral hygiene technique with the water pik[7] and introduced interproximal brushes (used to clean the spaces in between the teeth). Ms E said that again she stressed the importance of plaque control to maintain the health and stability of Mrs A's periodontal condition and recommended that Mrs A have continuing appointments at three-month intervals.

47. Mrs A told HDC that Dr F asked her to use household bleach in her water flosser, and she disliked the taste of it.

48. Dr F told HDC that sodium hypochlorite (the active ingredient in bleach) was a clinically appropriate treatment. He stated:

> "[Mrs A's] anecdotal discussions with her friends are irrelevant. The treatment recommended was inexpensive and effective. (Throughout cost was a significant issue for [Mr and Mrs A])."

[6] A locator-retained overdenture is a removable prosthesis containing replacement teeth that is placed in the mouth. The prosthesis is mounted in a base made of pink resin to create an exact fit over the existing gums. It snaps into place using button-like fittings called locators.

[7] A water flosser that sprays water to remove food from between the teeth.

Contact with Mrs A

49. Mrs A's records for 19 and 20 June 2016 contain an email from Dr F to Mrs A stating that a new treatment plan was attached (not in the records) and that the overall cost was now $20,845.00.

50. On 21 June 2016, Mrs A's records state: "Primary impressions taken of both jaws. Need special tray for upper only. Sufficient teeth to do bite without blocks." The records for the same day also refer to an appointment for tooth whitening for $200, but no further details are recorded. Mrs A expressed concern to HDC that her upper teeth were whitened when they were about to be extracted.

51. On 25 June 2016, Dr F emailed Mrs A deferring her appointment for extractions. In the email, Dr F apologised for a "duplicate prescription" and stated:

> "I wish you would have gone to our pharmacy … then the error would have been picked up and you could have come back for a new one. Also I do not answer ... UNKNOWN NUMBERS … PLS TAKE YOU[R] PHONE OFF OF THAT SETTING … not answer UNK[N]OWN NUMBERS." (Emphasis in original.)

Extractions

52. On 28 June 2016, Dr D extracted Mrs A's tooth 46 (a lower molar) and took an impression of Mrs A's upper jaw.

53. The records state that on 12 July 2016 Dr F extracted teeth 16, 14, 13, 12, 11, and 21, and the locators and upper implants were placed.

Denture fitting

54. Dr F said that Mrs A's immediate denture needed to be relined to fit while her maxillary arch remodelled. He said that it is very common after having full arch extraction to need to reline the immediate denture in order to improve its fit while the jaw is remodelling due to the root sockets of the teeth that were extracted.

55. Dr D told HDC that he eased the sore spots and carried out a temporary tissue conditioning reline of the denture. He stated that because of the periodontal loss of bone, the buccal flanges (the extensions of the denture on the cheek sides) had to be reduced on several occasions as the denture settled in, and this reduced Mrs A's retention of the plate. He said that as an interim measure, he suggested to Mrs A that she use "hold-tight adhesive" until the denture could be stabilised with the implants.

Extraction tooth 38 (wisdom tooth)

56. On 2 August 2016, Dr F extracted tooth 38 (the lower left wisdom tooth). No reason for this is stated in the records. The records on 20 October 2017 also state that tooth 38 was removed.

Further adjustments of denture and implants

57. On 9 August 2016, the denture was adjusted, and on 25 August 2016 Dr F prescribed Voltaren (a nonsteroidal anti-inflammatory drug used to treat pain and inflammatory disease) and metronidazole (an antibiotic). No reasons for the prescriptions are noted in the records.

58. On 30 August 2016, Dr F and Dr D placed a locator in the implant on site 25. This is the piece of the implant system that is screwed to the head of the implant fixture and fits into the denture to keep it in place but allows the patient to remove it for cleaning. The records state that the locator on the site 15 implant was very tight, so a longer locater was ordered and was to be placed in a month's time.

59. On 8 November 2016, it is documented that teeth 22, 23, and 24 were removed at that time and implant fixtures were placed in sites 13, 23 and 46.

60. Dr F told HDC that at the time of Mrs A's treatment with him in 2016, the Dental Council did not require written consent to be given by patients. He said that he had multiple consultations with Mrs A and her husband to explain the plan and prognosis. Dr F stated that he met with Mrs A on 8 November 2016 to discuss "her treatment during every consultation to ensure that she was informed regarding her treatment per the [Dental Council's] guidelines in effect at the time".

61. Dr D told HDC that the last time he saw Mrs A was on 15 November 2016. He stated that he was able to place only two locators, and at that time Mrs A was happy with the appearance and retention of the denture. Mrs A's records state: "[W]on't do 4 [locators] until the hard reline is done in six months." It is also noted that the lower implant looked "OK".

Construction of denture — Dr C

62. Dr C told HDC that he owns a practice where he practises all forms of dentistry (general, cosmetic, Invisalign orthodontics, implants, and complex rehabilitation). He stated that he worked closely with Dr F from 2016 to 2018.

63. Dr C said that he first met Mrs A on 20 January 2017 when Dr F introduced her to him. Dr C stated that he was briefed on the treatment plan, which was to construct a metal-reinforced upper locator denture with an open palate to be custom fitted to Mrs A's existing implants. He stated: "We reviewed her progress and she was happy and comfortable with the treatment to date."

64. Dr C said that he saw Mr and Mrs A regularly over the following four months to construct the new upper locator denture and restore a single crown on a lower implant. The site 46 implant crown (a surgical implant that replaces a missing tooth and has a crown placed on top to look and function like a normal tooth) was placed on 28 March 2017.

65. Dr C stated that careful planning and several try-ins of the denture were undertaken, and the final denture was delivered to Mrs A on 13 May 2017. He said that it was quite

challenging to deliver the aesthetics that Mrs A required, and to balance good function against the uneven bite plane of Mrs A's natural lower teeth.

Further appointments with Ms E

66. Ms E said that she saw Mrs A several times as Mrs A transitioned from a non-supported full upper denture to an implant-supported denture. Ms E said that Mrs A expressed frustration and concern over aspects of the denture that she felt were not right, and each time Ms E referred her to Dr C or Dr F.

67. Ms E said that in July 2017 Dr C referred Mrs A back to her because she had pain around tooth 26. Ms E stated that she assessed Mrs A and noted that the buccal attachment was pulling on the implant and there was also plaque present. Mrs A said that she was unable to clean the area well because of pain. Ms E said that she debrided[8] the area lightly with Curasept (an antibacterial product that helps to break down the bacteria that causes gum disease) and applied Betadine (an antiseptic used for skin disinfection). She said that she advised Dr F of her findings and noted that Mrs A was scheduled for an adjustment appointment with Dr F the following week.

68. Ms E said that she saw Mrs A again on 18 September 2017 following an appointment with Dr C regarding tooth 26 showing worsening inflammation and heavy sub-gingival plaque.

Further appointments with Dr C

69. Dr C said that over the six months following the supply of the denture, he saw Mrs A eight times and applied various adjustments to help improve the comfort of the denture. He stated that many of the adjustments involved the denture on the left side at the back, as it was uncomfortable because it pressed against the gum tissue surrounding one of the implants. He said that generally there was some degree of plaque-associated inflammation around the teeth and implants, and this varied depending on Mrs A's ability to maintain a high level of oral hygiene at home. He said that the plaque-induced inflammation around the implant at the tooth 25/26 region improved when Mrs A's home care with the water flosser was more consistent.

70. Dr C said that his final appointment with Mrs A was on 3 November 2017, and at that stage all the implants were comfortable, and Mrs A's oral hygiene was particularly good. However, she was complaining that the denture was rocking slightly and dropping down at the back when she was biting on the front teeth. The records note that the denture manufacturer had advised that this could be improved only with a new denture. Dr C recorded that he had told Mrs A that he was not sure that a new denture would make much difference, as her lower anterior teeth were much higher than the posterior ones. He noted that Mrs A had asked whether she would have to pay for a new denture, and he told her to discuss that with Dr F.

[8] Cleaned.

71. Dr C said that on Dr F's advice he offered to either fit tighter rubber inserts on Mrs A's locators with the back implant, or refer Mrs A to the denture manufacturer, and Mrs A said that she would think about it.

72. Ms E said that Mrs A was scheduled for her next hygiene appointment in December 2017, but Mrs A said that she wanted to wait until her new denture had been fitted. Ms E said that she contacted Mrs A again in March 2018, at which time Mrs A said that she had seen a hygienist locally and everything was fine.

73. Ms E told HDC that she advised Mrs A that her situation should be reviewed. Following discussion with Dr F, Ms E sent an email to Mrs A stating that it was strongly recommended that she continue to have her care with them. The email states:

> "[Dr F] is a specialist periodontist and if he is unable to review your mouth regularly we will have to downgrade your long-term prognosis to poor/indeterminate. Any future problems will then become the responsibility of the practice that you have chosen to care for you in the interim. It has been a pleasure treating you, we wish you luck with your future care. You are always welcome here."

Problems with implant

74. Mrs A told HDC that at the time Dr C fitted the denture in November 2017, and during Ms E's regular hygiene processes, they both found inflammation around the implant in the 25 position. Mrs A stated that they put medication around it, and told her that this problem should be sorted out by Dr F, otherwise it would cause serious problems and the implant would fail, and they said that they would let Dr F know about the issue.

75. Mrs A stated that she had a problem with her denture rocking, so at the end of 2017 Dr F sent her to the manufacturer for another denture. Dr F told HDC that it was Dr C who referred Mrs A to the denture manufacturer, which he said demonstrated that he (Dr F) was not the lead clinician. Mrs A told HDC that the new denture was satisfactory when she was eating, but after a couple of months her tongue felt increasingly painful, and she could not wear the denture for a whole day. She said that the problem appeared to be related to overclosure, and she asked the denture manufacturer to adjust the denture a few times, but they said that they could not improve it further.

76. Mrs A told HDC that when she asked Dr F to organise for the denture to be fixed, he said that she should deal with the manufacturer, but they said that she had to go through him, because he had referred the job to them, and he was responsible for the payment. Mrs A said that no one was willing to be involved in repairing the denture until the implant issue was resolved, so she was in a "hopeless and helpless situation".

77. Mrs A told HDC that she and her husband asked Dr F to check the implant, but he always said, "that's fine", and did not want to examine it. She stated that they insisted on an appointment with Dr F for him to check the implant. Mrs A attended an appointment with Dr F on 20 April 2018. Mrs A said: "[At this appointment, Dr F] spent only one minute knocking the implant and said '[it's] fine' and he didn't want to see me anymore."

Second opinion sought — Dr B

78. Mrs A told HDC that she sought a second opinion from a registered specialist in periodontics and dental implants, Dr B. Mrs A stated that he checked her implants on 5 September 2018. Dr B's report documenting Mrs A condition stated:

> "Inflammation and bone loss was associated with the implant in the 25 position. A lack of attached gum tissue around this particular implant also has resulted in exposure of a portion of the implant which has now become infected."

79. In the report, Dr B documented that the use of individual implants with locators to support a full upper denture was not a conventional treatment approach and, while it is widely used by some clinicians, it can lead to problems that are often soft tissue related regarding the gums around the implants, as would appear to be the case for Mrs A's implant in the 25 position.

80. Dr B offered Mrs A two treatment options in relation to the implant in the 25 position:

Option 1: To try to salvage or improve the condition around the implant, which would require surgery involving reflecting the gum to clean the implant surface using a Waterlase[9] and air powder abrasion. A gum graft on the outside of the implant would be necessary to try to gain some attached gum tissue around the implant. However, this approach would still leave the implant in a compromised position in the medium to long term.

Option 2: Remove the implant and allow for some healing to take place. In the interim, Mrs A would wear her existing denture on the three remaining implants and continue with regular periodontal maintenance. Following 2–3 months of healing, he could reassess the 25 site and potentially look at a replacement implant in this area. It was likely that this would still need to be undertaken in conjunction with some gum grafting to improve the quality and quantity of attached gum tissue in the area either before or at the same time as the implant was placed.

81. With regard to Mrs A's difficulties with the comfort of the existing denture and her discomfort and swelling of her tongue, Dr B noted that there appeared to be some restriction of her tongue with the existing design of the upper overdenture and possibly a degree of overclosure. Dr B's report concluded that the existing denture should be replaced.

82. Mrs A told HDC that she passed on Dr B's report to Dr F and wanted him to organise a remedial plan, but he still said, "It is a tiny problem," and sent her to a dental laboratory to obtain an All-on-Four or All-on-Six denture to replace the existing denture at her own cost.

83. On 28 October 2018, Mrs A emailed Dr F and asked for a remedial plan for the implant in the 25 position. He responded:

[9] Waterlase dentistry uses laser energy and a gentle spray of water to perform a wide range of dental procedures without the heat, vibration and pressure associated with the dental drill.

"Hello [Mr and Mrs A],

You asked me to write a plan for [Mrs A].

The following is a plan.

Differential Diagnostics … which we are doing

Treatment plan.

Kindly, [Dr F]"

84. Dr F told HDC that periodontal disease and peri-implantitis do not inherently have clinical symptoms of pain, and he believed Mrs A's pain was a result of her not being able to insert her denture vertically into her mouth, so he referred her to the dental laboratory to build her a fixed denture so that her difficulty with placement would not become a chronic problem.

85. Mrs A sent Dr F a copy of the X-Ray performed by Dr B. Mrs A told HDC that at the end of September 2018, Dr F admitted for the first time that the implant in the 25 position had a serious problem, despite the problem having developed 18 months previously.

Transfer of care to Dr B

86. Mrs A said that she had no confidence in Dr F's advice, because he did not have a plan to resolve the issue with the implant in the 25 position and he did not want to take any responsibility to fix the denture. She said that he just wanted to get rid of her case.

87. Mrs A decided to transfer her care to Dr B and to continue the denture work with [the dental laboratory]. She requested a refund from Dr F but he refused the request.

88. On 11 October 2018, Ms E sent the following email to Mrs A:

"Hi [Mrs A].

After re reading [Dr C's] correspondence regarding your mouth I saw he had noted your current oral hygiene was contributing to some inflammation in the mouth. Bacteria is the main contributing factor to inflammation in the mouth and the leading cause of Perimucositis & Periimplantitis. I know you work hard on your home care [Mrs A] so I would like to offer you a hygiene appointment to review your oral hygiene and home care techniques. Please contact me to arrange a suitable appointment.

Regards

[Ms E]"

89. That same day, Dr F sent the following email to Mr A:

"Hi [Mr A],

My best advice to you and [Mrs A] is to let [the dental laboratory] help in the diagnosis of [Mrs A's] atypical pain in her upper left posterior. Since her problems are functional … we know this from her not wearing her denture … no pain. They have some ideas to

help [Mrs A]. The cause of the pain has to be established before any treatment can proceed. More importantly [Mrs A] needs to improve the effect of her oral hygiene efforts … she works so hard but has inconsistent plaque and bio film control … we have many many photos of this when she has had her visits with [Ms G] … and documented promises from [Mrs A] that she will focus her efforts … and of course we would have her come in for double ck's of her focus, shortly after her hygiene visit. At this time … we need to get her stable … Please help us do that.

Kindly

[Dr F]"

90. On 18 November 2018, Dr F requested that Mrs A sign an agreement stating:

"Agreement between [Mrs A] and [the clinic]

I, ([Mrs A]) are in agreement that the problems I have with my denture and implant are common to having dental implants and/or implant retained dentures.

I also understand that bacteria is one of the main causes of peri mucositis and peri implantitis.

I understand that in the construction of a denture the lab asks important questions such as tooth position and if I am happy with the feel and fit and that the accuracy of my answers are important as they determine the final result.

I have also been advised and understand that a screw retained denture is the best solution with the best prognosis going forward and the cost of this will be my responsibility."

91. Mrs A refused to sign the agreement.

92. Dr B removed the implant in February 2019 and advised Mrs A to consult a prosthodontist to obtain a new overdenture.

Discrepancies in records

93. On 25 July 2019, in response to the initial complaint to HDC, Dr F provided a copy of Mrs A's records dated 23 July 2019. This was provided to my independent advisor, dentist Dr Jeffrey Annan, for initial advice. On 15 July 2020, in response to notification by HDC, Dr F provided another copy of the records, dated 29 June 2019. A second copy of Mrs A's progress notes was provided to Dr Annan for further advice.

94. Additional entries were identified in the initial copy of the records that do not appear in the second copy. The additional entries were not marked as having been added retrospectively.

95. In the initial copy of the notes, additional information is documented on 15 visits, and on four visits, information has been deleted relating to discussions Dr F had with Mrs A, and relating to treatment by Ms E.

Responses to provisional opinion

96. Dr F was given the opportunity to respond to the provisional report. He submitted:

> "In review your last expert report verified that
>
> 1. [Dr D] did [Mrs A's] first denture
> 2. [Dr C] did her second denture
> 3. [Ms E] … worked with her to clean consistently
>
> I [Dr F] did her implants that the last expert wrote in his report that they were reviewed by independent periodontal registered specialists and were fine.
>
> Please review the last expert's report.
>
> I don't direct the dentists … they are licensed dentist … **I refer to them** [emphasis in original] and they are responsible for their work. Therefore I am not responsible for their results … although they had good results …"

97. Mr and Mrs A were given the opportunity to respond to the "Information gathered during investigation" section of the provisional report. They told HDC: "This was our nightmare scenario five years ago … we just want [Dr F's] unprofessional and irresponsible service [not to] harm the interest of more patients."

Opinion: Dr F — breach

Introduction

98. Mrs A consulted Dr F over an extended period, during which she repeatedly sought his help to resolve the painful and distressing issues she had with her dental implant. Dr F denied that his role was to be the "clinical leader", and said that he did not direct the dentists who were involved in treating Mrs A. He stated that his only involvement was the placement of the implants, and that dentists Dr D and Dr C worked on Mrs A independently.

99. My independent advisor, Dr Annan, stated that in any case involving implants, it is important that the three component parts of the treatment plan are managed by a lead dentist. Dr Annan said that the surgical part should be performed by the surgeon, the prosthodontic part by the prosthodontist/general dentist, and the laboratory aspect by the laboratory technician. Dr Annan considered that Dr F was the person in charge in Mrs A's case, as he carried out the initial consultation, discussed and agreed on the treatment plan, covered the informed consent considerations, and carried out the surgery. Dr Annan stated that it is clear that Dr F was the lead clinician.

100. I note that Mrs A paid the full cost of around $16,000 to Dr F, rather than to Dr D and Dr C. I agree with Dr Annan that Dr F was the lead clinician responsible for Mrs A's overall

treatment plan and coordination of care. After careful review of the supporting documentation, I found no issues or concerns with the care Dr D and Dr C provided to Mrs A from 2016 to 2018. I discuss the care provided by Dr F below.

Treatment of periodontitis prior to installation of implants — breach

101. On 12 January 2016, at Mrs A's initial appointment, Dr F diagnosed her with "moderate–severe periodontal disease" with treatment including controlling plaque and maintaining good oral hygiene. Dr Annan advised that Dr F had a reasonable plan to treat periodontal disease before removing Mrs A's teeth and installing implants.

102. However, Mrs A's clinical notes on 12 January 2016 record the following prescription to treat periodontitis: vitamin C 1500mg, calcium 283mg, magnesium, vitamin D, Augmentin 625mg, and metronidazole 400mg. Dr Annan stated that these medications appear to have been a "blanket prescription" as part of Ms E's hygienist "disinfection programme", without a definitive diagnosis of deficiency in the vitamins and without reference to Mrs A's current medical history.

103. In response to Dr Annan's opinion, Dr F told HDC that the disinfection programme was carefully and thoughtfully designed to deal with his diagnosis of serious periodontal disease, and with reference to Mrs A's up-to-date medical history, which he said she supplied to him on 12 January 2016. Dr F stated that the use of antimicrobials and antibiotics has been integrated into the treatment of periodontitis over the past 20 years and has resulted in complete healing of many infected periodontal areas.

104. Dr Annan agreed with Dr F that antibiotics were used in acute infections but stated that the process of subjecting patients to regular heavy doses of Augmentin, metronidazole and vitamins could not be considered the normal standard and was a severe departure from accepted practice. Dr Annan advised that Dr F was not registered as a specialist periodontist in New Zealand, and it would have been prudent to plan for a referral to a periodontist if Mrs A's gum health had not improved sufficiently following this treatment.

105. Dr Annan further stated that in order to judge the status of periodontitis objectively, regular charting of the depth of the pockets around teeth, and the presence of deposits, bleeding and recession were essential. Dr Annan advised that there were no periodontal charts to follow the improvement of Mrs A's periodontitis throughout her treatment with Dr F and Ms E, and, considering that these records did not exist, this was a moderate to severe departure from accepted practice.

106. I note that Mrs A's clinical notes do not contain any assurance that her periodontitis was under control before her teeth were removed and implants installed. Dr Annan advised that as controlling the periodontitis was the motivation for the periodontal treatment, it would have been important to have the assurance that the disease was under control before proceeding.

Medical history

107. I also note that a three-page "Welcome to my practice" document was filled out by Mrs A documenting her medical history. The document allows the author to tick certain medical conditions they may have had or had at the time.

108. Dr F made a note stating that "what was recorded [in the medical history] … could not be deciphered". Dr Annan said that no further entries were made about whether Dr F later actually "deciphered" Mrs A's medical history. Dr Annan advised that if Dr F did not obtain, or decipher, Mrs A's medical history during the initial appointment, this would be a severe departure from accepted practice.

109. Dr F told HDC that at all times Mrs A was treated with her medical history known, as she had supplied this herself. Dr F did not elaborate on the issue further.

Use of household bleach

110. Mrs A told HDC that as part of her treatment with Dr F, she was asked to use household bleach in her water flosser to clean her mouth and teeth. Mrs A stated: "I mentioned this to some other dentists and hygienists, [and] they all felt surprised to hear this."

111. Dr F told HDC that the use of sodium hypochlorite, which is found in some specialised bleaches, was clinically appropriate, and "[Mrs A's] anecdotal discussions with her friends [were] irrelevant. The treatment recommended was inexpensive and effective."

112. Dr Annan advised that the use of household bleach in a water flosser at home was unusual and not recommended as a standard practice. He considered that this was a moderate departure from accepted practice.

Conclusion

113. I accept Dr Annan's advice on the matters discussed above. Mrs A's records do not support deficiency in the prescribed vitamins. I am very concerned about Dr F's use of a blanket prescription of medication and a recommendation to use what Mrs A understood to be household bleach.

114. I am also very critical that Dr F did not chart the progress of Mrs A's periodontitis treatment, considering that tooth extraction and implant installation depended on this. It is not clear whether the treatment was successful, and therefore I am unable to comment on the outcome. However, I find that the treatment of Mrs A's periodontitis was not of an appropriate standard, and that Dr F failed to provide services to Mrs A with reasonable care and skill. Accordingly, I find that Dr F breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

115. I accept that Dr F did provide some of Mrs A's medical history, but I am critical that he does not appear to have followed up on the note to clarify her history.

[10] Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.

Response to peri-implantitis and issues with implant — breach

116. Dr Annan advised that the extractions and placement of the implants "appears to have gone smoothly" and apart from some errors in the clinical notes that "do not seem to match the treatment" (discussed further below), there is nothing to suggest that reasonable care and skill was not employed. In light of Dr Annan's advice, this report will not focus on the clinical procedure of the extraction and placement of implants. However, there are several other notable matters regarding Dr F's care that are of serious concern.

117. Mrs A complained about Dr F's response to her concerns about the implant placed in the upper left region of her mouth. I note that the documentation provided to HDC, including that from Mrs A, interchangeably refers to both implant positions 25 and 26. It is my understanding that there was only one implant in this position, and therefore, for the purpose of discussing the concerns around this particular implant, I will refer to it as implant 25/26.

118. Mrs A told HDC that at the end of 2016, when she started wearing the denture on the implants, it "was always uncomfortable, although it was adjusted a few times. It was rocky and would fall when chewing." Mrs A said that she asked Dr F repeatedly to check the implant 25/26 throughout 2017 and 2018, but he always maintained that it was "fine" and did not want to examine it.

119. Dr F told HDC that he had no knowledge of "any failure" of implant 25/26, and he maintains that Mrs A's issues around this area stemmed from 40 years of neglect of her oral hygiene causing severe loss of bone around her upper teeth. Mrs A's clinical notes completed by Dr F on 20 January 2017 recorded Mrs A to be comfortable and happy with progress. However, Mrs A's clinical records in the subsequent months began to demonstrate her obvious and significant discomfort. In the meantime, Dr C continued to make adjustments to the dental prosthesis to ease Mrs A's discomfort, and Ms E continued to provide hygiene support.

120. On 11 August 2017, Ms E noted that there was a problem with the implant in position 25/26, which was worsening, and the prognosis was "poor". Subsequently, Mrs A's clinical notes record that "the [25/26] fixture was not right".

121. Mrs A said that Dr C and Ms E asked Dr F to check the implant at 25/26, which eventually he did on 20 April 2018. Mrs A stated: "He spent only one minute knocking the implant and said [it's] fine and he didn't want to see me anymore."

122. Mrs A told HDC that when she gave Dr B's report to Dr F and asked him to organise a remedial plan, he still said that implant 25/26 was "a tiny problem" and sent her to a dental laboratory to obtain an All-on-Four or All-on-Six denture to replace the existing denture (at her own cost).

123. Dr Annan stated that Dr F disregarded Mrs A's pleas for help with the denture and the pain from the peri-implantitis at the implant 25/26. Dr Annan pointed out that even when Dr B, a specialist periodontist, diagnosed peri-implantitis, there was still no action by Dr F.

124. Dr Annan stated:

> "As the person who planned and implemented the treatment, it was clearly [Dr F's] responsibility to make attempts personally or to have others carry out measures to remedy the situation [Mrs A] was in. Not responding to a patient's pleas for help is a breach of the contract with the patient and clearly is not putting the patient's interests first, which is the first of five ethical principles in the [Dental Council's] Practice Standards. I believe that [Dr F] also failed to uphold the other four principles; to ensure safe practice, to communicate effectively, to provide good care and to maintain public trust and confidence."

125. As Dr Annan noted, over time Dr F distanced himself from the position of control and took less and less responsibility for the treatment outcome, until he encouraged Mrs A to have treatment elsewhere. Dr Annan concluded that his peers would be very concerned that a member of their profession would ignore so many pleas for help from Mrs A, his patient.

Conclusion

126. It is evident that the ongoing alterations to Mrs A's dental prosthesis, as well as the hygienist appointments throughout 2017 and 2018, were making no difference to Mrs A's pain and discomfort. I am very critical that Dr F did not address this lack of progress and left Mrs A in significant pain for over a year. Furthermore, despite Mrs A's contemporaneous records suggesting issues with implant 25/26, Dr F continued to deny this. I consider that Dr F did not provide services to Mrs A in a manner that minimised potential harm to her, and, accordingly, I find that he breached Right 4(4) of the Code.[11]

Request for written treatment plan — breach

127. Mrs A also stated that once she began to experience issues with the implants, Dr F failed to provide her with a written treatment plan of how to correct the issues and minimise her pain. Mrs A said that she asked Dr F to email her a written treatment plan because that was her preferred type of communication, as English is not her first language.

128. Mrs A told HDC that after she developed significant pain and discomfort with the implant 25/26, Dr F wanted her to continue her treatment with him, by focusing on changing the denture and without addressing the pain, and (according to Dr Annan and Dr B) significant peri-implantitis. Mrs A said that Dr F never told her what her treatment plan was to address the pain, and he rarely responded to her requests for a treatment plan.

129. Dr F provided HDC with copies of his email correspondence with Mr and Mrs A. One email (undated) stated:

> "Hello [Mr and Mrs A]
>
> You asked me to write a [treatment] plan for [Mrs A].

[11] Right 4(4) of the Code states that every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

The following is a plan.

1. Differential Diagnostics … which we are doing.

2. Treatment plan.

Kindly, [Dr F]"

130. Dr Annan stated that considering that English is not Mrs A's first language and she struggled to understand it when spoken, her requests for Dr F to email the treatment plan were reasonable. Dr Annan said that despite requests, Mrs A did not receive a written treatment plan from Dr F, and the above response to Mrs A was cynical and disrespectful and entirely unprofessional.

131. Dr F told HDC that a formal written treatment plan was not required, and he never received a formal written request from Mrs A for a treatment plan. However, Dr F also stated that he did provide Mrs A with two emails outlining the proposed treatment plan, when it was requested.

132. I acknowledge Dr F's statement, but the email communication provided to HDC does not support his statement. It is clear that Mrs A did make a request for a treatment plan, which Dr F acknowledged in his reply. I note that Mr and Mrs A repeatedly requested Dr F's plan on how he was going to respond to the pain and issues Mrs A was experiencing, and I am very critical of Dr F's reluctance to address Mrs A's concerns.

133. I consider that Dr F failed to provide Mrs A with a written summary of his proposed treatment, even though it was requested across multiple emails. Accordingly, I find that Dr F breached Right 6(4) of the Code.[12] The disrespectful and unprofessional communication with Mrs A is dealt with below (paragraph 143).

Request to sign disclaimer — breach

134. As documented above, Mrs A contacted Dr F numerous times because of pain and frustration with her concerns about implant 25/26. Mrs A stated that the first time she put her concerns in writing was in a letter from Mr A to Dr F on 26 August 2018. The letter asked Dr F to treat the implant "right now, or even before" and stated: "The last time we saw you in April this year, [Mrs A] was quite concerned about the implant, but you still said no problem."

135. Mrs A told HDC that Dr F did not address her concerns with implant 25/26, and she and Mr A wrote to Dr F again on 30 August, 19 September, and 4 October 2018 requesting an immediate solution to the implant 25/26 issues.

136. Mrs A said that on 18 November 2018, Dr F sent an "unfair agreement and asked [her] to sign [it]".

[12] Right 6(4) of the Code states that every consumer has the right to receive, on request, a written summary of information provided.

137. The agreement stated (in part):

> "I, [Mrs A] are in agreement that the problems I have with my denture and implant are common to having dental implants and/or implant retained dentures. I also understand that bacteria is one of the main causes of peri mucositis and peri implantitis."

138. Dr Annan advised that the document sent by Dr F intended to absolve Dr F of all responsibility for the poor treatment outcome. Dr Annan stated that this document sought to remove all of Mrs A's rights to redress, which he considered to be a severe departure from accepted practice in New Zealand.

139. Dr F told HDC that he was not willing to treat Mrs A unless she signed the agreement, because he was becoming increasingly concerned about Mrs A's failure to maintain good oral hygiene, particularly in controlling the build-up and accumulation of plaque and biofilm.

140. Clause 1(3) of the Code states that every provider must take action to inform consumers of their rights and enable consumers to exercise their rights. In addition, Right 10 of the Code states that every consumer has a right to complain about a provider, and Right 10(3) of the Code states that every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

141. I consider that in requesting Mrs A to sign the document absolving him of his responsibility to fix the implant 25/26 issues, Dr F failed to uphold his duty under the Code. The intent of the document was to circumvent Mrs A's rights as a consumer to complain about the services she received by accepting that the problems she was having were "common to having dental implants".

142. Furthermore, I find that Dr F breached Right 10(1)[13] of the Code by not accepting Mrs A's verbal complaints about implant 25/26 from late 2016, and subsequent written complaints in which Mr A clearly outlined Mrs A's dissatisfaction. I am very critical that Dr F failed to respond to Mrs A's letters and instead asked her to sign a disclaimer absolving him of all responsibility to fix the issues. I find that Dr F did not facilitate a fair, simple, speedy and efficient resolution of Mrs A's complaint and, accordingly, breached Right 10(3) of the Code.

Respect — breach

143. I have considered Dr F's emails to Mrs A, and I am very concerned by the repeated examples of Dr F communicating with Mrs A in a disrespectful and dismissive and unprofessional manner. Below, I refer to a number of examples of cynical responses by Dr F to Mrs A's actions or requests.

144. On 21 June 2016, Dr F gave Mrs A a medical prescription and subsequently sent an email to Mrs A stating:

[13] Right 10(1) states that every consumer has the right to complain about a provider in any form appropriate to the consumer.

> "I wish you would have gone to our pharmacy … then the error would have been picked up and you could have come back for a new one. Also I do not answer ... UNKNOWN NUMBERS ... PLS TAKE YOU[R] PHONE OFF OF THAT SETTING ... not answer UNK[N]OWN NUMBERS." (Emphasis in original.)

145. In March 2018, Mrs A was having problems with implant 25/26, and, as per the above email, Dr F was refusing to respond to her. Mrs A said that at this time, she decided to consult a hygienist outside of Dr F's practice. She stated that in response to this, Ms E consulted Dr F and sent her an email stating that it was strongly recommended that she continue to have her care with the new hygienist outside of Dr F's practice. The email stated:

> "[Dr F] is a specialist periodontist and if he is unable to review your mouth regularly we will have to downgrade your long-term prognosis to poor/indeterminate. Any future problems will then become the responsibility of the practice that you have chosen to care for you in the interim. It has been a pleasure treating you, we wish you luck with your future care. You are always welcome here."

146. Furthermore, as noted above, when Mrs A asked Dr F for a copy of her treatment plan, his response on 28 October 2018 included: "The following is a plan … Treatment plan … Kindly [Dr F]."

147. Dr Annan advised that Dr F's response to Mrs A's request for a treatment plan was cynical and disrespectful. I agree that Dr F's communication with Mrs A, as demonstrated by the above examples, lacked respect. I am concerned by Dr F's use of capitalisation in emails, especially mid-sentence, as it can be interpreted as "shouting", which can be distressing for the recipient. I consider that it was unnecessary for Dr F to capitalise part of his email, and in this context, he was again speaking to Mrs A in a disrespectful manner. The email reads as a demand, which is unreasonable in that it is not, in any way, Mrs A's responsibility or task, as the patient, to change the status of or access to her own phone number simply to suit the desired needs of the provider in this way.

148. Right 1(1) of the Code provides that consumers have the right to be treated with respect. The above examples demonstrate that Dr F had a dismissive attitude toward Mrs A. Accordingly, I find that Dr F failed to treat Mrs A with respect and breached Right 1(1) of the Code.

Documentation — breach

149. Overall, Dr F's documentation of Mrs A's treatment was very poor, as demonstrated above. I am very concerned that the records provided by Dr F are marred by omissions and inaccuracies.

Alteration of records

150. I sought Mrs A's clinical records to ascertain the details of the treatment that Dr F provided to her. However, this process has been impeded by Dr F having provided HDC with two different versions of the records.

151. On 25 July 2019, in response to the initial complaint to HDC, Dr F provided a copy of Mrs A's records dated 23 July 2019 (Version 1). On 15 July 2020, in response to notification of this investigation, Dr F provided a further copy of the records, dated 29 June 2019 (Version 2). Both copies of Mrs A's records were provided to Dr Annan for further advice.

152. Version 1 of the records contains entries that do not appear in Version 2. The additions are not marked as having been added retrospectively. In Version 1, additional information is documented on 15 visits, and on four visits information relating to discussions Dr F had with Mrs A has been deleted, and there are hygiene appointments that do not appear in Version 2.

153. The New Zealand Dental Association and the Dental Council's standard "Patient Information and Records Practice Standard" (2006) (the Standard) states that dentists or their staff must not alter or delete information recorded at an earlier date.

154. I am concerned that Dr F altered the clinical records without identifying clearly that he did so and the reasons why. The multiple alterations of the clinical records casts doubt on Dr F's credibility. The nature of the changes is concerning, and Dr F's conduct in this regard is unacceptable. In addition, I am concerned about the incompleteness and inaccuracy of Dr F's record-keeping. The Standard provides that the patient's treatment record must contain 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.

155. The Standard states that the records must include detail of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon; a concise description of any and all treatment or services provided; and any medicines prescribed or dispensed including the quantity, dose and instructions.

156. Dr Annan has outlined a number of examples in which Dr F's record-keeping failed to meet the expected Standard. I support Dr Annan's analysis and outline the errors and omissions below.

Initial appointment and lack of photos for desired objective

157. Dr Annan stated that Dr F's initial appointment with Mrs A was very short and very little was recorded. Dr Annan advised that Mrs A's initial appointment notes contain no records of charting or any radiographs. Mrs A stated that during her consultation with Dr F on 29 January 2016, she said that she disliked the look of her upper front teeth and saw her mouth as "ugly", and she wanted it fixed so that she could "smile again". Dr Annan stated that the objective of Mrs A's dental treatment was to improve her appearance, but he could not identify any documentation about the final appearance of the denture.

158. Dr Annan advised that there was no mention of function in the planning discussions, and no evidence of a preoperative "wax-up" being carried out. Dr Annan concluded that the lack of photographs was a major omission and a moderate departure from the accepted standard of care, where appearance was the reason for driving the treatment.

159. Dr F disagreed with Dr Annan's opinion and stated that photographs were neither required nor necessary. Dr F said that he relied solidly on the X-rays.

Charting errors

160. Dr Annan stated that when charting was done of Mrs A's teeth, the records often contained errors, for example:

- Dr F recorded having removed Mrs A's tooth 38 on both 2 August 2016 and 20 October 2017.
- Lateral incisors were recorded as being present despite Mrs A not having any.
- Tooth numbers were documented incorrectly, and the position of implant 26 was represented as 25.

161. Dr Annan advised that the identified omissions and charting errors in Mrs A's clinical records constitutes a severe departure from accepted practice.

162. I agree with Dr Annan's advice. I consider that the standard of record-keeping did not comply with professional standards, and I find that Dr F breached Right 4(2) of the Code.

Opinion: Totalhealthdentistry Limited — adverse comment

163. Totalhealthdentistry Limited owned and operated the clinic. As a healthcare provider, the clinic was responsible for providing services in accordance with the Code. In my view, the primary issues identified in this report were the result of individual clinical decision-making made solely by Dr F. However, Mrs A identified concerns relating to the operation of the clinic, which I address below.

164. Mrs A told HDC that she was concerned about the level of professionalism in the operation of the clinic. She said that the clinic had no receptionist, so patients had to leave a message on Dr F's mobile phone, and then he would make an appointment to see the patient. She stated that about 80% of her appointments were changed and, on one occasion when she attended for an appointment, the clinic door was closed, and nobody was there. Mrs A said:

> "When they were treating patients, they spent lots of time looking for tools and materials. [The clinic] is located in a garret. It has only one room in which include office, reception, storage, hygiene area, X-Ray area, surgery area and patient waiting area … I don't think it is suitable for a dental clinic."

165. Dr Annan advised that it was unusual not to have a receptionist to answer telephone calls, and that this could have caused frustration and confusion. With regard to the suitability of the premises, he said that as Mrs A had about 50 appointments over three years, she was in a good position to suggest that the premises were not fit for purpose. Dr Annan stated: "The premises seem to be unsuitable for a dental practice carrying out surgical procedures." I

accept this advice and consider it appropriate for an independent inspection of the premises to be undertaken to determine whether they are suitable for the procedures being performed.

166. Mrs A also told HDC that the clinic required that she pay the full amount for her treatment prior to the commencement of the treatment. Dr Annan advised that the practice of demanding full payment before treatment is unusual and not recommended by any dental authority. He stated:

> "A half payment before and the balance at the time of treatment is reasonable. It is unreasonable for the full fee to be demanded for a treatment which is to take six months or more to complete and a serious financial risk for the patient."

167. I agree with this advice and am concerned about the overall management of the clinic. I encourage the clinic to reflect on Dr Annan's advice, specifically on requesting full payment before commencement of treatment. I acknowledge that paying upfront can be of benefit for some customers, as it may eliminate an element of surprise in the form of hidden costs. However, as noted by Dr Annan, asking for payment up front for a long-term treatment can create a financial risk for the patient, and as shown in Mrs A's case, the situation can change at any time, leaving the individual with limited access to redress and potentially a long complaint process.

Recommendations

168. I recommend that Dr F undertake the following:

a) Apologise in writing to Mrs A for the breaches of care identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

b) Take steps to ensure that neither he nor others with whom he works refer to him as a periodontist (or otherwise suggest that he practises as one) for as long as he remains unregistered with the Dental Council as a specialist in that area. Dr F is to report to HDC on the steps taken to meet this recommendation within three weeks of the date of this report.

169. The Dental Council register currently states that Dr F "[m]ay not practise in the General Dental Practice Scope of Practice". I recommend that in addition to the above, Dr F:

c) Within three months of the date of this opinion, or within one month of the date on which Dr F returns to practice (whichever date is later), comply with any and all restrictions and supervision of practice as advised by the Dental Council, and that HDC is advised of the audit/progress reports of any such measures at least six monthly for a period of two years.

170. I recommend that within three months of the date of this report, Totalhealthdentistry Limited:

a) Arrange for an inspection of the clinic by an independent evaluator approved by the Dental Council and provide the report to HDC.

b) Develop policies relating to payment for services and provide the policies to HDC.

c) In light of the breaches of care identified, consider providing a refund to Mrs A for treatment provided between 2016 and 2018, and report to HDC on the consideration and outcome.

Follow-up actions

171. Dr F 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. The referral is made based on the care provided to Mrs A having been severely below the appropriate standard across all areas, as well as the dishonest conduct demonstrated by Dr F in altering Mrs A's clinical records.

172. A copy of this report, with details identifying the parties removed, except the advisor on this case and Totalhealthdentistry Limited, will be sent to the Dental Council, and it will be advised of Dr F's name.

173. A copy of this report with details identifying the parties removed, except the advisor on this case and Totalhealthdentistry Limited, will be sent to the NZ Society of Periodontology, the NZ Dental Association, the NZ Association of Prosthodontists & Restorative Dentists, Te Whatu Ora|Health New Zealand, and Te Tāhū Hauora|Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

174. The Director of Proceedings decided not to issue proceedings.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from registered dentist Dr Jeffrey Annan:

"**Report to the Health and Disability Commissioner 14 February 2020**
I have been asked to provide an opinion to the Commissioner on case no C19HDC00777 concerning treatment provided by [Dr F] at [the clinic] to [Mrs A] in the years 2016, 2018 and 2019.

I am not aware of a conflict of interest with anyone mentioned in the documentation and have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a registered Dentist and practise at The Wellington Dental Practice, a group whose focus is largely restorative dentistry. I have a Bachelor of Dental Surgery and a Postgraduate Diploma in Restorative Dentistry from Otago University. While I do not carry out the surgical aspects of implant dentistry, my colleagues do. A significant part of my practice involves restorations based on implant fixtures.

I have been asked to review the documentation provided and advise whether I consider the care provided to [Mrs A] by [Dr F] was reasonable in the circumstances and why.

In particular, to comment on:

1) Whether [Mrs A] was provided with all reasonable treatment options available to her prior to the tooth extraction and implant procedures performed during 2016.

   a) I am to specify what all these options are in [Mrs A's] case; and
   b) Were these adequately documented in [Mrs A's] clinical notes?

2) [Dr F] acknowledges that there were no written consent forms for the tooth extraction and implant procedures he performed. He states that his practice of procuring only verbal consent was in keeping with the Dental Council's standard at the time (2016). I should advise whether [Dr F's] practices were in accordance with the Dental Council's expectations.

3) Whether [Dr F] carried out the tooth extractions and implant procedures with reasonable care and skill.

4) Whether the treatment plans and dental care provided by [Dr F] during 2017 and 2018 (subsequent to the tooth extraction and implant procedures) were appropriate in the circumstances. As a part of the analysis, I should comment on the adequacy of [Dr F's] written correspondence with [Mrs A] and her husband ([Mr A]), with regard to discussion of treatment options and treatment plans, taking into account that English is not [Mrs A's] first language.

5) Any other matters in this case which I consider warrant comment or amount to a departure from the standard of care or accepted practice.

For each question I am to advise:

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care, or accepted practice, how significant a departure I consider this to be. I should quantify the significance of any departure using the terms **mild, moderate or severe**.

c) How it would be viewed by my peers?

d) Recommendation for improvement that may help to prevent a similar occurrence in future.

Material provided by The Commissioner's Office:

1) Letter of Complaint dated 30th April 2019
2) [Dr F's] response dated 25th July 2019
3) [Ms E's] (Dental Hygienist) response dated 12th July 2019
4) [Dr F's] response regarding consent dated 20th November 2019.
5) Clinical records from [Dr F] covering the period 12 January 2016 to July 23 2019.
6) A statement from [the] Dental Nurse/Treatment Coordinator. (Not listed)

Summary of Events
[Mrs A] first attended [Dr F's] practice on 12 January 2016, when what appears to have been a brief 'screening' assessment was carried out. [Mrs A's] concerns were noted as 'periodontal disease and cosmetics'. Moderate to severe periodontal disease was noted on her chart and a Treatment plan was entered consisting of:

1) Plaque control,
2) Perio/Hygiene visits with [Ms E] and
3) Re-valuation

It is disclosed from notes of a further consultation on 29 January that she disliked the look of her upper front teeth where I suspect loss of attachment (gum tissue) had produced dark spaces between her teeth. There are no photographs provided in the clinical records to confirm this nor a description of the condition of her teeth. However, what I assume to be the pre-treatment OPG X Ray included in [Dr F's] response, although it is not dated, shows significant bone loss between all of her teeth and the fact that [Mrs A] had four missing lateral incisors, as well as teeth 18 16 26 27 28 33. There are no records of charting, radiographs nor photographs being taken at the initial appointment, but [Mrs A] mentions that an X ray was taken at this time. No Medical History is recorded in the copy of [Mrs A's] file I have been provided.

However, the following medications and supplements were prescribed:

Vitamin C 1500mg,
Calcium 283
Magnesium,
Vitamin D,

Augmentin 625mg # 28 and #15
Metronidazole 400mg #27

This I suspect constituted the 'disinfection programme' mentioned in notes from [Ms E] … which formed a part of the treatment plan to enhance the effect of the debridement (tooth cleaning) which took place on 14 and 21 January 2016. This seems to be a blanket prescription without definitive diagnosis of deficiency nor disease and without reference to a current medical history.

The use of antibiotics and supplements in this way is non-standard practice for treatment of Periodontitis.

An occlusal composite on tooth 37 was charted to be carried out (no record of this being done) and tooth 48 was charted for extraction. No mention of tooth 46 which was unrestorable and required removal.

Verbal consent was given for Hygienist appointments scheduled for 14 and 21 January 2016 with [Ms E]. Notes from the first appointment include mention of '5mm pockets being present through lower mand'. And that 'what was recorded in the medical history could not be deciphered'. Whether this issue was cleared up before treatment is not recorded. If it was not, then [Mrs A] received Hygienist treatment without her medical history being known. This would be a severe departure from expected/accepted practice.

On 29 January 2016, a consultation appointment was held with [Dr F], [Mrs A] and her husband [Mr A]. [Mrs A] struggled to understand and speak English, but could understand it when written. Her husband, who was mentioned as being fluent in English, attended all of her appointments to ensure that they understood the treatment planned and to interpret when any decisions needed to be made. Notes indicate [Mrs A's] dislike of the appearance of her upper teeth and the spaces between them. She explained that she had a history of periodontal disease and had received periodontal surgery twenty years previously.

She saw her mouth as ugly and 'wanted to smile again'. [Dr F] demonstrated full upper denture replacement with and without implant support using videos. This consultation seems to have covered an in-depth discussion of [Mrs A's] wishes to improve the aesthetics of her upper teeth.

There was no mention in the notes of her lower teeth nor any matters concerning function. A decision to extract all of the upper teeth and replace them with a full denture which would be implant supported was recorded as [Mrs A] and her husband's decision. There followed a discussion about whether the support would be in the form of a removable denture using locators or a fixed restoration screw retained on four implant fixtures. Four was the only number of fixtures mentioned in the notes. The decision in favour of a removable denture on locators appears to have been made on the basis of the cost given as $15000 to $16000 verses $40000 for the fixed screw

retained option. Although there was a possibility that at a later date a fixed 'All on Four' prosthesis could be made. Discussion of the pros and cons of fixed versus removable prostheses does not appear in the notes. There are many clinicians who strongly believe that patients who have suffered generalised periodontitis have a better prospect of keeping their fixtures clean and therefore free from peri-implantitis if they wear prostheses which can be removed for cleaning. This is a reasonable view, and I think it should have formed part of the discussion and decision-making process, but the implications of this do not appear to have been discussed. The possibility of using a bar, which is a more stable form of retention for removable prostheses and requires less maintenance, seems also not to have been considered. The decision on the choice of design seems to have been made solely on the basis of cost.

There was no mention of the condition of nor prognosis for the lower teeth or how they were responding to treatment from the Hygienist. The notes state that [Mrs A] chose to have locators for retention of her upper prosthesis and to have two implant fixtures placed at the time of the extractions and two placed later. There is no reason given for not placing the anterior implant fixtures at the extraction appointment as immediate placements. Life with a full arch prosthesis was discussed. The effect of not having any teeth in the upper arch (jaw) was not mentioned.

Assurance was given that an implant which failed would be replaced at no charge.

Ibuprofen and augmentin were prescribed, but no reasons are given for this.

A new treatment plan, costed at $20,845 is mentioned in June 2016 including the removal of tooth 46 and its replacement with an implant crown. A Hygienist appointment prior to the extractions mentions much improved gingival health.

On 21.06.16 impressions were taken for the fabrication of an interim 'temporary' denture to be worn after the upper teeth were extracted. There is also the word 'Whitening' in the notes for $200. No other reference to this procedure is made. However in her letter of complaint [Mrs A] poses the question of why the upper teeth were whitened when they were to be extracted in less than a month. There is no explanation for this and it would constitute a moderate departure from the accepted/ expected practice. A prescription was given to [Mrs A] for:

Codeine Phosphate 60mg
Codeine Phosphate 10mg
Voltaren 100mg X10
Voltaren 100mg X10
Diazepam 2mg X3

The duplications were apparently noted at the pharmacy and [Dr F] apologised in an email but was critical of [Mrs A] for not taking the script to 'our pharmacy where the duplication would have been picked up'. He also asked her not to call him on his phone.

On 12 July 2016 teeth 16 15 14 13 12 11 21 were noted as being extracted and [implant fixtures] placed in sites 15 and 26. From the first OPG, it would seem that it was 17 15 14 13 11 21 that were removed and the right side implant seems to be in the 16 position. That left teeth 23 24 25 in position. These were removed according to the notes on 08.11.2016. There is no record of the temporary denture being fitted on 12 July, but a week later at an Observation appointment, the denture was 'hollowed out', the flanges were adjusted and sore spots eased. A soft relining material was placed in the denture to try to make it more stable as [Mrs A] complained that it was loose and she couldn't eat and couldn't talk.

On 02 August, the tooth 38 was extracted by [Dr F]. This tooth has not previously been referred to in the notes. [Dr F] apologised for his behaviour during the previous appointment, presumably on 26 July. There is no mention of an incident.

There were two more adjustments to the denture and a prescription for Voltaren and Metronidazole on 25 August. No reason is given.

The first locator was placed in the implant on site 26 on 30 August. This is the piece of the implant system which is screwed to the head of the implant fixture and fits into the denture.

Similar to a ball and socket. This keeps the denture firmly in place, but allows the patient to remove it for cleaning. The locator was very tight on the 16 implant and was not placed. A longer locater was ordered to be placed in a month.

It is not explained why the implant fixtures were not placed in sites 13 and 23 until 08 November at the time teeth 22 23 25 (most likely 23 24 25) and 46 were removed. It would have been possible to remove the nine teeth and place four implants at one time. This would have made the temporary denture an easier proposition and speeded up the process. There is no indication in the notes to explain why the process was carried out in two operations. It may have been to avoid the large surgical load of ten extractions and having four implants placed.

[Mrs A] was receiving Hygienist treatment from [Ms E] on a regular basis. She objected to the taste of the household bleach she was asked to use in her WaterFlosser, (a device which directs a jet of high velocity water between teeth to remove debris and biofilm). Although Sodium Hypochlorite, the active ingredient in bleach, is used as an antibacterial irrigation for root canals, it is not usual practice to include it in the reservoir of home care tooth cleaning devices and as [Mrs A] points out in her letter, she encountered surprise when she discussed this with other contacts. This would constitute a moderate departure from expected/accepted practice.

At a consultation on 20.01.2017, [Mrs A] was reported to be comfortable and happy with progress. This seems at odds with [Mrs A's] letter of complaint. A plan to have a full upper denture without a palate, made to fit onto four locators on the implants, was agreed to. The addition of a crown to be made to attach to the fixture which had been

placed in the lower right first molar position was agreed to. This tooth was clearly unrestorable when viewed on the pre treatment OPG X Ray. It was probably mobile as there was virtually no bone about the roots and an apical radiolucency indicative of infection. It is surprising that 46 was not indicated for extraction at the start of treatment planning and no surprise that it caused symptoms. It was causing pain on 13 June but not removed until 8 November and should have been treated with higher priority and been in the plan from the beginning. 38 was removed on 2 August with no mention of any symptoms. 46 implant crown was placed on 23 March 2017.The new upper prosthesis was fitted to the locators on 13 June 2017. When seen six days later the buccal (cheek side surface) was sore and the tongue and cheek were being bitten. The teeth were reset (positions changed) by [Dr C], who noted that [Mrs A] 'may be more comfortable with an "All on Four"'.

Reference to the method of having the denture fixed to four implants with screws which only a dentist can undo. So the patient cannot take out the denture for cleaning.

Cheek-biting was reported during June and [Mrs A] reported that the denture was too thick.

Hygienist [Ms E] noted that 'the gingiva was being pulled away from the 26 locator.' Localised 'mucositis' was mentioned in notes from 11 July 2017.

There were almost weekly appointments while the denture was adjusted and the last two locators were added in mid July. One, not specified, caused concern and was not brought into function.

Four areas of concern with the denture were addressed on 11 August and [Ms E] noted that the 26 problem was worsening and its 'prognosis was poor'. However, home care was noted as good with the patient using the water flosser, Interdental Brushes, floss and Curasept gel, a 0.5% chlorhexidine based product which is recommended for short term use, not continuous application. However 'the 26 fixture was not right'. Photos were taken, but there are only two images of a locator, presumably 26, undated, which appears in [Dr F's] response of 25 July 2019.

[Mrs A] requested to have 'the last tooth (27) on the denture removed'. This would then be the same as the right side which was more comfortable. This did not seem to be followed up. The possibility of surgically repositioning the muscle attachment about the 26 locator was mentioned in notes from [Ms E], but the presence of biofilm is given as the reason for no action.

On 05.09.17 the 26 locator was removed and a healing cap placed. This would limit the denture contact to three locators. A report of 'no pain and good oral hygiene' appeared in the notes. [Dr F] recorded that plaque was present on the 26 locator due to [Mrs A] 'not cleaning'. However he also noted that 'OH [oral hygiene] was reasonably good and it was the best he had seen it'. However [Mrs A] said that she could not clean the 26 area because it was too sore.

The prosthesis continued to be unsatisfactory, dropping during eating. [The denture manufacturer] [was] reported as saying that an improvement could only be achieved by making a new denture. [Dr F] expressed reservations as the lower anterior teeth are at a much higher level than the posterior teeth. I think that this indicates a problem with the occlusal plane producing a problem in achieving a stable functional arrangement. A lack of balance when there is contact on the front teeth. This issue is not expanded on and there are no images available. It probably represents a fundamental problem not identified in the initial planning phase. So again no remedial action is taken.

In December 2017 [Mrs A] sought hygiene treatment at a local dental practice. [Ms E] emailed a warning of consequences and in April 2018 she returned for a hygiene review. The 26 area was still sore and inflamed and the denture manufacturer continued to see her for adjustments to the denture. This treatment would and should be carried out by the lead provider, [Dr F]. [Ms E] noted [Mrs A] had seen [Dr B], Periodontist, for a second opinion on the painful 26 implant.

At a meeting, [Dr F] accused [Mr A] of lying, about what is not clear, and stated that he could not work on the new denture made by [the denture manufacturer] as that would void their warranty.

On 11.09.18 at a hygiene appointment, [Ms E] noted the presence of early implantitis at the 26 site and the visit to [Dr B] is recorded.

At a meeting between [Dr F], [Ms E] and [Mr and Mrs A], on 25.09.18 to discuss how to proceed with treatment, [Mr and Mrs A] sought resolution of the problems with the 26 implant and the unsatisfactory denture prosthesis. The pain from the 26 implant had worsened since the locator had been replaced with a healing abutment and the denture was working no better despite [the denture manufacturer's] efforts. [Mr and Mrs A] wanted the denture problems resolved before any more treatment or hygienist appointments. They wished to have treatment for the failing 26 fixture elsewhere ([Dr B]) and a refund of the monies paid to [Dr F]. [Dr F] stated that he would not discuss money, but what had been paid for the denture could be used to off-set the cost of future treatment at THD.

He was still suggesting that a screw retained fixed prosthesis could be a solution. This is an unusual suggestion for a patient with a failing implant who is struggling to maintain implant health with a removable prosthesis.

On 28.10/18 [Mr and Mrs A] sent an email to [Dr F] willing to compromise, but stating that both their patience and their trust in [Dr F] were exhausted.

[Dr F's] response on 26.09.18 was 'Hi … this is simple … please send X Rays … so we can have best Diagnosis. Kindly [Dr F]'

[Dr F's] email of 03.10.18 was more expansive but did not recognise [Mr and Mrs A's] frustration nor acknowledge that he had any responsibility for their situation.

It contained a description of the origin of peri-implant disease, something that [Mrs A] would have heard many times in the previous two years, and laying the blame for her failed implant solely with her ineffective cleaning.

He claimed the problem with the denture had nothing to do with him or THD. He suggested that [Mrs A] should have [the denture manufacturer] or some other lab remedy the situation.

THD **was** prepared to continue to carry out hygienist treatment at $184 an hour and $250 for each sequence of antibiotic treatment with [Dr F]. Apart from this offer, the email implied that [Mrs A] should have her treatment with [Dr B] and her denture attended to by [the dental laboratory].

The suggestion was that [Mrs A] work with [the dental laboratory] and that a bar support had been suggested by [Dr B], [the dental laboratory] and THD, (himself). So the implication is that it should be the next line of treatment.

Clinical records from the lab [the dental laboratory] were said to be attached to the email. This apparently showed that [Mrs A] had misrepresented her experiences with [the dental laboratory] and the admonishment that 'You need to make sure what you are saying to the lab people that are trying to help you, when they ask you questions … so you can get the best results.' There were no records from any laboratories in the material I received.

[Mr and Mrs A's] response followed on 04.09.18.

They pointed out that this was the first time [Dr F] had acknowledged that there was a serious problem with the 26 implant. Although it was identified by two other clinicians over eighteen months earlier and by [Dr B] in his second opinion letter. They posed the question as to who had delayed the treatment and who was responsible. They say they were told during the initial consultation that any failed implant would be replaced free of charge, so they were seeking some assurance from [Dr F] that some form of redress was available to them.

The existing denture, made by [the denture manufacturer], was unsatisfactory and [the dental laboratory], which [Dr F] referred them to, has stated that there is nothing they can do to make the present denture satisfactory. Not unreasonable as they did not make it. They say that a new denture is the only remedy. [Mr and Mrs A] paid [Dr F] for the denture directly and do not think it reasonable to have to pay for another. There is mention of an earlier email in which [Dr F] offered to refund the cost of the denture. I have not seen that email. Both [Dr B] and [the dental laboratory] had told them they thought that the current denture was 'Overclosed' i.e. [Mrs A's] lower jaw has to close too much for her lower teeth and the denture to contact. They agree that a new denture is required. If overclosure was present, I think overclosure alone would constitute a reason for a new denture.

[Mrs A] was not prepared to have any more treatment with [Dr F] at THD. She wanted a refund from [Dr F] so that she could have remedial treatment with [Dr B] and [the dental laboratory].

There were unusual emails from [Ms E] and [Dr F] on 11.10.18. After two and a half years of hygiene therapy it is strange to be explaining the reasoning behind the treatment which was carried out. If a patient has not implemented the cleaning message in that time there is very little chance of a successful treatment outcome and the implication is that the treatment has failed to have the desired effect. My impression from reading the emails from [Mr and Mrs A] is that they had understood the connection between oral hygiene and periodontal disease very well.

[Dr F's] email, addressed to [Mr A], advises [Mrs A] to have [the dental laboratory], assist in the diagnosis of her 'atypical pain'. I cannot see a mystery. It seems clear that the pain is being caused by peri-implantitis, an infection in the bone and could not be termed atypical. The infection has been diagnosed by a Periodontist, [Dr B], and was identified by [Dr C] and referred to by [Ms E], other members of the team. The fact that it is the denture that is the exciting factor does not mean that it is a 'functional' problem. Claiming that a diagnosis is required is surprising. The email ends with another plea for [Mr A] to help [Mrs A] to improve her oral hygiene.

[Dr F] avoids addressing the serious problems which [Mrs A] is having deflecting her request for help with suggestions which do not involve him taking any action and involving others who are acting outside their scope of practice. Sanctioning a technician removing a locator is an example.

Even more surprising is the document sent by [Dr F] for [Mrs A] to sign which would absolve [Dr F] of responsibility for her poor treatment outcome. This is a document which could be described as a severe departure from expected/accepted practice in New Zealand. It seeks to remove the patient's rights to redress.

On 05.09.18 [Mrs A] consulted [Dr B] for an opinion on her implants. His letter of the same day gives his diagnosis and offers two treatment options. He identifies peri-implant mucositis about all of the implants and peri-implantitis at implant 26. He does not comment on [Mrs A's] cleaning, as stated by [Dr F]. The prognosis for the implant 26 is poor and for the others and the lower teeth fair. The two treatment options offered for 26 are:

1) Surgically uncovering and cleaning. This would still leave the implant with a poor prognosis.
2) Implant removal and replacement of another implant after healing, and a gum graft.

In his opinion, this is the only way to achieve a satisfactory outcome.

There is no criticism of the position of the implant, although there is a comment from [Mr and Mrs A] in an email that implied that the implant's position was contributing to the difficulty in maintaining peri-implant health.

[Dr B] is adamant that an 'All on Four' screw retained denture could not be recommended and that a bar retained denture was more conventional. His assertion that bar retention is more convenient and conventional for a patient with a history of periodontitis like [Mrs A], is in my opinion correct. The cost of the removal and replacement option was $7075. [Mrs A] chose this to be done.

[Dr F] insisted that no remedial surgery could be done while there was active infection in the area and as the 26 was never controlled, he could not operate. [Dr B] did not see a barrier to surgery and probably neither would other Periodontists.

[Dr F] also claimed that he had no responsibility for the denture and insisted that the Lab [the denture manufacturer] was in control and had a warranty that he could not breach.

In any case involving implants, it is important that the three component parts of the treatment plan are managed by a 'Lead Dentist'. The three parts, the surgical part, the prosthodontic part and the laboratory aspect should be competently carried out by the Surgeon, the Prosthodontist/General Dentist and Laboratory Technician. The person in charge in [Mrs A's] case was [Dr F]. He carried out the initial consultation, discussed and agreed on the treatment plan, covered the informed consent consideration, and carried out the surgery. Other dentists, [Dr C] and [Dr D] attended to some of the early denture work and [Ms E] was responsible for the hygiene.

However it is clear that [Dr F] set up the operation and was the lead clinician. However, as time passed, he seems to have distanced himself from the position of control and took less and less responsibility for the treatment outcome. Until in the end, he is encouraging [Mrs A] to have treatment elsewhere, with [Dr B], and to be guided by the laboratory [the dental laboratory], in her choice of denture design. He credits the Lab with responsibility for the denture and [Mrs A's] poor cleaning for the failure of implant 26.

In October 2018, [Mr and Mrs A] informed [Dr F] that as he was not prepared to take any action to remedy the situation with implant 26, [Mrs A] would be having treatment with [Dr B]. They would pay [Dr B] to have the problem resolved and [Dr F] should be responsible for covering the cost of the new denture. [The dental laboratory] would advise on the design as [Dr F] was not prepared to. Legal action would be started if they received no refund.

On 23 October [Dr F] emailed the following. He 'acknowledged the transfer of your therapy to [Dr B's] practice. [Dr B] is an excellent periodontist and with your history of moderate–severe Periodontitis and the associated atypical problems you will be in good hands. We highly recommend this. The New Zealand Dental Act allows for autonomy so it is your choice where you choose to have your future care, however for continuity of

care, we recommend that you have all your care under the umbrella of the one practice including hygiene.'

This seems to indicate total disengagement from the patient–dentist relationship.

[Dr F] mentions the clinical notes from [the denture manufacturer], and is critical of [Mrs A] for finding fault with her denture, having initially been satisfied with it. It must be a patient's right to change their mind about a treatment or device and up to the clinicians and patient to work out a remedy.

The final paragraph, below, is ironic as it instructs [Mrs A] to seek reassurances from [Dr B] for matters he, [Dr F], has failed to address with her treatment.

'We recommend that you make sure that you have a clear understanding of the treatment recommendations and what you are choosing to do. We recommend that you ask for not only a clinical diagnosis but also a prognosis. Also what the clinical support will be around this.'

This is after he has been made aware of the clinical diagnosis, treatment plan and prognosis from [Dr B] as set out in the letter of 05.09.2018.

In response to the message indicating a legal complaint be made, [Dr F] sends a four part agreement on 16.11.19 for [Mrs A] to sign. In it she is asked:

1) To agree that the problems she is having with her denture and implants are common.

   (This is not in agreement with his description of 'atypical pain' in other documents, and does not relate to the experience of vast numbers of cases of her kind.)

2) For her agreement on bacteria being a cause of peri-implant disease.

   (This is inaccurate as bacteria are the cause. It is perhaps acknowledging that THD has failed to establish control of the infection in [Mrs A's] mouth.)

3) To acknowledge that [Mrs A's] communications with [the denture manufacturer] at the time of her denture construction could have been a cause of her denture problem.

4) To agree that she has been informed about and agrees to a screw retained denture being the best solution for her denture problem with the best prognosis and that she will be responsible for the cost. (This is at odds with what [Mrs A] has been told by [Dr B], that a bar retained removable denture is the treatment of choice; the literature would support this.)

The document appears to be an attempt to absolve THD of responsibility for the unsatisfactory treatment outcome.

The Question of Reasonable Care

Aesthetics

[Mrs A's] request for treatment from [Dr F] was clear. The desire for an improved aesthetic result was the stated objective. [Mrs A] makes no comment on her ability to eat prior to the upper teeth being removed. Nowhere in the documentation can I see any comments about the final appearance of the denture. So it could be assumed that the aesthetic goal was achieved. However, there was no mention of function in the planning discussions and no evidence of a preoperative 'wax-up' being carried out. A wax up is a way of examining the proposed arrangement of the teeth on an articulator, (simulated jaw) so the positions can be checked for appearance and function. This would have been useful in diagnosing the problem with the lower front teeth being at a higher level than the back teeth, referred to by [Dr C] in 2017 which seems to have caused instability when eating on the front teeth. There are no photographs nor models provided so it is difficult to comment on the tooth positions on the denture nor their appearance. The lack of photographs is a major omission and a departure from usual practice where appearance is the reason driving the treatment. A moderate departure from standards of care/accepted practice.

Periodontitis History

[Mrs A] clearly disclosed her previous periodontal disease. This is stated and documented. It was an obvious concern to her that implants may not be suitable in her situation. This point she mentions often in correspondence, but there is no comment from [Dr F] about this in the notes, just reported statements from [Mr and Mrs A] that [Dr F] assured them that implants were 98% successful, there would be no problems with her implants and if there were, they could be replaced. The fact that patients with a history of periodontitis are more at risk of peri-implant disease is well understood and referenced in the dental literature. It is a risk factor which should be addressed and documented before treatment. I cannot see notes of this discussion. The periodontitis is acknowledged in the notes but the implication for implant survival is not. I think there should have been a conversation documented on this issue. This is a moderate–severe departure from the standard of care/accepted practice.

Initial assessment

The first appointment was short and very little was recorded. No tooth charting. No information about the lower teeth, which is important as these teeth are going to have to withstand considerably more force than they were currently under once the implants are loaded. One lower tooth 46 was affected by bone loss almost to the apex and must have been mobile, but nothing is recorded.

One OPG (orthopantogram) X ray was taken which I believe shows the congenital absence of all four lateral incisors. This would mean that the canine teeth are angled forward into the spaces where the missing teeth would have been. This is likely to have contributed to the aesthetic problem perceived by [Mrs A]. There is no charting of the teeth or restorations present to check if this was appreciated. However, when the teeth for extraction were listed, the lateral incisors, teeth 12 and 22 were listed as present, other tooth numbers were incorrect and the position of the implant 26 was represented

as 25. A Medical History was filled out, at the first visit but was later reported to be indecipherable and there was no note made about whether this was corrected.

No copy of the Medical History has been sighted.

The information recorded was insufficient and inaccurate. This is a severe departure from the standard of care/accepted practice.

1) Treatment Plan Discussion
This aspect appears to have been handled reasonably well with clear notes on the discussion held. However there was no mention of the potential problems which could be encountered with implant treatment, and no discussion about the lower teeth. There was no examination recorded of the upper teeth so the option of leaving them was not discussed and apparently not considered. [Mrs A] makes the point that she has ended up worse off after treatment than before. She cannot eat, her tongue is sore and she has pain from the infected implant 26. The status quo should always be an option to consider.

The plan was to remove all nine upper teeth and place two implant fixtures. This was then modified to include replacing tooth 46 with an implant crown. [Mrs A] recalls discussion of removal of her lower third molars (wisdom teeth). This is not in the initial plan, but 38 is noted as being removed on 02 August 2016 and 20 October 2017. Obviously a charting error. One of the '38' entries was probably 48. The charting errors and omissions constitute severe departures from expected/accepted practice.

2) Consent
[Dr F] is correct in stating that written consent was not required for the treatment he carried out under the Dental Council of New Zealand Practice Standards. However, informed consent is not a document but a process in which all information required to make a decision for treatment has been provided by the clinician and all questions answered.

Considering the fact that English was [Mrs A's] second language and she struggled to understand it when spoken, her requests for [Dr F] to email information were reasonable. She did not receive a written treatment plan and she complains that any emails she did receive were 'just a few words with incorrect spelling'. The cynical response to her request for a treatment plan is disrespectful.

'Hello [Mr and Mrs A],

You asked me to write a plan for [Mrs A]. The following is a plan.

1. Differential Diagnostics … which we are doing

2. Treatment plan.

Kindly

[Dr F]'

From the information provided by [Mr and Mrs A] and the notes, there was information missing in the preliminary discussions about the denture process, the risks from peri-implant infection, options for implant support and their pros and cons. The decision to have locators support the denture seemed to be based on cost, $15,000 vs $40,000 for a screw retained prosthesis, not on clinical indications. The advice from [Dr B] and the majority of those placing implants for patients with a history of periodontal disease I am aware of, is to use a bar and removable denture. [Dr F] did not offer a bar and was persisting with the notion that a screw retained 'all on four' fixed prosthesis was the solution to [Mrs A's] problems right to the last when submitting the agreement for her to sign on 16,11.18.

The documents indicate that there was a failure to provide important information for making an informed decision, thereby contravening the DCNZ Practice Standard on Informed Consent.

This is a severe departure from the standard of care/accepted practice.

Peers would consider that [Dr F] was negligent in not recording an examination of the upper teeth and not presenting full information on the merits of the various implant retention systems.

Periodontal Treatment

There was an initial diagnosis recorded on 12.01.16 of 'moderate–severe periodontal disease' and a treatment plan for plaque control and hygiene with [Ms E], then re-evaluation. This is an acknowledgement of the periodontitis and a reasonable plan to treat it. There was however, no plan for dealing with a negative outcome from this treatment plan. It would have been prudent to plan for referral to a Periodontist if the gum health had not improved sufficiently. Although [Dr F] has a postgraduate qualification in periodontology, he is not registered as a specialist in New Zealand. This may be his choice, or possibly he did not meet the Dental Council's requirement for specialist registration. Although there are encouraging comments by [Ms E] on [Mrs A's] gingival (gum) tissue response during treatment, there are no periodontal charts to follow the improvement in her condition. Apart from the initial diagnosis and the comment about '5mm pockets in the lower mand' from [Ms E] there is no objective evidence of the disease, nor any improvement in it. For patients suffering from Periodontitis, regular charting of the depth of the pockets around their teeth, the presence of deposits, bleeding and recession is essential for any objective judgement of their disease status.

If these records do not exist, this would be a departure from the usual standard of care/ accepted practice. A moderate to severe departure.

So there is no measurement of the success of treatment apart from subjective comments about the amount of biofilm and inflammation. There is little detail of the debridement procedures carried out by [Ms E] and the fact that iodine was often placed about teeth indicates persistent infection.

The Perio Disinfection regime using multiple vitamin supplements and antibiotics carried out by [Dr F] is not a recognised mainstream treatment. Although antibiotics are used in acute infections, the process of regularly subjecting patients to heavy doses of Augmentin, Metronidazole and vitamins could not be considered normal standard of care/accepted practice. This is a severe departure.

The use of household bleach in a water flosser for oral hygiene at home is not usual and not recommended as a standard practice. This would be a moderate departure.

I see no evaluation statement at the end of the periodontal treatment to give the go-ahead for the teeth to be removed and the implants to be placed. As this was the motivation for the periodontal treatment, it would have been important to have the assurance that the disease was controllable before proceeding. Especially in the light of [Dr F's] insistence that he would not operate on implant 26 without control of gum disease. There seemed to be a belief that the hygienist treatment and disinfection programme would be successful. The question whether the gum condition was healthy at the time of the implant placement is not answered, but if it were not, then according to [Dr F's] protocol they should not have been placed.

3) Extractions and implant surgery

On 12 July eight upper teeth, 16 15 14 13 12 11 21 26 were recorded as being extracted and two implant fixtures placed in the sites 16 and 26. In fact it seems that the teeth removed were teeth 17 15 14 13 11 21, leaving teeth 23 24 25. On 08 Nov teeth 22 23 24 were noted as being extracted but were in fact 23 24 25 and the painful, unrestorable lower right first molar 46. As well, implant fixtures were placed in the 13 and 23 positions. I have difficulty aligning these treatment notes with [Mrs A's] recollection in her letter of complaint, of having her 9 upper teeth removed 'all at once'. As explained in the summary, there were nine upper teeth present as seen on the original OPG, and these did not include teeth 12 and 22. Eleven upper teeth are recorded as being removed in two operations. How a temporary denture was constructed to replace all but three teeth is difficult to fathom, and why it was done even more puzzling. There are significant discrepancies in the notes so this may be one more, and possibly the upper teeth were all removed on 12.07.16. It would be helpful for this to be clarified, as the treatment with the temporary denture is difficult to reconcile with there being three teeth present from 12.07.16 to 08.11.16. It would have been much more usual to have removed all of the upper teeth and placed two fixtures into the available spaces 16 and 26, as [Mrs A] recalls, and await healing for placement of the 13 23 implants. Or to have the 13 and 23 fixtures placed as immediates (placed into the sockets of the extracted canine teeth at the time of their removal) during the first and only surgery.

These clinical entries are confusing the sequence of treatment and are a severe departure from the normal standard of care/accepted practice.

The notes relating to the extractions and implant placement are expansive and detailed.

However much of them is composed of template entries. Entered with one keystroke. Each extraction has exactly the same entry and it is unlikely that no variation was encountered in removing 10 teeth. Placing exactly the same amount of local anaesthetic for each extraction is also unlikely, and the same error 'cha Hi [Mrs A]' appears in each entry Templates are useful but should not occupy the entire treatment entry.

The extractions and placement of the implants appears to have gone smoothly and apart from the errors in the notes, there is nothing to suggest that reasonable care and skill were not employed.

There is a possibility that the implant 26 was placed in the bone too much towards the cheek and thereby limiting the gingival (gum) covering. The fact that the threads of the implant were visible within two years of placement and that repair with [Dr B] would require a gingival graft, would suggest this to be the case. The photo with the more advanced inflammation also suggests this.

From the notes and [Mrs A's] correspondence, Peers would have no reason to believe that the extractions and implant placement were not carried out with reasonable care and skill. They would however, be confused and concerned by the clinical entries which do not seem to match the treatment.

4) Dealing with the Dentures and complaints during 2017–2018

The immediate temporary denture was difficult for [Mrs A] to manage. It was a surprise to her that she could not talk nor eat, but the post-extraction period is usually a difficult time for patients, who should be forewarned. [Mrs A] was not. The treatment by [Dr C] and [Dr D] seems to be routine for such a period. The denture had a soft lining placed. There was early difficulty with the locators, (the connecting piece between the denture and the implant). Some were too tight and made getting the denture out difficult. At no stage does [Mrs A] appear to be comfortable or confident with the denture. There were difficulties with the denture made in early 2017 by [Dr C] but he seemed to take appropriate action to overcome the cheek-biting, instability and other problems.

Each item is addressed in turn over the course of 2017. However in less than a year, infection about the implants 26 and 46 caused concern for [Dr C] and [Ms E] who, [Mrs A] claims, referred the matter to [Dr F], as did she. During 2017 there is little comment or contact with [Dr F]. By the end of 2017 [the denture manufacturer] is advising a new denture to replace that completed in May. The question of who pays was presented to [Dr F]. He disregarded [Mrs A's] pleas for help with the denture and the pain from the implantitis about the 26 implant. [Mr and Mrs A] documented their requests well. They were correct when they diagnosed peri implantitis from the internet and [Dr B] confirmed this on 05.09.18. There was still no action from [Dr F] who clung to his dictum of any infection-no surgery. So the 26 implant continued to cause pain. [Dr F] failed to take any action to remedy the problems with the denture claiming that [the denture manufacturer] was responsible for this. He did offer continuing hygiene treatment from [Ms E] at $174 an hour and further 'disinfection treatment' from him at $250 a prescription.

As the person who planned and implemented the treatment, it was clearly his responsibility to make attempts personally or to have others carry out measures to remedy the situation [Mrs A] was in. Not responding to a patient's pleas for help is a breach of the contract with the patient and clearly is not putting the patient's interests first, which is the first of five ethical principles in the DCNZ's Practice Standards. I believe that [Dr F] also failed to uphold the other four principles:

To ensure safe practice, To communicate effectively, To provide good care and To maintain public trust and confidence.

[Mr and Mrs A] have shown great patience and persistence in the face of [Dr F's] disregard for [Mrs A's] pain and denture distress. They have documented their experience very clearly and been willing to compromise to achieve a resolution. [Dr F] has shown no intention to assist in the alleviation of pain from the implant 26 nor to help in finding a remedy for the unsatisfactory denture. Both situations clearly being the result of his treatment.

Peers would be very concerned that a member of their profession would ignore the many pleas for help from his patient [Mrs A]. They would be surprised at the content of his emails and the rigidity of thinking they conveyed. They would also likely express concern at the unusual treatment he employed. As well, the ease with which he could deflect his responsibility to blame a laboratory and the patient herself for the unfortunate clinical outcome and then enthusiastically pass [Mrs A] over to [Dr B] to treat her problems.

5) Other matters

1) I think I should comment on matters [Mr and Mrs A] raise about the THD facility and its communication. They outline their difficulties in making appointments and generally communicating with the practice. Not having a receptionist to answer phone calls is unusual and this obviously made for frustration and confusion. Having had about fifty appointments over the three years, they are in a good position to suggest that the premises are not fit for purpose.

   Their description of the one roomed 'garrett' is alarming. They raise the issues of hygiene, bad management and poor communication in their letter of complaint. The premises seem to be unsuitable for a dental practice carrying out surgical procedures.

2) The practice of demanding full payment before treatment is unusual and not recommended by any dental authority I am aware of. A half payment before and the balance at the time of treatment is reasonable. It is unreasonable for the full fee to be demanded for a treatment which is to take six months or more to complete and a serious financial risk for the patient.

Jeffrey Annan"

Addendum 13 October 2020

"Preliminary remarks

Of the 27 attachments sent by the HDC dated 20.07.20 and received on 16.09.2020 containing additional material, 17 have previously not been seen by me. This is despite having received from the Commission on January 30 2020, confirmation from [Dr F] that he had provided all of the information that he held for the case of [Mrs A]. Having specifically asked for further images and radiographs and been told they do not exist and to have them provided now significantly impedes the investigation process.

I acknowledge a mistake in reporting the timing of the extraction of tooth 46 which I stated was 08.11.2016. It was noted as being unrestorable on 12.01.2016, mentioned as causing pain on 01.06.2016 and removed on 28.06.2016, not 08.11.2016 as I reported. It was the implant fixture which was placed in the 46 site on 08.11.2016. However, tooth 48 that was noted as extracted on 14.01.16 was still present in February 2019. It was tooth 38 that was removed.

Review of Advice

Of the files not seen previously, several are images. The four labeled 'X Ray' comprise No1 the original OPG which I had seen and reported on. Nos 2 & 3 are CT Scans which I had not seen and are not referred to in any clinical notes, and No 4 which is a periapical view of mandibular teeth which are not [Mrs A's]. The CT images and the CT model of the edentulous maxilla and the mandibular teeth show that a greater level of planning was carried out than previously revealed. The 'plaque at locator' image was received previously. The colour coded 'chart progress notes' were all contained within the original clinical material previously sent and reviewed.

Although the volume of additional material is considerable, there is little which impinges on [Mrs A's] treatment. Her medical history filled out on her first visit on 12.01.16 was good to finally see. It was reasonably clear and not difficult to decipher as stated by [Ms E]. There are statements from [Dr C] and [Dr D], commenting on [Mrs A's] treatment. These are useful. The patient instruction forms show that [Dr F] was well prepared with information for patients before and after procedures. The notes from the laboratory were referred to in the clinical notes and are good to have for completeness.

Three scientific articles were included. A 2009 review article outlines the advances in periodontology in the United States. An abstract from a 1998 article by Mariotti and Monroe is equivocal on the use of antibiotics in the treatment of periodontitis. The Abstract from a recent study of periodontitis in mice from the Journal of Bone and Mineral Research suggested a future line of research in humans. These were not really pertinent to [Mrs A's] treatment. Approximately fifty patient evaluation forms [were provided] which are mostly very positive. The major issue expressed in the complaint and I think dealt with fully, is that no action was taken to treat the problems [Mrs A] was having with:

1. pain from the infected implant
2. difficulty with her denture and
3. pain from her tongue.

These matters are now in the process of being remedied by other practitioners at [Mrs A's] expense. My opinion was, and continues to be, that it was [Dr F's] responsibility as the instigator of the treatment and the lead clinician, to acknowledge these problems and take appropriate action. Insisting that there be no plaque nor infection present before remedial surgery was undertaken for the 25 implant was an unreasonable position to maintain.

From August 2017, when the peri-implant mucositis was identified by Hygienist [Ms E] and [Dr C], for over a year [Mrs A] complained about these issues until she sought help from [Dr B] on September 5th 2018. He subsequently removed the implant in February 2019 and gave her advice to seek treatment from [a] Prosthodontist, for a new overdenture. Even after receiving advice from [Dr B], [Mrs A] was asked by [Dr F] on 16.11.2018 to sign a document stating that the problems she was experiencing 'were common to having dental implants and/or implant retained dentures'. The dental literature reports percentage success rates for implants after two years, to be in the high 90s. The disclaimer also implies that the answers given by [Mrs A] to the technicians making her denture, in some way brought about the unsatisfactory result. She and her husband were accused by [Dr F] of lying about [the denture manufacturer] in the clinical notes from 21.04.18.

The document's final clause asked [Mrs A] to agree to the advice that a screw retained denture would be the best option for her. This is in contrast to what she had been advised by [Dr B] and [the prosthodontist] and is contrary to mainstream advice for patients who have experienced tooth loss from periodontitis and need to have the best access possible for cleaning.

This document seeks to absolve [Dr F] as the lead clinician, of responsibility for the treatment of [Mrs A]. [Dr F] did not honour his initial undertaking to replace any failed implant. He did not compensate her for the unsatisfactory treatment outcome in any way.

Comments on my qualifications and experience

I stated that I am not a specialist Periodontist and that I do not carry out implant surgery. However I think that I have sufficient training and experience to evaluate the quality of treatment in this case. It is not simply a matter of evaluating the implant placement procedure nor the plan to retain the denture using locators, although I consider that an integrated bar should have been considered in the planning stage. The central issue for [Mrs A] is one of not receiving fair and reasonable treatment when she found that the outcomes of her treatment were unsatisfactory. As some further background, I have been a member of the DCNZ for two terms and served as deputy Chair and on the Registration Committee. I have served as a member of DCNZ

Professional Conduct Committees over the past twelve years and have a reasonable understanding of the HPCA Act under which dentists practice. I have reported to the Accident Compensation Corporation as an advisor on matters of dentist performance.

Scope of practice

[Dr F] is registered in the General Dental Practice Scope of Practice. Whether or why he has chosen not to seek registration as a specialist Periodontist in New Zealand is immaterial. His training and experience as outlined in the CV material provided details a long career in the specialty areas of periodontics and implant dentistry in the USA.

Although I have been critical of aspects of the accuracy of clinical notes and the extensive use of antibiotics in the treatment of periodontitis and bleach in water flossers, I do not have any evidence that the surgical procedures carried out by [Dr F] were at fault in [Mrs A's] treatment.

Response to Reply to Opinion February 2020

This should be read in conjunction with the numbered order of the reply.

1. The length of the initial appointment is not recorded. Although the notes from the subsequent planning appointment on 29.01.2016 were more detailed, this is when the decision to remove all of [Mrs A's] upper teeth and place four implants to retain an upper denture using implants was made. The recorded options given were a denture alone, or one retained using locators. No form of bar support was discussed. Clinical notes from the 12.01.2016 appointment I received were brief and superficial. There was some discussion on an 'all on four' fixed option which might be looked at in the future.

1.1 The only photographic image of [Mrs A] is a full-face showing 7 lower teeth and no upper teeth. It gives no information about the appearance of [Mrs A's] upper teeth. The OPG is referred to by me as the source of the inaccurate recording of the teeth present as there was no charting of this. There is no mention in the clinical notes of an OPG being taken on 12.01.2016. [Mrs A's] age is recorded on the image but I cannot see any other information.

1.2 I could report only on the clinical notes provided in January. There was no medical history provided in the initial material, but a copy was received in September. In this [Mrs A] records that her biggest concerns were 'Nervous about pain' and 'Can't eat properly'. She noted that she was not satisfied with her appearance and against the question 'Would you like to keep your teeth', she placed a question mark. An OPG X Ray was taken early in the treatment, but no date is ascribed to that. It is the only X ray image I have received taken before treatment commenced. There is no tooth nor periodontal charting recorded in the clinical notes I have received, even though [Ms E] comments on '5mm pocketing through the lower mandible'.

1.4. The previous comment does not constitute periodontal 'charting'. There is no record of the teeth which were present.

2. My comments regarding the medical history have been explained. The disinfection programme, while constituting an adjunctive treatment for periodontitis, is not main-stream periodontal therapy.

2.1 As mentioned in the preliminary comments, the three articles: A 2009 review article outlining the advances in periodontology in the United States. An abstract from a 1998 article by Mariotti and Monroe which is equivocal on the use of antibiotics in the treatment of periodontitis. And the Abstract from a recent study of periodontitis in mice from the Journal of Bone and Mineral Research, an animal study pointing to a possible avenue for research in humans. I did not see any of this material being pertinent to [Mrs A's] treatment.

3. I have referred to my error in not noting that tooth 46 was removed on 28.06.2016. However, tooth 48 which has been stated as being extracted, has never been removed and is reported on as recently as Sept 2018 by [Dr B] when he carried out periodontal charting. It appears that tooth 38 was removed by [Dr F] on 14.01.2016 and 48 was recorded in error.

4. Already commented on.

5. When [Mrs A] has stated that she finds listening to English difficult and prefers email contact I cannot disagree.

5.1 I have previously stated that I have had no contact with [Mrs A] nor her husband.

6. These comments are uninformed. It is unwise to consider treatment for one arch without assessing the opposing teeth. It would be unfortunate if opposing teeth were not able to accept the occlusal load of an implant denture. Comments made on 03.11.2017 by [Dr C] on the instability of the denture and whether a new denture would solve the problem, were that the lower anterior teeth are much higher than the posterior teeth and that this was a problem which would persist even if a new denture was made. Perhaps if this had been noticed at the planning stage some allowance could have been made for this factor.

I mentioned that there is no discussion on the merits of a fixed implant borne prosthesis versus a removable which I considered to be an important issue. That may well have happened, but I did not see a record of that discussion. It is not for a clinician to 'advise' but to inform patients so they can consider their options and make an informed choice.

8. [Mrs A] states this in her letter of complaint.

11. This is stated in the letter of complaint. The clinical notes contain [Dr F] saying 'I do not answer unknown numbers. Take your phone off that setting'.

13. There is no criticism of the implant placement. Just a reiteration of what is in the clinical notes.

14. Again my reference is made in relation to the notes received. The explanation relating to pain was not supplied.

15. Although it can be assumed that the prescriptions were for pain and infection I would have expected to see some reference to this in the notes.

17. There was no criticism here, just a lack of information regarding the decision.

18. My comment indicates the unusual nature of the treatment.

19. My error. Acknowledged earlier.

21. The patient is complaining of pain. Oral Hygiene is the remedy suggested by [Dr F] and his team. Home cleaning causes pain. Removing the locator is not a long term solution. Some other remedy is indicated.

22. My comments only repeat what is in the clinical notes.

23. It is unreasonable to expect oral hygiene to remedy the pain and an unsatisfactory denture. Dismissing a request to discuss a refund I think is unreasonable considering that the problem had existed for a year.

24. [Dr F] was off-loading the restorative problem onto [the denture manufacturer]. He was the lead clinician and should have taken responsibility for the outcome.

25. The unsatisfactory clinical situation clearly needed to be resolved and [Dr F] I consider was responsible for bringing about the resolution.

26. If the patient and [the dental laboratory] thought that a new denture was required, some action was needed. [Dr F] had received the payment for the denture so the ball was in his court.

27. My comment refers to the understanding of the relationship between oral hygiene and periodontal disease, not [Mrs A's] understanding of English. I am sorry if this is inferred by the writer of the reply but it was not my intended implication.

28. If the fixture with peri-implantitis was the cause of the pain and was worsened by wearing the denture, the primary cause of the pain would seem to be the peri-implant infection. That would not be classified as 'atypical pain'. On the evidence received, the diagnosis seems reasonably clear.

29. The disclaimer of responsibility is not a reasonable course of action. I had no knowledge of a contract with [Dr B].

30. No comment necessary.

31. A specialist is unlikely to change a treatment plan unless the new plan was seen as having a better chance of success.

32. From the information received, it seems that [Dr B] was willing to undertake surgery in the circumstances which existed.

33. The person controlling the finances and the treatment plan I believe should be seen as the Lead Clinician.

34–37. No comment.

38. No photographic images have been seen other than the preoperative full face with no view of the upper teeth. The images I reviewed were:

1. 5 OPGs
2. 2 images of locator 25.
3. 1 full face showing only 6 lower teeth.

39. I could only assess the material provided. If the clinical notes don't mention oral hygiene discussions, I cannot assume that they occurred.

40. 'Nearly fluent in English' appears in the informed consent. [Ms E] says that 'English is not good but happy for her husband to translate'. There was no medical history form provided until September.

41. The absence of tooth and periodontal charting, photographs and x rays was the basis of the comments.

42. On the matter of consent, having no written treatment plan, makes consent difficult to achieve. At the initial consultation, there was no treatment plan to consent to.

43–44. The chart progress notes are detailed and explained the intended treatment. However, [Mrs A's] complaint was that she did not receive a written treatment plan which she requested. When asked to comment on whether all treatment options were included, it is only possible to include what has been documented. The comment on Periodontal charting 'No chart-no pockets' does not correlate with '5mm pockets through lower mandible' from [Ms E]. My comments were required by the HDC on what was documented, not verbally given.

45. [Dr F's] registration in the general practice scope of practice is a matter of factual information, not in any way a criticism.

46. See no 44. [Ms E's] statement is a generalised observation and cannot be taken as a recording of a detailed examination of the periodontal tissues.

47. The disinfection regime is not a routine periodontal practice. Exhibits 8 are 11 and 22 years old and do not constitute support for [Dr F's] treatment.

48. This description was provided by [Mrs A] in her letter of complaint. She was complaining about the taste and that in her experience, and mine, this suggestion of

using household bleach in her water-flosser was unusual. There was no use of the words 'any old'.

49. The initial OPG was viewed. Yes there is generalised bone loss, but there is no evidence of a statement to this effect in the material I received. It is not uncommon for patients to diagnose their condition inaccurately. It was the appearance of the teeth which was the primary reason for [Mrs A] requesting their removal. The condition of the teeth is not discussed in the clinical notes I received. The prognosis ascribed to them is almost certainly correct but not documented.

50. The points made are that there were errors made in the charting of the teeth present and those extracted. Leaving three teeth, 23 24 25 to assist with eating and speech is strange as teeth 24 25 were the teeth showing most bone loss.

52. No comment. But to note that the teeth extracted were not accurately recorded.

53. Criticisms were made only where I considered there was justification.

54. My comments are based on reading the clinical notes, [Mrs A's] letter of complaint, and pertinent emails and other correspondence provided. It seems unlikely that [Mrs A] just stopped her cleaning. Information on her oral health received from both [Dr B] and [the prosthodontist] was that it was reasonable at the time of their examinations. Receipt of the patient pre and post procedure information for extraction, implant placement and immediate dentures indicated that these issues were addressed.

55. The comments here are matters recorded in the clinical notes and the letter of complaint.

56. The perceptions of the patient and operator will differ but a letter of complaint should be taken seriously and on its merits. It cannot be dismissed on the grounds of bias.

57. My opinion is based on the evidence I have been provided with.

58. It was my task to assess the material supplied and I stand by what I have said.

59. My comments are taken directly from [Mrs A's] letter of complaint, pages 2 and 3 under the headings of Hygiene Problem, Bad Management and Poor Communication. I am asked to comment on any other matters and feel that the description of the practice and its communication with patients warrants mention. A practice visit was not part of my instructions.

60. 'Insisted' is the word [Mrs A] uses in the letter of complaint which I submit is a reasonable simile for demanded.

None of the additional material nor the criticisms of my opinion changed my thinking on the central issues and did not alter the advice I have given.

Summary of departures identified in further expert advice

a) There is no evidence of a wax model or photographs of [Mrs A's] teeth in [Dr F's] notes. The lack of photographs is a moderate departure.

b) There is no documented discussion about the risk periodontitis has on subsequent peri-implant disease. This is a moderate to severe departure.

c) The information recorded at the initial consultation was insufficient and inaccurate and constitutes a moderate departure.

d) The lack of baseline and follow-up charting information for the periodontal treatment and the unconventional nature of the disinfection protocol is a severe departure.

e) The clinical notes do not accurately reflect the dates that the extractions or implant placements occurred and is a severe departure.

f) The failure by [Dr F] to acknowledge the problems with the 26 implant and the dentures is a severe departure.

g) Criticism is made about the adequacy of the clinic rooms and the management of [the clinic]."