HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Case 21HDC02127

Dental care provided to a woman who underwent tooth extraction

Contents

Complaint background

1. On 4 September 2021 a complaint was received from Ms A about the care provided to her by dentist Dr B at a dental practice.

2. In her complaint, Ms A explained that usually she had treatment at a university dental practice, where she had been seen on 15 and 17 Month1[1] with an infected impacted wisdom tooth. She had been prescribed antibiotics and advised that extraction was required.

3. On 23 Month1 Ms A emailed the dental practice and sought an emergency appointment to have her lower right wisdom tooth removed due to pain and distress. Prior to the appointment, she emailed the practice her dental X-rays from the university dental practice.

4. Ms A stated that prior to the procedure, she was not provided with any information on the procedure and was not asked to sign any consent forms. There was no discussion about side effects or potential risks of the procedure.

5. In her complaint, Ms A described the procedure as very painful despite receiving three numbing injections. She stated that she thrashed out in pain many times, but Dr B ignored her and continued with the procedure.

[1] Relevant months are referred to as Month1–Month7 to protect privacy.

6. Ms A stated that after the procedure, no aftercare or safety-netting advice were provided to her.

7. Ms A said that since the procedure, she has experienced ongoing pain, numbness of her tongue, and inflammation of the extraction site.

8. When Ms A first raised her concerns with the dental practice, she was provided pain medication. When the pain continued, Ms A was prescribed antibiotics but received no explanation of what they were for. She was also provided with dry socket[2] treatment but was not told how to use it and what to expect.

9. Ms A raised her concerns directly with the practice and requested a copy of her dental records. She was informed by the owner, Dr C, that she had suffered nerve damage and that it would take months to heal. Ms A noted that this information was not recorded in her dental notes.

10. Ms A stated that she was advised by the dental practice that she would be referred back to her usual dentist for ongoing care, but this did not happen, and she had to make her own appointment.

11. Following further investigation by the university dental practice, Ms A was diagnosed with possible lingual nerve damage, and in Month3 the dental wound was debrided.

12. A referral was made to an oral and maxillofacial surgeon,[3] who performed an inferior alveolar[4] and lingual nerve[5] exploration and repair.

13. Dr B completed an ACC claim for nerve injury, refunded the fees Ms A had paid, and sent her a written apology.

Scope of investigation

14. The following issue arising from the complaint was investigated:

- *Whether [Dr B] provided [Ms A] with an appropriate standard of care between [Month1] and [Month3] 2021 in relation to the wisdom tooth extraction procedure and aftercare.*

Response to complaint

15. The dental practice told HDC that its usual practice is to request notes when patients transfer, but Dr B was under the impression that Ms A had had a prior consultation at the

[2] Dry socket is a painful condition that can occur after tooth extraction. It happens when the blood clot that covers the wound becomes dislodged or does not form fully.
[3] Oral and maxillofacial surgeons are specialists in the diagnosis and treatment of a broad range of disorders that affect the facial complex and skeleton, including the jaws and oral cavity.
[4] The inferior alveolar nerve is a sensory branch of the mandibular nerve, which provides sensory innervation to the lower/mandibular teeth and their corresponding gingiva as well as a small area of the face.
[5] The lingual nerve carries sensory innervation from the anterior two-thirds of the tongue.

university dental practice about extraction, as she had emailed her orthopantomogram[6] to the dental practice.

16. Dr B said that normally he would assess a patient for extraction, but he felt under pressure to relieve Ms A's pain and distress by removing her wisdom tooth on 23 Month1.

17. Ms A's expectations and the risks of the procedure were not documented by Dr B, and he accepts that he did not discuss the force required or the possibility of nerve damage as a result of the extraction. Dr B said that the surgical technique used was designed to avoid nerve damage, and the treatment was performed under local anaesthetic (x3). He stated: '[It was a] highly difficult extraction on a nervous patient [and it was] a struggle for both practitioner and patient.' Dr B agrees that Ms A had a terrible experience.

18. The dental practice acknowledged that a 'fuller consultation may have highlighted some of the risks of extraction'; that documentation was deficient; and that lingual nerve damage was missed.

19. At the time of Ms A's appointment, Dr B was a subcontractor at the dental practice. He is now retired and has asked to be removed from the Dental Council register.

Independent advice

20. Independent advice was obtained from Dr Robin Whyman, who noted the following departures from the expected standard of care provided by Dr B:

- Severe departure: evaluation of the patient prior to treatment
- Severe departure: provision of information and informed consent
- Moderate departure: the level of surgical skill Dr B used to remove the wisdom tooth
- Mild departure: follow-up care with the complainant.

21. Dr B was provided with the opportunity to comment on Dr Whyman's report, and he advised that he accepts the report and findings.

Decision

22. Having reviewed all the information in this case, I consider that Dr B breached Rights 6(2), 7(1), and 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). I have outlined the reasons for my decision below.

23. Right 6(2) of the Code states that before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

[6] An orthopantomogram is a common radiograph used to identify the hard tissues of the oral cavity and surrounding skeletal structures.

24. In the circumstances of this case, Dr B did not provide Ms A with information about the procedure, and he did not discuss the force required or explain the potential risks, including nerve damage. This is not in dispute.

25. That this did not occur is a breach by Dr B of Right 6(2) of the Code and, consequently, Right 7(1) of the Code — the right to make an informed choice and give informed consent. Put simply, Ms A was unable to consent to the procedure adequately, as she had not been fully informed by Dr B.

26. I also consider that Dr B breached Right 4(1) of the Code, which requires that services are provided with reasonable care and skill. Dr Wyland identified that Dr B's surgical skill was below the standard expected, and it is on this basis that I find Dr B in breach of Right 4(1).

27. To achieve a timely and pragmatic resolution of the complaint, Dr B was provided with details of the assessment, a copy of the independent advice, and details of the departures from the accepted standard of care (namely Rights 4(1), 6(2), and 7(1)), together with the reasons why these were considered a breach of the Code. Dr B accepted the findings.

Changes made since events

28. I am pleased to note that on receipt of a copy of the independent advisor's report, the dental practice accepted the findings and acknowledged the recommendations made. These included:

- Continued education for all staff at the dental practice about the importance of full consultation, informed consent, and thorough note-taking; and
- The availability of consent forms and information sheets on all complex procedures, for use by all practitioners at the practice.

29. The dental practice advised HDC that the above recommendations have been implemented.

Further recommendation

30. Noting that Dr B has retired, I recommend that in line with my independent advisor's report, should Dr B return to practice, he familiarise himself with the clinical technique for wisdom teeth removal, the complication of altered nerve sensation following removal, and the appropriate postoperative care.

Follow-up actions

31. This report will be provided to Dr B, the dental practice, Ms A, and the Dental Council of New Zealand.

32. The Dental Council of New Zealand will be made aware of my findings by being provided with this report should Dr B decide to re-register to provide dental services within New Zealand.

33. A copy of this decision with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website for educational purposes.

Appendix A: Independent dental advice to Commissioner

The following advice was obtained from dentist Dr Robin Whyman:

'Complaint:	**[Ms A] / [Dr B]**
Our ref:	**C21HDC02172**
Independent advisor:	**Dr Robin Whyman**

I have been asked to provide clinical advice to HDC on case number C21HDC02172. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:

1. I qualified Bachelor of Dental Surgery (Otago) in 1986. I am registered with the Dental Council as a general dentist. I am also registered as a dental specialist in public health dentistry having qualified with a Master of Community Dentistry (Otago) in 1993.
2. I was employed by Hawke's Bay District Health in January 2013 as Clinical Director Oral Health and between February 2019 and August 2023 I was Chief Medical and Dental Officer.
3. I am currently employed by [Health NZ|]Te Whatu Ora Hawke's Bay as a general dentist and dental specialist in the Dental Service.
4. I have also been clinical director for the oral health services at Wellington Hospital, Hutt Hospital and Whanganui Hospital.
5. I was a member of the Dental Council between June 2011 and June 2021. I am no longer a member of the Dental Council.
6. [Dr B], and the complainant are not known to me.
7. I undertake a range of hospital-based clinical practice including minor oral surgery, that includes the surgical removal of teeth including wisdom teeth, special needs dentistry and paediatric dentistry for patients referred to the Hospital Dental Service.
8. I have practised hospital-based dentistry with a similar scope of practice for most of my career at Wellington Hospital, Hutt Hospital, Whanganui Hospital and Hawke's Bay Hospital.
9. I am also employed part time by the NZ Dental Association as Director (Dental Policy) — a role that involves my knowledge and experience in public health

dentistry, considering policy primarily related to oral health promotion and prevention of disease, access to care and workforce issues.

Documents provided by HDC:

1. Letter of complaint to HDC dated 4 September 2021
2. The dental practice's response to complaint with enclosures, including clinical notes for the relevant period.
3. Clinical records (photos and radiography) from [the university]

Referral instructions from HDC:

1. Whether the evaluation of [Ms A] prior to her dental extraction by [the dental practice] was adequate/appropriate, including what the accepted process is for a dentist to evaluate and obtain information regarding a new patient requiring dental extraction, prior to treatment.
2. Whether [Ms A's] dental extraction on 23 [Month1] met accepted standards of care, including management of a situation where extraction is not progressing as expected.
3. Whether follow-up care for [Ms A's] extraction, including the communication, diagnosis and management of complications was of an accepted standard.
4. Any other matters that you consider warrant comment or amount to a departure from accepted standards.

Also,

5. The expected information that would be discussed with a patient undergoing surgical removal of tooth 48 under local anaesthetic, including potential risks, instructions for follow-up care and safety netting advice.
6. What is the usual process and timeframe for communicating x-ray results to a patient?

Factual Summary of Care Provided: Brief summary of clinical events:

1. [Ms A] had an infected lower right wisdom tooth which was impacted. She initially consulted the [university dental practice] and then attended [Dr B] at [the dental practice] to have the tooth removed.

2. [Ms A] had an appointment on 23 [Month1] at [the dental practice] when the tooth was removed. The procedure was approximately one hour long and [Ms A's] complaint includes concerns that there was minimal interaction with her prior to the procedure, the procedure was very uncomfortable and that she was and distressed and "thrashing" during the procedure.

3. Following the procedure she experienced a great deal of pain and discomfort and 25 [Month1] she phoned the practice and explained that she was in pain and had continued numbness in her tongue.

4. [Ms A] attended post operative appointments at [the dental practice] with [Dr B] on 2 [Month2] and 9 [Month2], and then on 1 [Month3] with [Dr C]. She was noted to be experiencing ongoing post operative pain and had tingling in her tongue. Notes on the 9 [Month2] consultation record "feeling in tongue nearly back to normal". [Ms A] disputes that this was an accurate record of the situation at that time.

5. On 15 [Month3] [Ms A] was referred to the [university dental practice] and ACC Treatment Injury forms were completed by [Dr B].

6. [The dental practice] have provided a review (undated) of the situation related to [Ms A's] wisdom tooth removal. [Dr B] agrees that [Ms A] attended for removal of her lower right wisdom tooth with him on 23 [Month1], with an OPG film (radiograph) of the tooth available that had been taken on 15 [Month1] (although the document is undated on the copy seen) at the [university dental practice].

7. [Dr B] agrees that the procedure was undertaken on the 23 [Month1] without a prior consultation, as he understood this had occurred previously at the [university dental practice] and [Ms A] wished to proceed with treatment due to the level of pain she was experiencing from the tooth.

8. [Dr B] believes he did explain the procedure but did not record this in his notes. He agrees he did not seek written consent or provide written information to the patients about the treatment and the expectations, risks and side effects that may occur.

9. [Dr B] has explained in his review of the procedure that the removal of the tooth required a surgical procedure that involved raising of a buccal flap to expose the tooth and the bone surrounding the tooth, removal of bone with a bur and elevation of the tooth out of the socket. He then checked the socket and closed the gum flap with a stitch and ensured that bleeding had stopped.

10. [Dr B] agrees the surgery was more difficult than he had expected, that he needed to remove more bone than expected and that removal of the tooth required a greater level of force on the tooth and the jaw than he had expected. He agrees that he had not prepared [Ms A] prior to the procedure of the degree of difficulty with the surgery or warned her of the possibility of damage to the lingual nerve.

11. [Dr B] agrees that the procedure was difficult and stressful and agrees [Ms A] "is right to say it was a terrible experience".

12. I have summarised this information from the review of the procedure by [the dental practice], including an explanation from [Dr B]. The clinical notes from the day of

surgery are brief and only record that the patient had a very mildly elevated temperature, had already had 2 courses of antibiotics, that local anaesthetic was placed, tooth 48 was removed with a flap raised, bone removed, the tooth elevated, and 1 suture placed. Post operative instructions were given and an appointment for suture removal to be made.

13. Subsequent to [Ms A's] complaint to [the dental practice] she was referred to the [university dental practice] and reviewed.

14. The [university dental practice] outpatient clinic notes were provided with the documents for review and the summary below is from reading those notes.

15. [Ms A] had a series of outpatient appointments and was prescribed a number of pain relief medications endeavouring to control her pain including paracetamol, ibuprofen, codeine and a period taking pregabalin. None of the analgesia had been particularly successful at managing her post procedure pain.

16. She subsequently underwent 2 further surgical procedures.

17. The first under local anaesthetic on 17 [Month4] for washout to debride (remove) bony debris from the lower right wisdom tooth socket and to endeavour to alleviate post operative pain.

18. The second procedure was approximately 6 [Month6] (operative notes not provided for this review) at [the public hospital] in a combined procedure between the maxillofacial surgery and ENT surgeons to undertake a repair of her lingual nerve. A series of appointments were undertaken with the maxillofacial surgeon and a postgraduate student to discuss this procedure prior to it occurring.

19. Follow up notes extend to 3 [Month7] when recovery was ongoing.

Question 1: Whether the evaluation of [Ms A] prior to her dental extraction by [the dental practice] was adequate/appropriate, including what the accepted process is for a dentist to evaluate and obtain information regarding a new patient requiring dental extraction, prior to treatment.

List any sources of information reviewed other than the documents provided by HDC:

1. Chiapasco M. Manual of Oral Surgery 3rd edition 2013. Edra S.p.A
2. Code of Health and Disability Services Consumers' Rights
3. Dental Council of New Zealand Standards Framework for Oral Health Practitioners

Advisor's opinion:

1. [Ms A] attended [the dental practice] on 23 [Month1] and [Dr B] proceeded at that same appointment to undertake a surgical procedure that eventuated to be of moderate complexity and intensity, before the tooth was eventually removed.

2. [Ms A] had made email contact prior to the appointment explaining her significant pain, that she had already been seen at the [university dental practice] and providing a copy of the OPG film that had been taken at the [university dental practice].

3. [Ms A's] complaint indicates that minimal conversation occurred prior to the procedure being embarked upon and the procedure was undertaken almost immediately at the appointment on 23 [Month1].

4. [Dr B's] notes from the day of surgery give no indication of any pre-procedural discussion, explanation of the procedure and the risks, benefits and side effects that may occur with the removal of a lower wisdom tooth.

5. No written information was provided to [Ms A] and no written consent form was completed.

6. In [Dr B's] reply to the HDC he explains that he usually "comments on what to expect with the surgery" after he administers the local anaesthetic and believes he did this but did not record it.

7. [Ms A] did indicate that she had already been seen at the [university dental practice] regarding her infected wisdom tooth and been advised to have the tooth removed.

8. Unfortunately [Dr B] appears to have relied heavily upon the fact that [Ms A] had previously been seen at the [university dental practice] regarding her painful wisdom tooth and that she would have been informed as to the nature of the procedure to be undertaken.

9. I do note that [Dr B] was in receipt of the OPG film from the [university dental practice] prior to seeing [Ms A]. I believe the OPG film was a reasonable radiological level of investigation prior to the procedure. However, this radiological investigation should have flagged to [Dr B] that the procedure required to remove [Ms A's] wisdom tooth would require a moderate level of surgery, including bone removal and the possibility of needing to cut the tooth into pieces with a bur.

10. [Dr B] appears to have felt under pressure to proceed with the removal of the wisdom tooth as [Ms A] had explained she was in significant pain.

11. However, [Dr B] was not in a position to know the nature of the previous discussion. He did not take the time to discuss the procedure with [Ms A] or to consider whether proceeding on the same day was prudent.

12. I note that [Dr B] did not provide any written information or have [Ms A] provide written consent to the procedure. These steps would not be absolute requirements for this surgical procedure to be undertaken under local anaesthetic alone. However, they would have been prudent for a procedure of this level of complexity

and with accepted risks and side effects that include those subsequently experienced by [Ms A].

13. I consider that the surgical removal of an impacted lower wisdom tooth that is minimally erupted, significantly impacted distally in bone and necessitating bone removal with a drill, to constitute a surgical procedure of moderate complexity. At the least I would have expected a discussion and agreement of the procedure to have occurred and for the record of that conversation to have been recorded in some detail in the patient notes.

14. I also cannot support [Dr B's] suggestion that it would be appropriate to explain to the patient the procedure after the local anaesthetic had been placed. This was a surgical procedure of moderate difficulty and once the local anaesthetic had been placed the procedure had effectively commenced. A patient cannot be considered to be able to be properly advised of the procedure, to be able to ask questions and to agree to the procedure once a procedure has already commenced.

15. In my opinion [Dr B] did not ensure that he was sufficiently informed about the patient, their situation and the surgical procedure he was undertaking prior to undertaking the surgical procedure. [Dr B] did not meet his obligations to ensure that the patient was fully informed (Right 6) and did not ensure that the patient was able to make an informed choice and give informed consent to the procedure (Right 7) before he commenced.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

1. The relevant standards are those explained in Right 6 and 7 of the Code of Health and Disability Services Consumers' Rights.

2. The standards are also those of the Dental Council of New Zealand Standards Framework for Oral Health Practitioners. Professional standards 14 and 15 (You must listen to your patients and consider their preferences and concerns and You must give patients the information they need or request, in a way they can understand, so that they can make informed decisions) and the Informed Practice Standard.

Was there a departure from the standard of care or accepted practice?

- *No departure;*
- *Mild departure;*
- *Moderate departure; or*
- *Severe departure.*

1. I consider that there was a severe departure from the standard of care in relation to the evaluation of the patient requiring a surgical dental extraction prior to treatment and in failing to ensure the patient was fully informed and gave informed consent prior to the procedure.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

1. I believe that the requirement for a discussion of the procedure, the risks, side effects and possible complications would be regarded as the usual standard of care by peers.

2. I have not discussed this particular complaint with any peers. However, the process for patients to be fully informed, to make an informed choice and to provide informed consent prior to proceeding (or not) with dental surgery is one that we regularly discuss within my own Hospital Dental Unit, where we regularly undertake such surgery.

Please outline any factors that may limit your assessment of the events.

1. I am limited to the information that has been provided in the patient's complaint, in the dental records of the [university dental practice] and [the dental practice], the summary of events from [the dental practice], [Dr B] and [Dr C].

Recommendations for improvement that may help to prevent a similar occurrence in future.

1. I recommend that [the dental practice] review the process for consulting with and undertaking a procedure, especially a surgical dental procedure even when a patient presents with acute dental pain. Sufficient time needs to be available to discuss and explain the procedure to the patient, and to make an informed decision both by the patient and the dentist about the prudence of proceeding immediately, or managing the immediate pain and infection, undertaking a planned procedure or referral of the patient to another practitioner.

2. I recommend that [the dental practice] develops a written informed consent form for procedures of moderate complexity, such as the surgical removal of wisdom teeth.

3. I recommend [the dental practice] has available written information for patients about the surgical removal of wisdom teeth including reasonable issues to expect post-surgery and the risks and complications. This could either be developed for their own practice, or made available from existing information brochures such as that from the NZ Dental Association or a number of other sources that can be readily found online.

4. I do note that in the response provided by [the dental practice] and [Dr B] they do state "… I did not have a form for [Ms A] to sign consenting to the surgery at that time. We now have written information that informs patients of what to expect, possible risks, and side effects. Since this complaint I have been much more aware of the need to ensure that people are fully informed and of what they should normally expect from a procedure."

5. Therefore I conclude that development of written advice and a consent form does appear to have been acted on by the practice already.

6. I also note that [Dr C] as the practice owner stated "I have highlighted to all our staff at the practice the importance of a full consultation process prior to complex treatment. We have consent forms and information sheets on all complex procedures available to be used by all practitioners at our practice. There is a very comprehensive one that I routinely supply to all my patients when removing third molars which highlights the possibility of nerve damage. I have also emphasised that all patient records from previous practices be viewed when treatment planning or consulting with patients."

7. I support these steps by the practice as appropriate improvements in response to [Ms A's] experience.

Question 2: Whether [Ms A's] dental extraction on 23 [Month1] met accepted standards of care, including management of a situation where extraction is not progressing as expected.

List any sources of information reviewed other than the documents provided by HDC:

1. Auyong TG and Le A. Dentoalveolar nerve injury. Oral Maxillofacial Surg Clin N Am 23, 395–400, 2011

2. Robinson PP, Loescher AR, Yates JM and Smith KG. Current management of damage to the inferior alveolar and lingual nerves as a result of removal of third molars. B J Oral Maxfac Surgery 42, 285–292, 2004

3. Bailey E, Kashbour W, Shah N, Worthington HV, Renton TF, Coulthard P. Surgical techniques for the removal of mandibular wisdom teeth. Cochrane Database of Systematic Reviews 2020, Issue 7. Accessed 25 May 2024

4. Chiapasco M. Manual of Oral Surgery 3rd edition 2013. Edra S.p.A

Advisor's opinion:

1. In response to this question I will concentrate on the period of the actual surgical removal of [Ms A's] lower right wisdom tooth as I have already provided my opinion on the standard of care in the preoperative period.

2. [Dr B] explains that he proceeded with removal of the tooth under local anaesthesia, he reflected a soft tissue flap to expose the crown of the tooth and the bone that covered the back of the tooth.

3. He then removed bone surrounding the tooth with a bur, and elevated and removed the tooth. This was undertaken with some difficulty and [Ms A] experienced pain during the procedure for which he placed additional local anaesthesia.

4. Both [Dr B] and [Ms A] appear to agree that the procedure was difficult and uncomfortable for [Ms A].

5. Following removal of the tooth [Dr B] states he checked the socket and placed a suture to close the gum flap

6. Overall, the basic technique followed by [Dr B] appears consistent with that needing to be adopted for the surgical removal of a lower wisdom tooth that was impacted into the bone of the jaw.

7. The decision by [Dr B] to remove [Ms A's] lower left wisdom tooth using local anaesthesia alone is not of itself outside the scope of practice or the standard of care that would be undertaken in general dental practice by a general dental practitioner experienced in the surgical removal of wisdom teeth.

8. However, the lack of discussion of options to improve the comfort of the procedure such as use of sedation or undertaking the procedure under general anaesthesia is a departure from the expected preparatory considerations for this procedure.

9. I note that [Dr B] elected to continue on with the procedure at the point discomfort and difficulty removing the tooth occurred. An alternative could have been to cease the procedure, close the soft tissue gum flap, and refer the patient to a specialist or other provider who could complete the procedure more easily. However, this is a judgement call that is difficult to balance with how far through the procedure this discomfort occurred and whether in a short period the procedure can be completed. The alternative being ceasing the procedure but needing to then undergo a second procedure at a later date.

10. I do note that subsequently [Ms A] experienced significant pain and she had to undergo a further procedure to debride the socket of bony debris at the university dental practice, to assist with relieving her pain and to improve the return of sensation in her lower lip (this was separate to the issues with the loss of sensation to her tongue).

11. I am of the opinion that the fact bony debris was left in the socket to a degree that required a second debriding procedure indicates that inadequate attention was paid to checking the socket and washing and cleaning bony debris following removal of the tooth. This surgical debris is created from drilling of the bone and elevating of the tooth from the socket. It is a normal standard of care to carefully remove such bony debris from the socket. The debridement is to decrease the chance of infection and issues with altered sensation, especially in the inferior dental nerve.

12. I also note that [Ms A] has experienced significant issues with loss of sensation and taste in her right tongue, and she has had serious ongoing pain in the nerve. She has undergone a nerve repair procedure at [a public hospital].

13. I am not critical that loss of normal sensation occurred with the removal of [Ms A's] lower right wisdom tooth. This is a recognised potential complication of the removal of lower wisdom teeth. The incidence of this complication varies and wide

ranges have been reported. A 2020 Cochrane Review of the literature on surgical techniques for removing mandibular wisdom teeth (Bailey et al 2020) estimated the incidence of temporary lingual nerve disturbance at 0–15% and permanent disturbance at 0–2%. This review also states "… that the incidence varies considerably between reports and may be related to a number of factors including the difficulty of surgery, surgical technique, and the skill of the surgeon." Auyong and Le (2011) reported the incidence to vary between 0.1–22%, but did note that a disto-angular impaction of the tooth was found to increase the risk of lingual nerve deficit significantly.

14. [Ms A's] tooth was a mild distoangular impaction in my assessment of the OPG radiograph. Therefore, the increased potential for damage to the lingual nerve should have been appreciated.

15. I note that [Dr B] states "I also hadn't warned her of the possibility of nerve damage, particularly lingual nerve damage as the surgical technique I adopt is designed to avoid this." I am uncertain what [Dr B] means by this, but there is debate about the use of a lingual retractor to protect the lingual tissues when undertaking this procedure. In my experience a lingual retractor is not always used.

16. However, I am aware that Robinson et al (2004) in their review of management of damage to inferior alveolar and lingual nerves as a result of third molar surgery state "There is good and increasing evidence that lingual flap retraction should be avoided for most cases, but this issue has been extensively debated elsewhere and will not be pursued here".

17. However, Bailey et al (2020) in their Cochrane Review state "When bone is being removed buccally only, there is no danger to the lingual nerve that lies in close proximity to the wisdom tooth on its lingual aspect. However, the lingual nerve is at risk of physical injury from the bur when distolingual bone is removed. Distolingual bone may need to be removed to permit tooth removal according to its type of impaction and typically for distolingually impacted teeth. An instrument may be placed between the bone to be removed and the lingual flap enclosing the nerve to protect it from physical injury during bone removal. … This 'lingual nerve protection' has been the tradition in the UK and in some other parts of the world, but less so in the USA (Pell 1933). Whilst the intention of placing a barrier instrument is to prevent permanent lingual nerve injury, some surgeons believe that it is preferable not to place an instrument for nerve protection, as there is the potential to cause a temporary nerve injury (Renton 2001). However, in this situation, it is imperative not to remove bone distal to the tooth and only bone on the buccal aspect".

18. I cannot therefore make any comment about whether a lingual retractor was used or not, but I do note that [Dr B's] response to the HDC states he removed bone around the distal and buccal of the tooth with a bur.

19. If a lingual retractor was not used, the literature indicates that removal of bone from the distal of a lower third molar tooth that was impacted disto-angularly, without lingual retractor protection, may have an increased the potential for surgical injury to the lingual nerve.

20. I also note that subsequently the oral and maxillofacial surgeon elected to undertake a surgical repair of [Ms A's] lingual nerve which suggests that the level of damage to the nerve appears to have been sufficient to divide or significantly damage the nerve.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

1. I am not of the opinion that the fact [Ms A] has experienced loss of sensation in the right lingual nerve is of itself an indication that the standard of care was below an acceptable level, as this is a recognised and reported complication with this procedure.

2. I am of the opinion that the level of surgical skill used to remove her lower right wisdom tooth was below that expected for the procedure.

3. I draw this conclusion noting that [Ms A] has had to undergo 2 further surgical procedures following the removal of her lower right third molar tooth, the first to debride bony debris from the socket and the second to repair her right lingual nerve.

4. The standard of care is established by the Dental Council Standards Framework and the Ethical Principle — Provide Good Care and Professional Standard 19 — You must take a holistic approach to care appropriate to the individual.

5. The removal of wisdom teeth is a long standing surgical procedure and the standard is therefore also established by contemporary textbook descriptions of surgical interventions in dentistry such as Chiapasco M. Manual of Oral Surgery 3rd edition 2013. Edra S.p.A.

Was there a departure from the standard of care or accepted practice?

- *No departure;*
- *Mild departure;*
- *Moderate departure; or Severe departure.*

1. I am of the opinion that there was a moderate departure from the accepted standard of practice.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

1. I have not discussed this particular complaint with any peers but the process for patients to be fully informed of their options for the level of anaesthesia and

sedation available prior to the procedure, and for the surgical site to be thoroughly debrided of bony debris would be a usual standard of care

2. I practise in conjunction with dentist colleagues in my department to undertake removal of wisdom teeth procedures. We do undertake procedures operating together from time to time.

3. Thorough debridement and irrigation of the socket following tooth removal is the standard of care we undertake, recognising the risk that residual bony debris in the socket creates for infection and altered inferior alveolar nerve sensation.

4. Use of lingual retraction is the usually used standard of care when removing bone with a bur distally from a third molar tooth.

Please outline any factors that may limit your assessment of the events.

1. I am limited to the information that has been provided in the patient's complaint, in the dental records of the [university dental practice] and [the dental practice], the summary of events from [the practice], [Dr B] and [Dr C].

Recommendations for improvement that may help to prevent a similar occurrence in future.

1. I note that [Dr C's] report to the HDC indicates that [Dr B] has retired from dental practice and that a review of the Dental Council register of dentists indicates that he is no longer registered. In respect of [Dr B] I therefore make these recommendations only in the event that he were to decide to return to practice.

2. I recommend that [Dr B] should review and re-familiarise himself with the clinical techniques for the surgical removal of wisdom teeth.

3. I recommend that if [Dr C] and the clinical staff of [the dental practice] are also undertaking the surgical removal of wisdom teeth they should also re-familiarise themselves with the clinical techniques and complications with the surgical removal of wisdom teeth. I make this recommendation noting that [Dr C] became involved in managing [Ms A's] complaint but states he was "… perplexed that she was still numb" after his first contact with her following her procedure at the dental practice.

4. I recommend that [Dr B] and the dental practice should develop a system for the assessment of the patient complexity for surgery to satisfy themselves that case selection matches their level of experience and ensure this assessment is documented in the records.

5. I recommend that the clinical records include a record of the initial assessment of the patient, document that the procedure was discussed, record the risks, complications and usual outcomes that have been discussed and that informed consent was obtained.

6. The clinical record should also record sufficient detail to describe the surgical procedure to a level that the technique used, and any issues that arose, can be understood and reviewed.

Question 3: Whether follow-up care for [Ms A's] extraction, including the communication, diagnosis and management of complications was of an accepted standard.

List any sources of information reviewed other than the documents provided by HDC:
1. Chiapasco M. Manual of Oral Surgery 3rd edition 2013. Edra S.p.A

Advisor's opinion:
1. [Ms A's] dental surgery occurred on 23 [Month1] and she first made contact with the surgery on 25 [Month1].

2. [Dr C] made contact with [Ms A] that evening by phone.

3. [Dr C] prescribed a short course of prednisone over 5 days that was collected on 26 [Month1]. There is limited evidence that steroid is effective in addressing post operative altered nerve sensation but it is commonly used to decrease post operative swelling and discomfort following wisdom tooth surgery, and so this appeared a reasonable action at that time.

4. [Ms A] then had postoperative appointments at the practice on 2 and 9 [Month2] with [Dr B]. On 2 [Month2] [Ms A] was continuing to experience pain and altered sensation. Her stitch was removed and she was recommended to return if not continuing to improve.

5. [Ms A] did return on 9 [Month2]. The clinical records state that the feeling in her tongue was nearly back to normal. The records also record that she had bad breath, throbbing and "hard white pus?" A clinical assessment that she may have a dry socket was made and the socket was dressed with Alvogyl. She was prescribed antibiotics (Amoxycillin 500mg tid).

6. [Ms A] disputes that the assessment and description of the sensation in her tongue was correct and given the subsequent care that she required through the [university dental practice] and [the public hospital] this appears to have been a significant under assessment of the situation.

7. The clinical assessment that she may have dry socket was reasonable in my view although somewhat later than would normally occur following removal of a tooth. Dry socket occurs when there is an inflammation and infection in the healing bony socket following removal of a tooth and loss of the associated blood clot, but more usually develops within the first week. The description that there appeared to be "hard white pus" is unusual and I suspect this was more likely to have been the emergence of the first of the bony debris that was left in the socket and subsequently debrided in the procedure at the [university dental practice].

8. A prescription for antibiotics was reasonable at that point given the clinical impression was one of active infection.

9. [Ms A] however, does not appear to have had an explanation of the situation that was clear to her, and she was unsure about why she was prescribed antibiotics and what to expect with the Alvogyl dressing that was placed.

10. Alvogyl is a fibrous dressing placed directly into the socket that has a sedating, antimicrobial and anaesthetic effect, but it is recommended that it is removed.

11. I am concerned that no further post operative appointment appears to have been planned by [Dr B], or that he had arranged with the practice, despite the ongoing problems [Ms A] was having.

12. I do note that [Dr C] subsequently met with [Ms A] on 1 [Month3] after she made a complaint to the practice on 30 [Month2]. He noted that in the meantime [Ms A] had returned to the [school of dentistry] for post operative care. He also noted she was continuing to have altered sensation in her tongue including numbness, tingling and shooting pains.

13. At this point [Ms A] was 5 weeks post operative and it was reasonable in my view to believe that recovery of her lingual nerve may be ongoing. The literature indicates that sensation can continue to return when there is alteration of sensation in the lingual nerve, for between 3 to 6 months, and even 12 months or more although the potential for recovery at this point is less.

14. [Dr C] indicates in his response to the HDC that he planned to review her again in another 2 months, but it is unclear if [Ms A] knew of that plan or if a further appointment had been made.

15. On the 14 [Month3] [Ms A] contacted [an oral surgeon at a different practice]. He then contacted [Dr C] and recommended referral of [Ms A] to the [university dental practice] for management of her post operative pain and continued altered tongue sensation.

16. [Dr B] did then complete a referral to [an oral and maxillofacial surgeon] at [the university dental practice] on 15 [Month3] and completed an ACC2152 Treatment Injury Claim. It appears there was a delay until late [Month3] with this being accepted at ACC as one of the forms lacked [Ms A's] signature.

17. [Dr C] indicates that the fee paid by [Ms A] to [the dental practice] was refunded. I note this occurred in [Month5].

18. Neither [Dr B] nor [Dr C] have provided further follow up to [Ms A] after the 15 [Month3] when they had referred her care to the [university dental practice].

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

1. I am of the opinion that [Ms A's] post operative care by [Dr B] was of low quality given the level of post operative pain and discomfort she was experiencing.

2. I am of the opinion that an initial postoperative visit 9 days following her initial surgery (2 [Month2]) was within the normal standard of care following wisdom tooth surgery.

3. I am concerned that her second post operative visit 1 week later (9 [Month2]) needed to be prompted by [Ms A] and was not made by the practice following the issues she was experiencing on 2 [Month2].

4. I am of the opinion that [Dr B's] assessment of [Ms A's] situation on 9 [Month2] was of mixed quality — it can be very difficult to assess the issues that are causing pain and altered function following a difficult post operative surgical event. Therefore his placing of a surgical dressing and prescribing of antibiotics was reasonable. However, there did not appear to have been sufficient ongoing post operative care, with no further appointment booked.

5. Given that there was an alteration of sensation in the lingual nerve, ongoing post operative assessment should have continued or there should have been a referral to specialist oral and maxillofacial surgery care.

6. Referral to specialist care did not occur until 15 [Month3] when prompted by [Ms A's] discussion with [the oral surgeon].

7. I am of the opinion [Dr C's] post operative follow up on 25 and 26 [Month1] was reasonable as the practice owner, but not the operating dentist, and his actions at that time appropriate.

8. I also note [Dr C] met with [Ms A] promptly on 1 [Month3] following her complaint on 30 [Month2]. However, it is unclear what his follow up plan was for her, and he did not refer her to specialist care.

9. The standard of care is established by the Dental Council Standards Framework and the Ethical Principle — Provide Good Care and Professional Standard 19 — You must take a holistic approach to care appropriate to the individual.

10. The removal of wisdom teeth is a long standing surgical procedure in the practice of dentistry. The standard of care for the procedure and associated complications is therefore also established by contemporary textbook descriptions of surgical interventions in dentistry such as Chiapasco M. Manual of Oral Surgery 3rd edition 2013. Edra S.p.A

Was there a departure from the standard of care or accepted practice?

- *No departure;*
- *Mild departure;*
- *Moderate departure; or Severe departure.*

1. I am of the opinion that [Dr B's] follow up care for [Ms A] was a mild departure from the accepted standard of care.

2. I am of the opinion that [Dr C's] follow up care was no departure from the accepted standard of care.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

1. I have not discussed this particular complaint with any peers but as a former clinical director for several DHB oral health departments and Chief Medical and Dental Officer of Hawke's Bay DHB I am very familiar with responding to patient concerns and complaints.

2. A minimum acceptable standard of care when post operative concerns have not reached a mutually acceptable resolution, especially early in the clinical course when issues are still expected to change and develop, is to continue to provide post operative care. Alternatively post operative care may be referred or transferred to an appropriate alternative practitioner or health care provider, but the operating practitioner is expected to ensure this has occurred.

Please outline any factors that may limit your assessment of the events.

1. I am limited to the information that has been provided in the patient's complaint, in the dental records of the [school of dentistry] and [the dental practice], the summary of events from [the practice], [Dr B] and [Dr C].

Recommendations for improvement that may help to prevent a similar occurrence in future.

1. I note that [Dr C's] report to the HDC indicates that [Dr B] has retired from dental practice and that a review of the Dental Council register of dentists indicates that he is no longer registered. In respect of [Dr B] I therefore make these recommendations only in the event that he were to decide to return to practice.

2. I recommend that [Dr B] should review and re-familiarise himself with the complication of altered nerve sensation following removal of wisdom teeth and appropriate post operative care.

Question 4: Any other matters that you consider warrant comment or amount to a departure from accepted standards

Advisor's opinion:

1. I have no issues to comment on other than those raised in the questions asked by the HDC.

Question 5: The expected information that would be discussed with a patient undergoing surgical removal of tooth 48 under local anaesthetic, including potential risks, instructions for follow-up care and safety netting advice.

List any sources of information reviewed other than the documents provided by HDC:

1. Australian and New Zealand Association of Oral and Maxillofacial Surgeons brochure — Wisdom Teeth and what to do about them

2. Hawke's Bay Hospital information sheet — Information for patients after dental extractions

3. New Zealand Dental Council Standards Framework for Oral Health Practitioners

Advisor's opinion:

1. When discussing the planned removal of a lower wisdom tooth (such as tooth 48) the issues I would expect to be discussed would be

    i) The reasons for the recommended removal of the tooth. These would commonly include recurrent infection of the tissue surrounding the tooth, especially when the tooth only emerges partially into the mouth.

    ii) Dental decay either in the wisdom tooth or in an adjacent tooth, influenced by the wisdom tooth

2. The common side effects that I would routinely discuss with a patient would include

    i) The need to make a cut into the gum around the tooth when the tooth has only partially emerged into the mouth, as in [Ms A's] case.

    ii) An expectation of the need to drill bone away from around the tooth, and/or to drill the tooth to cut it into parts to make it smaller to remove, which will cause noise and a vibrating sensation and is unpleasant for some people.

    iii) The expectation for post operative pain that will require pain relief such as paracetamol, ibuprofen, codeine phosphate or other medications to be taken for approximately a week.

    iv) The expectation for swelling and limitation of opening for approximately a week.

    v) The need to eat a soft diet and to use hot salt water mouth washes to aid cleansing of the wound and aid healing of the gum.

3. The potential risks I would routinely discuss with the patient would include

    i) The risk that the wound may ooze or bleed following the surgery.

ii) The risk of change in sensation (partial numbness, tingling or complete numbness) to occur in the lingual nerve. This nerve supplies sensation to the tongue and the gums on the inside of the lower teeth. There is an associated nerve involved in taste sensation which can also be affected and cause partial loss of taste.

iii) The risk of change in sensation (partial numbness, tingling or complete numbness) to occur in the inferior dental (also called the inferior alveolar) nerve which supplies sensation to the lip, chin, gums on the lip side and teeth at the front of the lower jaw.

iv) I would explain why those issues can occur — the pathway of the lingual nerve in the gum on the tongue side of the lower wisdom tooth and the inferior dental nerve in the jaw bone commonly in close proximity to the roots of the lower wisdom tooth. The pathway of this nerve should be assessed when reviewing the preoperative OPG and other available radiographs and radiology imaging.

v) I would record that conversation had occurred in the dental notes.

4. The post operative care I would routinely discuss with the patient would include

i) The need for rest, a soft diet that avoids hot food and drinks while the jaw remains numb from the local anaesthetic.

ii) To expect a small amount of blood stained saliva, but to apply pressure to the socket by biting on a gauze swab (which we provide routinely on discharge) and to sit up if a greater level of bleeding starts again.

iii) How to manage bleeding if it occurs, both self-management by the patient and how to make contact with a dentist if it occurs after normal practice hours

iv) To call for support if that bleeding persists.

v) To avoid smoking.

vi) To start hot salt water mouthwashes the day following the surgery.

vii) To expect swelling and bruising that can last around a week.

viii) To expect and some jaw stiffness and limited opening.

ix) What to expect with any stitches that have been placed, these are usually dissolving, but sometimes require removal.

x) To provide a post operative prescription with at least pain relief medication.

xi) To provide the phone numbers to call if the patient experiences problems following the surgery.

5. I would frequently provide the patient with written information at the appointment to discuss removal of wisdom teeth to support the conversation at the consultation visit, and routinely provide written postoperative information and additional gauze when discharging the patient from the treatment appointment.

6. The plan for post operative follow up should be clear. Follow up would usually be provided by the operating dentist, but could also reasonably be with another dentist when arrangements are clear, or in some cases for contact with a general practitioner if access to the dentist is difficult (eg patients living rurally and when the procedure has proceeded routinely).

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

1. The accepted standard of care is established by the Dental Council Standards Framework.

2. The Ethical Principle — Communicate Effectively and Professional Standard 15 — You must give patients the information they need or request, in a way they can understand, so they can make informed decisions.

3. The Ethical Principle — Provide Good Care and Professional Standard 22 — You must protect and promote the health of patients and the public.

Question 6: What is the usual process and timeframe for communicating x-ray results to a patient?

List any sources of information reviewed other than the documents provided by HDC:

1. New Zealand Dental Council Standards Framework for Oral Health Practitioners

Advisor's opinion:

1. In my opinion a range of processes and timeframes for communicating radiograph results would apply in the context of dental practice.

2. A common process is to communicate the findings of a radiograph with a patient either at the visit it is taken and planned treatment is discussed, in the period between an initial consultation and planned care commencing, or at a second visit if the planned care requires further discussion and consideration.

3. If it is in the period between an initial visit and planned care commencing, the discussion may be by phone or in a tele health consultation.

4. Alternatively the findings from the radiograph and the planned care would be discussed at the first visit when treatment also commences, as part of an informed

consent discussion. This discussion would occur prior to care commencing, but at the same appointment.

5. The latter scenario can arise as it did in this case, when the radiograph has been taken elsewhere and is not available to the dentist to discuss with the patient until they are seen for a first appointment.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

1. The accepted standard of care is established by the Dental Council Standards Framework.

2. In particular the Ethical Principle — Communicate Effectively and the Professional Standard 15 — You must give patients the information they need or request, in a way they can understand, so they can make informed decisions.

Signature:
Name: Dr Robin Whyman
Date of Advice: 3 June 2024’