Dentist, Dr D

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC01103)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Miss A received dental treatment from dentist Dr D from 2004 to 2010.

2. In 2004, when Miss A was six years old, Dr D recommended that she commence "orthopaedic" dental treatment.[1] This was aimed at encouraging the development of her lower jaw out of crossbite[2] and into a more ideal occlusion.[3] It was hoped that Miss A would thereby avoid the need for orthodontic treatment at a later date. Orthopaedic treatment was provided to Miss A by Dr D and his staff over the course of more than 40 appointments.

3. Dr D also provided Miss A with general dental treatment. In July 2007, Dr D placed a filling in one of Miss A's adult teeth, tooth 36, owing to the presence of caries.[4] In June 2008, Dr D placed a further filling in tooth 36. An X-ray taken by Dr D in January 2010 showed a radiolucent area beneath the filling, indicating probable caries. This was not treated by Dr D. In June 2010, another dentist diagnosed an acute abscess in tooth 36 and, in September 2010, the tooth was extracted.

Findings

4. Dr D failed to provide Miss A's legal guardians or their representative with sufficient information regarding the proposed orthopaedic treatment in order to obtain informed consent, and so breached Rights 6(1)[5] and 7(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code).

5. With respect to the orthopaedic treatment, Dr D did not obtain sufficient diagnostic information to assess Miss A's condition adequately and to guide her treatment plan. This was a breach of Right 4(1) of the Code.[7]

6. Dr D failed to monitor tooth 36 or take intra-oral radiographs (X-rays) following the detection of the initial caries. In addition, he failed to read the radiograph taken in January 2010 thoroughly and accurately, did not identify the pathology, and did not advise on treatment options. Accordingly, Dr D failed to provide services with reasonable care and skill, and so breached Right 4(1) of the Code.

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[1] Dr D describes "orthopaedics" with respect to dentistry as a discipline concerned with aligning and balancing the supporting structures of the teeth and jaws.
[2] Crossbite is an irregularity in the position of a tooth or teeth. It occurs when the tooth (or teeth) in one jaw is either closer to the cheek or to the tongue than the corresponding tooth or teeth in the other jaw.
[3] Occlusion refers to how the teeth come together.
[4] Tooth 36 is the first permanent molar on the lower left side, according to the FDI World Dental Federation dental numbering system.
[5] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — (a) an explanation of his or her condition; and (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and (c) advice of the estimated time within which the services will be provided …"
[6] Right 7(1) states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provisions of this Code provide otherwise."
[7] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

7. Dr D failed to maintain records to the expected standard, and so breached Right 4(2) of the Code.[8]

Complaint and investigation

8. The Commissioner received a complaint from Mrs B[9] about the services provided by a dentist, Dr D, to Miss A.[10] The following issues were identified for investigation:

   - *The standard of care provided to Miss A by dentist Dr D between July 2004 and March 2010, including the adequacy of the clinical documentation.*
   - *The adequacy of the information provided to Miss A's guardians and/or their authorised representative by dentist Dr D.*
   - *The adequacy of the steps taken by dentist Dr D to obtain informed consent for Miss A's treatment.*

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

10. The parties directly involved in the investigation were:

Miss A	Consumer
Mrs B	Complainant/consumer's grandmother
Mr A	Consumer's father
Mrs A	Consumer's mother
Ms C	Consumer Affairs Officer, NZ Dental Association
Dr D	Provider, dentist
Dr E	Provider, specialist paediatric dentist
Dr F	Provider, dentist
Also mentioned in this report	
Ms G	Dental hygienist
Ms H	Dental hygienist
Mr I	Dental hygienist

11. Information was also reviewed from ACC and an orthodontist.

12. Independent expert advice was obtained from two dentists, Dr Andrea Cayford (attached as **Appendix A**) and Dr Tim Little (attached as **Appendix B**).

[8] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[9] Mrs B's complaint was written on her behalf by, and sent to HDC by, the Consumer Affairs Officer of a branch of the New Zealand Dental Association.
[10] Mrs B is Miss A's grandmother, and she made the complaint with the support of Miss A's parents.

Information gathered during investigation

Background

Introduction

13. Miss A first went to a dental clinic on 21 July 2004, when she was not quite six years old. Miss A was taken to the dental clinic by her grandmother, Mrs B.[11]

14. Mrs B advised HDC that she took Miss A for a general check-up, and that the family wanted her to see a dentist rather than use the school dental service. Mrs B said that Dr D was recommended to her as a dentist, by one of her clients. Dr D recalls that Mrs B brought Miss A to see him because the family had heard that he was able to provide early treatment to children with crowded teeth.

15. Between 21 July 2004 and March 2010, Miss A attended the dental clinic more than 40 times, where she was seen by Dr D, and/or by a dental hygienist. There were three hygienists working at the dental clinic throughout this period: Ms G and Ms H (dental hygienists and registered dental auxiliaries), and Mr I (a graduate dentist from overseas practising as a dental hygienist pending registration as a dentist in New Zealand).[12]

16. Dr D advised:

> "[Miss A was seen] … 42 times comprising of 7 times for examination by myself and prophylaxis by one of the hygienists, 4 times for preventative and restorative care, 2 times for the taking of impressions, 1 time for a consultation and treatment for acute necrotizing ulcerative gingivitis from poor oral hygiene and 28 times for orthopaedic assessment and follow-up."

17. Mrs B complained to HDC about the care and treatment Dr D provided to Miss A over that time. In particular, Mrs B complained about Dr D's treatment of tooth 36, and his "orthodontic" care. She has also complained that she thought Dr D was an orthodontist because of the nature of the work he was undertaking, and stated that she would not have proceeded with Miss A's treatment with Dr D if she had known that Dr D was not an orthodontist. Dr D advised that he provided orthopaedic care, not orthodontic care (see paragraphs 20–24).

18. Dr D advised that he found Miss A to be a "challenging child to work with" because she "regularly attended the clinic under a cloud of poor oral hygiene and a low tolerance to dental procedures", and because she had a limited tolerance for intraoral radiographs, which limited his diagnostic capabilities. He also said that "she did not adequately, much less consistently, comply with the procedural requirements of her interceptive orthopaedic treatment". Mrs B disagrees with Dr D's statement that Miss

[11] Mrs B was acting on behalf of Miss A's legal guardians (ie, her parents) and with their consent with regard to Miss A's dental care. Mrs B recalls that she took Miss A to most, if not all of her appointments at the dental clinic. Miss A's mother, Mrs A, stated that she may have accompanied her mother and her daughter to the dental clinic once or twice, but she does not recall having any direct contact with Dr D, or receiving any information from him regarding Miss A's treatment.

[12] Records show that 23 of Miss A's appointments were with Dr D. Dr D advised HDC that he also saw Miss A during some of the appointments that appear in the records as hygienist appointments.

A's oral hygiene was poor. There are no references in the clinical notes to Miss A not tolerating bitewing radiographs.

19. A full copy of Miss A's clinical notes is attached as **Appendix C**.

"Orthodontic"/orthopaedic care

Introduction

20. Mrs B stated that she was always under the impression that the work being carried out was orthodontic, and she would have expected this type of treatment to be provided by a registered or qualified orthodontist.

21. According to the New Zealand Association of Orthodontists (NZAO), orthodontics is a specialist area of dentistry concerned with improving the appearance, function, and stability of teeth and jaws.[13] The NZAO further states that most dentists can provide minor orthodontic treatment, but if a dentist proposes to undertake comprehensive orthodontic work, the patient should confirm in writing that he or she understands that the work is outside the dentist's skill, and that the patient is happy for the dentist to provide this treatment.

22. Miss A's first appointment at the dental clinic was on 21 July 2004. Records show that at this time, a panoramic radiograph was taken and study models were made. The panoramic X-ray is of a poor quality. Miss A's orthodontic/ orthopaedic care commenced in August 2004, at which time Miss A was six years old. According to Dr D, treatment commenced because Mrs B requested it "for an obviously developing and significant malocclusion".[14] Dr D's recollection is that Miss A presented with a "class 2 division 1 skeletal dental malocclusion in the transitional dentition featuring a significantly underdeveloped mandible".[15] He also recalled that Mrs B's chief complaint was crowding in Miss A's lower front teeth. As noted above, Mrs B stated that she took Miss A to Dr D for a general dental check-up. Mrs B stated that it was Dr D who recommended further treatment to correct Miss A's crossbite.

23. While Miss A's clinical notes refer to her treatment as "orthodontic" treatment, Dr D has referred to it as both "orthopaedic" and "orthodontic" treatment. Dr D stated:

> "From the outset her treatment was orthopedically directed at developing the lower jaw out of crossbite and at a later date following the successful completion of that translating the lower jaw forward into a more ideal occlusion … This treatment … was interceptive in nature and by design directed towards avoiding or mitigating orthodontic treatment."

24. Dr D further stated:

> "At no time has any orthodontic treatment been undertaken on [Miss A's] behalf. This treatment was initiated with the sole intent to mitigate the need to remove

[13] www.orthodontists.org.nz.
[14] Malocclusion is a problem in the way the upper and lower teeth fit together in biting or chewing.
[15] The mandible is the lower jawbone.

permanent teeth as the occlusion matured as well as the need and or duration and expense of orthodontic treatment."

Information and consent

25. Mrs B complained that she did not receive a written description of the problem requiring treatment, and that she did not give her informed consent to the treatment for Miss A.

26. There is no record of the information that was given to Mrs B or Miss A's guardians prior to the commencement of treatment, and there is no record of the consent given by Miss A's guardians to such treatment. There is also no record of a diagnosis or treatment plan.

27. Dr D advised that he "[does] not know where the consent form is" because Miss A's records were inadvertently given to Mrs B by his staff.[16] Dr D advised, however, that this treatment was discussed with Mrs B on multiple occasions. Dr D set out what he advised when Mrs B brought Miss A to see him:

> "I described to [Mrs B] by way of idealised plastic models what an ideal dentition should be and function as. I further described to her what [Miss A's] teeth looked like at the present and more importantly where they appeared to be growing by way of these models. I further informed her that there were several options regarding treatment. The first option was what has been accepted as traditional braces at around the age of 11–13 years for girls. Because of the nature of the way [Miss A] was growing it was most likely the traditional treatment would involve the extraction of some teeth … She was then told another treatment option is to start early by way of a removable appliance to begin to normalise the growth of the lower jaw forward in relation to the upper jaw. This is classical orthopaedic treatment because it is treating the growth of the jaw and other cranial structures and not moving teeth … She was also told that when this treatment is started early the chances of avoiding the braces is a reasonable expectation but not a certainty."

28. Dr D further advised that he provides an Information Booklet and an "Information and Informed Consent" document to all patients to whom he recommends interceptive orthopaedic and/or orthodontic treatment, as well as a "fee disclosure document", and a personal letter from him outlining his diagnosis, the treatment options, expected outcomes, referral requirements, and the expected length of treatment and the fee. Dr D stated that this had been his standard operating procedure since about 2005.[17] He also stated:

> "On occasion where a child has presented with a single tooth or semi isolated problem, or an existing habit that needs modification, I would issue a single appliance with the appropriate instructions and expectations following discussions

[16] In her response to my provisional opinion, Mrs B advised that she was never given the original records and that any records received were faxed.

[17] In his response to my provisional opinion, Dr D stated that the informed consent process introduced in April–May 2005 was not a new process, but rather a formalisation of what was already communicated. Dr D advised that this formalisation came about as a result of the New Zealand Dental Association's publication in March 2005 of a Code of Practice on Informed Consent.

with the parent(s). No documentation would be issued in that instance. [Miss A] may have begun her crossbite correction in that way."

29. Dr D said that he could not confirm whether Mrs B was provided with a copy of the Information Booklet, because at that time he was not keeping duplicate records. He also noted that the Information Booklet changes periodically, as information deemed beneficial to parents and patients becomes available.

30. Mrs B said that she did not receive an Information Booklet or an "Information and Informed Consent" document, she does not recall signing any documents with Dr D, she was not given a quote, treatment options were not discussed with her, and she did not receive information about referral requirements or the expected length of treatment.

31. Dr D advised that there were two phases to Miss A's care: the first stage from August 2004 to October 2006, followed by the second stage.

First stage of treatment

32. Dr D advised that the first stage of Miss A's orthopaedic treatment "involved upper and lower arch development" and, for that purpose, she was provided with an "appliance" to wear.

33. Miss A attended the dental clinic 12 times during the first stage of her orthopaedic treatment. Dr D stated:

> "After some earlier but often common comfort issues [Miss A] settled into her personalised routine of wear of the orthopaedic appliances and her treatment proceeded slowly. I must note here that from the outset [Miss A] demonstrated a less than satisfactory attitude towards the care of her appliances and her own oral hygiene. The slow nature of her treatment occurred as a result of the fact that [Miss A] did not wear her appliances as directed."

34. In response to my provisional report, Mrs B said that to some extent she agrees with Dr D's comment. Miss A was 6–8 years old at this time. Mrs B said that she approached Dr D for guidance on this matter, and that he gave alternative time frames for wearing the appliance, and these were complied with.

Second stage of treatment

35. Dr D stated that the second stage of Miss A's orthopaedic treatment began in October 2006, when she was issued with a block appliance. The clinical records for the consultation on 4 October 2006 state: "[I]nsert clark twin wear and care see 4 wk [$]2170 for prepayment."[18] Dr D stated:

> "I made it very clear to [Miss A] and her grandmother [Mrs B] that this was the 'business' portion of her treatment and that if they wanted to avoid and or mitigate any orthodontic treatment [Miss A] must succeed with this phase of the treatment

[18] A Clark Twin Block is a removable appliance that incorporates the use of upper and lower bite blocks to position the lower jawbone forward.

> as the compliance factor was far more significant in relation to the outcome than the first phase of her treatment."

36. Dr D advised that Miss A did not wear the appliance as directed. He stated: "After a few months it became apparent that [Miss A's] attitude and intentions were not reflected in the orthopaedic outcome." Dr D advised that he reconfirmed the importance of compliance with wearing the appliance with meeting the expected outcome, but that Mrs B told him that Miss A was "far too busy" with her activities after school and before bedtime to wear the appliance. Dr D and Mrs B agree that Mrs B asked if the original appliance used in the first stage of treatment could continue to be used instead. Mrs B said that this was because the new appliance did not stay in Miss A's mouth. Dr D stated: "I informed [Mrs B] that these appliances would not create the mandibular movement required." There is no record of such conversations in Miss A's clinical records.

37. The clinical records for an appointment on 26 February 2007 record: "[T]old to wear night time only see 3 [monthly]." Dr D advised that, after several months of no progress, he suggested to Miss A and Mrs B that Miss A just wear the appliances at night, but that that strategy also showed inconsistent results. The clinical records for an appointment on 27 June 2007 record that Miss A was advised to continue wearing the appliance at night only.

38. On 12 September 2007, Dr D gave Miss A a "trainer", which he subsequently referred to as a "myofunctional trainer" in his correspondence with HDC. Myofunctional trainers are designed to re-educate or re-train oral muscles. The clinical records for the consultation record: "[I]nsert blue trainer, wear & care see 4 [weeks]." In his response to HDC Dr D stated:

> "[Miss A] began to have compliance issues when she transitioned into the myofunctional trainer. She was given several modes of this appliance of varying textures and comfort in an attempt to improve her compliance during this holding stage of treatment."

39. At the next consultation on 17 October 2007, the clinical notes record: "[D]oing well but not staying in all night every night told to [wear] more during the day. See 4 [weeks]." Dr D advised:

> "In effort to re-establish some order, discipline and results I recommended that she try wearing a myofunctional trainer at night time only … again she did not comply with my recommendations."

40. Mrs B stated that Miss A did comply, but the appliance did not always stay in throughout the night.

41. Miss A consulted Dr D again on 14 November 2007, and the clinical record for that consultation records: "[S]he found old acrylic [appliances] and started wearing !!!! Told her to stop [and] continue wearing trainer. See 4 [weeks]." Dr D advised:

> "… I was informed by [Mrs B] that after wearing the trainer for 3 months [Miss A] had found her old first phase appliances and had started wearing them again in contradiction to what I had previously told her and [Mrs B] … I instructed [Miss A] to stop wearing these appliances and asked that she return to wearing the trainer as directed."

42. The clinical record for the next consultation on 12 December 2007 records: "[W]earing well but still comes out during bouts of hay fever … see [January] to go on to pink [appliance]." The next appointment was on 6 February 2008, and the notes record: "[G]raduate to pink see 8 [weeks]."

43. Dr D advised HDC: "After continued poor compliance … [I] reluctantly issued [Miss A] with a single upper arch expansion appliance … but clinically it was apparent that [Miss A] was not wearing the appliance as directed."

44. Miss A consulted Dr D on 28 May 2008, and the clinical notes for that consultation record:

> "[N]ot staying in at night at all, not wearing [during] day time. Reinforced need to wear day time, finding time is hard for them but [advised] even 10–20 mins at a time is a help, doing homework, making bed etc. [Recommend] taping lips at night also, see 4 [weeks]."

45. In her response to my provisional opinion, Mrs B expressed her view that Dr D's recommendations, especially taping the mouth, seemed unreasonable.

46. Miss A continued to consult Dr D throughout 2008 and 2009. The clinical records for an appointment on 29 June 2009 record:

> "Day time wear non-exsistant [sic]. Falls out at night. [Mrs B] kept saying that she was doing well with the plates — explained that they will not work anymore — need to break the mouth breathing habit. Will review in 4 [months], if no improvement may have to hold out for braces."

47. Dr D saw Miss A on 15 February 2010 for what he described as "orthodontic treatment", and again on 15 March 2010. The consultation on 15 March 2010 was Miss A's last consultation with Dr D. Dental hygienist Ms G recorded the notes for this consultation:

> "[Dr D advised] needs to have 53 and 63 [extracted] ASAP to try & avoid braces & impaction of permanent canines. [Miss A] not happy with this. Discussed options of referral or having it done here. [Mrs B] decided it should be done here. [Recommend lorazepam] to calm her nerves."

48. Miss A subsequently began orthodontic treatment under the care of a specialist orthodontist. The orthodontist advised that Miss A had fixed appliances (braces) placed in February 2012.

Orthodontic or orthopaedic care provider

49. As noted above, Mrs B complained that she thought Dr D was an orthodontist because of the nature of the work he was undertaking. Mrs B provided HDC with a copy of an appointment card for Miss A on 17 November 2008, which recorded that the appointment was for "orthodontic check-up".

50. Dr D advised HDC that he has "never publicly, privately or professionally, over the course of 35 years, in any way inferred, promoted, represented or advertised [himself] as [a] registered specialist orthodontist". He further stated: "I do personally inform each and every new patient I consult with that I am indeed not a registered specialist orthodontist although I have practiced orthodontics for over 30 years." Furthermore, as noted above, Dr D advised that he provides all parents and/or patients with written information, including an Information Booklet that states, under the heading "About [Dr D] and his team": "He is not a registered specialist orthodontist."

51. Dr D provided HDC with a copy of the Information Booklet. The Information Booklet includes information about Dr D and his staff, information about "orthodontics/orthopedics", information about growth orthodontics, orthodontics and posture, how braces work, "How kids grow — an orthodontic perspective", "Instructions for the proper care of orthodontic appliances", an Informed Consent agreement, and a Retention Agreement and Orthodontic Treatment agreement. The Informed Consent agreement and the Retention Agreement both refer to "orthodontic" care.

Additional comments

52. Dr D advised: "It is my considered opinion that [Miss A] and [Mrs B] have failed the treatment plan and not the other way around." Dr D also advised HDC:

> "My communications with [Mrs B] and or [Miss A's] mother have been transparent and appropriate from the beginning. She was present in the treatment room at all times. Every procedure, progress report, and encouragement for [Miss A's] progress was shared with [Mrs B] … Every question that was asked was answered. The objective of the treatment and the progress [Miss A] was making was shared and communicated with [Mrs B] openly and transparently."

53. Ms H advised HDC that whenever she had Miss A booked into her room, Dr D always discussed Miss A's progress, or lack of progress, with Mrs B or Mrs A, depending on who was present at the consultation with Miss A. Ms G also advised HDC that she recalled frequent discussions in regard to Miss A's compliance and progress during her treatment.

54. In response to my provisional report, Mrs B said that Dr D provided "a good line of communication in regards to his treatment however he did not cover alternative options". Mrs B explained further that Dr D was always available, and as she always attended Miss A's appointments, there was regular communication between them. Mrs B said that it was true that Dr D talked about Miss A's progress, and that he answered every question that she asked. However, Mrs B does not consider that Dr D provided her with sufficient information — verbally or in writing — about what the

treatment was likely to cost, how long it would take, what it would involve, or other treatment options.

Tooth 36

55. Between September 2006 and 11 January 2010, Dr D treated Miss A's tooth 36. In June 2010, when Miss A developed an abscess in tooth 36, it became apparent that she also had caries, which had been evident in an earlier X-ray.

Treatment of tooth 36 by Dr D

56. Dr D advised HDC that, in September 2006, Miss A's tooth 36 was fissure sealed,[19] owing to the presence of deep fissures and "less than ideal oral hygiene". The clinical records for that consultation, as they pertain to the treatment provided to tooth 36, state: "FISS 36 O.[20] fissure sealant 36." The notes also record fissure sealants to teeth 46, 16 and 26, and "… quick clean also done, plus demo disclosing tab/where to pay more attn/floss". In July 2007, Dr D placed a medium sized one surface buccal composite[21] (a class 5 composite) restoration on tooth 36, owing to caries. The clinical notes for that consultation confirm that composite fillings were placed on teeth 36, 46, 16 and 26.

57. In June 2008, Dr D placed a class 2 composite in the distal part of tooth 36. The clinical notes for that consultation state: "C 36 DO,[22] composite filling 36."

58. Dr D advised HDC that the original caries in tooth 36 was small to moderate, not deep, and "visible from the buccal (cheek) aspect of the tooth". He stated:

> "The caries was removed from distal as well as to a slight degree the buccal surface. … Good visibility was achieved from the occlusal and buccal aspects and all caries appeared to have been removed … I accept that it is possible some caries may have remained but it certainly was not observed or intended and I believe unlikely."

59. Dr D advised HDC that "the notes do not show a lot of detail due to the fact the restoration was routine in nature". He also stated that the treatment options, namely treatment with or without an injection of anaesthetic or referral for treatment under sedation, were discussed with Mrs B and Miss A. Mrs B does not recall any discussion about treatment under sedation.

60. Dr D advised that, when he treats a child for examination and cleaning, the child is first seen by a hygienist, who takes radiographs, reviews homecare, scales and polishes the child's teeth, and makes notes for his follow-up. Dr D advised that he then examines the child in "a plaque free and clean oral environment with 2½ times magnification and a headlamp". Dr D also stated that he uses light magnification for all restorative procedures and often uses a Kavo Diagnodent instrument.[23]

[19] A fissure sealant is a non-invasive plastic sealant placed on top of a tooth to prevent decay.
[20] Occlusal.
[21] Also known as a buccal filling, a filling on the outside surface of the tooth.
[22] A distal occlusal (DO) filling is a filling that is placed between two teeth.
[23] An instrument used by dentists to help find caries.

61. Dr D stated that he reviewed Miss A in November 2008 and again in June 2009, and he noted no further significant findings regarding tooth 36. Dr D stated: "Had the restorations that were placed in this tooth been of a significant nature I would have made an entry on the record regarding the possibility of pulpal exposure[24] or other potentialities."

62. According to Dr D, Miss A was scheduled for two appointments on 14 December 2009: a routine monthly orthodontic appointment at 8.40am, and the six-monthly examination and cleaning at 2pm. Dr D stated that Mrs B cancelled the second of these appointments, as evidenced by the appointment record, which shows:

> "Mon 14/12/09 02:00pm [Ms G] Cancelled Appointment Not Required."

Dr D submitted that had this appointment been kept, "it is most likely that the caries would have been diagnosed during the examination and bite wing radiographs".

63. HDC asked Mrs B for her recollections in relation to this matter. She could not specifically recall what occurred on this date. She said that on occasion she rescheduled an appointment because of sickness, but that she would not have cancelled an appointment because she did not consider it necessary. She stated that she would have expected Dr D to advise on which appointments were and were not necessary, and to determine what kind of check-up was needed at any particular appointment. Mrs B was surprised that two appointments were apparently scheduled on the same day.

64. Dr D advised that on 11 January 2010, he recommended a panoramic radiograph to investigate "the delayed exfoliation of the upper deciduous cuspids and erupting permanent cuspids".[25] An X-ray was taken that day, but was noted to be of poor quality.

65. Dr D advised HDC that 11 January 2010 was the first day back after an extended Christmas break and annual leave. He stated that the developing and fixing radiographic solutions had not been emptied prior to the break and had sat in a hot clinic over the holiday period. Miss A's radiograph was the first film of the day as well as the first film of the New Year, and it was fixed in poor quality solutions — solutions that "should have been replenished and were not". However, Dr D advised that as the radiograph was adequate for "the main purpose for which it was taken" (ie, to show the slowly erupting cuspid teeth) he chose not to repeat it and to avoid exposing Miss A to further radiation.

Subsequent care and treatment — tooth 36

66. In June 2010, Miss A developed a toothache, and she was seen by dentist Dr F. Tooth 36 was diagnosed as having an abscess, and a filling on the tooth was leaking. Miss A

[24] Decay that is not treated will progress through the enamel and dentine into the pulp, which contains the nerves. When it reaches the pulp, it can cause intense pain. There is no relief until the pulp dies or is removed or the tooth is extracted.

[25] Exfoliation is the normal loss of primary teeth after the loss of their root structure. Cuspids are canines.

was treated with antibiotics and pain relief, and was referred to a specialist paediatric dentist, Dr E. Dr F noted that Miss A's other teeth were in "good general condition".

67. Dr F advised HDC that, in her opinion, the X-ray taken on 11 January 2010 "clearly showed that 36 had a radiolucent area under the leaking and deficient [distal occlusal] restoration".

68. Dr D said that the purpose of the X-ray was to identify and orient Miss A's delayed erupting canines, not to identify caries in the teeth. Dr D stated that Miss A did not complain of any symptoms with tooth 36 at his last appointment with her on 15 March 2010. He also stated that he is "comfortably confident" that no decay was left behind in tooth 36 during his treatments of Miss A in 2007 and 2008.

69. Dr E reviewed Miss A on 16 August 2010 and confirmed that Miss A had an abscessed tooth 36. Dr E subsequently noted that the restoration to tooth 36 was large. Dr E advised HDC that, at that time, Miss A's treatment options were either root canal treatment, or extraction. A decision was made to extract the tooth, and that procedure occurred on 8 September 2010, under general anaesthetic. Dr E also noted that the X-ray taken on 11 January 2010 "[demonstrated] a radiolucency beneath the existing restoration (which would indicate decay beneath the filling)".

Subsequent action

70. Dr D advised HDC that the dental clinic has taken the following action since this complaint:

(a) Reviewed the "Health and Disability Act".

(b) Reviewed the New Zealand Dental Association Codes of Practice concerning informed consent, complaints and criticism.

(c) Patients who are not able to tolerate bitewing radiographs are offered a radiographic examination via a digital panoramic cephalometric unit, which was purchased in June 2013. Accordingly, developing and fixing solutions are no longer required.

(d) Staff have been reminded that they need to document if a patient chooses not to have radiographs, and "ongoing patient documentation is protocol".

(e) Additional material has been inserted into the Orthodontic Information Booklet that aligns with the Informed Consent document recommended by the New Zealand Dental Association, indicating that the patient or parent has actually read and understands the material that they have been provided with. The booklet continues to evolve in accordance with Dr D's understanding of treatment protocols.

(f) Auditable protocols have been implemented to follow up patients who fail to attend appointments.

Responses to provisional report

71. Relevant information from the responses to my provisional report has been incorporated above. The following comments are also noted.

Mrs B

72. Mrs B stated that if Dr D was unhappy with Miss A's progress or her ability to wear an appliance, he should have recommended that treatment stop and restart when Miss A was older, or suggested an alternative method.

73. Mrs B stated that Miss A's first appliance was "excellent", but subsequent appliances either did not fit correctly or were "too bulky" to be worn at all times, especially at night. Mrs B said that Miss A had chronic hayfever, and that she advised Dr D of this. In addition, it was apparent from early on in Miss A's treatment that she was a "mouth breather". In these circumstances, Mrs B said that if Dr D had provided a treatment plan at the outset, and shown examples of the appliances to be worn in the future, it would have been apparent that these would not work.

74. Mrs B feels that the alternative treatment to braces continued for so many years "in an effort to retain [Miss A] as a (paying) patient rather than referring her [for] more appropriate treatment".

75. In relation to tooth 36, Mrs B considers that the extraction of this and the resultant need for additional specialist treatment could have been prevented by regular thorough examinations and good quality radiographs. However, decay was evident even on the poor quality radiographs, and this should have been diagnosed and treated.

Dr D

76. Dr D stated that there was "a great deal of discussion" with Miss A and Mrs B, as well as with all other patients, and that this is corroborated by staff who were present. Dr D stated that if his memory serves him correctly, the practice's appointment cards at that time specifically stated: "We inform before we perform." Dr D submitted that that statement "in and of itself is an invitation to ask questions on a continuing basis", and that Mrs B did so.

77. Dr D stated: "I am at a loss to understand how a patient might not register the fact [that he is not a registered specialist orthodontist] when it is written in black and white 'He is not a registered specialist orthodontist'." As noted above, Dr D's Information Booklet states: "He is not a registered specialist orthodontist." However, Mrs B said that she did not receive an Information Booklet and Dr D has no record that Mrs B was provided with one.

78. In response to the concerns identified with regard to tooth 36, and in particular Dr Little's comment that it is somewhat surprising that the caries was not picked up during the examinations on 17 November 2008 or 29 June 2009, Dr D stated: "It is apparent that no one has conceived or acknowledged the thought that perhaps the caries was not present at the time of these examinations." Dr D stated that given what occurred subsequently, he considers the appointment that he believes Mrs B cancelled on 14 December 2009 becomes "highly significant". He stated:

> "[I]rrespective of the unfortunate event of the poorly developed panoramic film a few weeks later as well as my decision not to have the film retaken … a decision I have freely taken responsibility for and openly acknowledged my regret, I

> continue to hold [Mrs B] contributory to the outcome by way of failing that December appointment."

79. Dr D is concerned that there has been no acknowledgement that Miss A may have been a difficult patient, and that to a large degree her orthopaedic treatment failed because she did not comply with the recommendations given to her. Dr D explained further:

> "I believe [Miss A] and perhaps more significantly her care givers failed the treatment plan because of her lack of compliance to recommendations. A fact that I wasn't made aware of by [Mrs B] for several years after the initiation of treatment …"

80. Dr D stated that Mrs B was not told that the recommended treatment would avoid braces. He stated:

> "The desired outcome is to correct aberrant growth patterns and thereby typically avoid the need to remove teeth and most early treatment cases avoid braces. I believe [Mrs B] has taken liberty with what she thought/expected as opposed to what she was repeatedly told."

81. Dr D stated that, given the time between treatment starting and her complaint, Mrs B can be forgiven for not remembering receiving any written materials. He noted that, as he has written previously, he cannot remember himself.

82. Dr D is surprised that Mrs B's concern that he is not an orthodontist did not surface sooner than it did. He noted that Mrs B witnessed Miss A having restorative dental procedures, which orthodontists do not undertake, on multiple occasions. Mrs B was also in the presence of multiple adult patients having restorative dental treatment. Dr D stated:

> "I can understand that the nomenclature of our statements and invoices as well as appointment cards could have contributed to this misunderstanding, but why wasn't it brought up prior to seeing [the orthodontist]. Subsequent to the initiation of this complaint we have canvassed the majority of our patients in active treatment regarding their understanding of my professional status and [credentials]. To date [Mrs B] is the only parent/caregiver who 'thought' I was an orthodontist and has made her misconception part of her complaint to the HDC."

83. Dr D submitted that he has been "open, honest and transparent from the beginning", and that he has been accountable by taking responsibility for some aspects of the complaint that he could easily have blamed on his staff or other employed professionals. He stated:

> "Irrespective of the fact that protocols were in place, they didn't change the developing and fixing solutions. They exposed the film, developed it in the poor quality solutions, fixed it and presented it to me for viewing. They made a mistake. I forgave them. I chose not to expose [Miss A] to more radiation on the

day and I have regretted it ever since. I made the decision and I have accepted responsibility for this decision and the circumstances."

84. Dr D advised that his clinic has been randomly audited three times in the last six years, and all codes of practice successfully met the required standards. He noted that he takes continuing education seriously and regularly exceeds the continuing education requirements.

Opinion: Breach — Dr D

Orthopaedic/Orthodontic care

85. In August 2004, Dr D commenced treatment of Miss A "for an obviously developing and significant malocclusion". Mrs B complained about several aspects of Dr D's treatment of Miss A's malocclusion. In particular, she complained about the information she was given prior to the treatment commencing, the informed consent process, and the nature of the treatment (ie, Mrs B was under the impression that the treatment was orthodontic and that Dr D was an orthodontist).

Information and consent

86. Under the Code, consumers have the right to be fully informed and to make an informed choice and give informed consent. In the case of children, "consumer" includes the child's legal guardians.

87. Mrs B is Miss A's grandmother. She is not a legal guardian of Miss A. However, Mrs B was acting on behalf of Miss A's legal guardians (ie, her parents) and with their consent with regard to Miss A's dental care from Dr D.

88. Mrs B stated that she thought that Dr D was an orthodontist and that Miss A was receiving orthodontic treatment, because of the nature of the work being undertaken. Dr D, on the other hand, advised that he has never held himself out as "[a] registered specialist orthodontist", and that he personally informs "each and every new patient" he consults with that he is not a registered specialist orthodontist, although he stated that he has "practised orthodontics for over 30 years". Dr D also advised HDC: "At no time has any orthodontic treatment been undertaken on [Miss A's] behalf."

89. However, Mrs B's confusion is understandable. Miss A's clinical records refer to orthodontic treatment. Furthermore, an appointment card for Miss A on 17 November 2008 records that the appointment was for "orthodontic check-up". Regardless of the initial discussions about these matters, Mrs B was subsequently provided with ambiguous and confusing information about the nature of Miss A's treatment.

90. Dr D was providing treatment to alter Miss A's bite and the positioning of her teeth. Most lay people would consider that to be orthodontic treatment. This impression is compounded by the inconsistent language used by Dr D himself.

91. As outlined above, in his response to my provisional opinion, Dr D expressed his surprise that Mrs B's concern that he is not an orthodontist did not surface sooner than it did. However, he acknowledges that the clinic's statements, invoices, and appointment cards could have contributed to this misunderstanding.

92. Dr D provided HDC with a copy of an information booklet that he says is similar to the one he gives to all his patients. As noted below, I do not accept that such a booklet was provided to Mrs B. In any event, I note that although it is said in the booklet that Dr D is not a registered specialist orthodontist, the booklet repeatedly refers to orthodontics and orthodontic appliances and care. In addition, the Informed Consent agreement and the Retention Agreement in that booklet both refer to "orthodontic" care. Such information has the potential to be misleading to the general public as to the nature of the treatment being offered.

93. In response to the provisional opinion, Mrs B stated that Dr D provided a good line of communication in regard to his treatment, but he did not cover alternative treatment options. Mrs B explained further that Dr D was always available, and as she always attended Miss A's appointments, there was regular communication between them. Mrs B said that it was true that Dr D talked about Miss A's progress, and that he answered every question that she asked. However, Mrs B complained that she did not receive a written description of the problem requiring treatment, and did not receive the information required to give informed consent to Miss A's treatment — either in writing or verbally. This included information about Miss A's diagnosis, the treatment plan, the likely costs and duration of the treatment, and other treatment options. Dr D stated that he does not know where the consent form is because Miss A's notes were inadvertently given to Mrs B by his staff, and no copy was taken. However, Mrs B denies receiving any original records. Moreover, Dr D also stated that on occasion where a child presented with a single tooth or semi-isolated problem, or an existing habit needing modification, he would issue a single appliance with appropriate instructions, and that in those circumstances no documentation would be issued. Dr D noted that Miss A may have commenced her treatment with him in that way. Dr D submitted, however, that he discussed Miss A's treatment with Mrs B on multiple occasions.

94. I have noted the comments Dr D made on this matter in his response to my provisional opinion. I remain of the view that Mrs B's misconception that Miss A was receiving orthodontic, not orthopaedic care, suggests that she was not adequately informed about the nature of the treatment. There is no information in the clinical records referring to discussions about Dr D's diagnosis, treatment options, the nature of the proposed orthopaedic treatment, the risks and benefits of treatment, the cost and the expected duration of treatment, or the decisions made. Neither do the notes record that a booklet or any other written information was provided to Mrs B or Miss A's legal guardians. Dr D states that since about 2005, it has been his standard operating practice to provide patients with a letter outlining his diagnosis, the treatment options, expected outcomes, referral requirements, and the expected length of treatment and fees. Miss A's first consultation with Dr D was in July 2004.

95. In these circumstances, I find that it is more likely that Mrs B was not sufficiently informed about the orthopaedic treatment Dr D proposed for Miss A and, therefore, Mrs B was unable to provide informed consent to the provision of such treatment. Accordingly, in my view, Dr D breached Rights 6(1) and 7(1) of the Code.

Orthopaedic treatment

96. Miss A's orthopaedic treatment commenced in August 2004, at which time she was six years old. There were two phases to Miss A's treatment: the first phase was from August 2004 to October 2006, followed by the second stage.

97. The Dental Council of New Zealand publication "Working as an Oral Health Practitioner in New Zealand: Handbook for the New Zealand Conditions of Practice" states that dentists are required to provide a high standard of care, which includes an adequate assessment of the patient's condition and the provision of appropriate treatment.[26]

98. As noted by my expert advisor, Dr Little, it appears that the only assessments undertaken prior to the commencement of Miss A's treatment in 2004 were the initial study models and a panoramic X-ray. Dr Little advised that, given the poor quality of the 2004 X-ray, it was of limited diagnostic use. In addition, Dr Little informed me: "The models are trimmed in such a way that it is difficult to assess the original 'bite'." As such, Dr D's diagnostic evidence for his treatment is very limited. I accept Dr Little's advice that "[p]hotographs showing facial profiles, lateral profiles from both left and right of the occlusion of the teeth, also full front photos of the teeth in occlusion would have been very useful", as well as a cephalometric analysis and additional models.[27]

99. Given the lack of records, it is difficult to ascertain whether Dr D's treatment of Miss A was appropriate, or whether it was undertaken with reasonable care and skill. However, at the very least, Dr D did not obtain sufficient diagnostic information to assess Miss A's condition adequately and to guide his treatment planning for her. Accordingly, I find that Dr D did not provide services with reasonable care and skill, and breached Right 4(1) of the Code.

Tooth 36

100. In September 2006, Miss A's tooth 36 was fissure sealed, owing to the presence of deep fissures. In June 2007, Dr D provided further treatment to tooth 36, placing a medium-sized one surface buccal composite restoration on the tooth, owing to caries. In June 2008, Dr D placed a class 2 composite in the distal part of tooth 36.

101. Dr D advised HDC that the original caries in tooth 36 was small to moderate, not deep, and was "visible from the buccal (cheek) aspect of the tooth". He advised that in removing the caries he had good visibility, and all caries appeared to have been removed. Dr D stated that the treatment was "routine in nature".

[26] See section 1, page 18. Available on the Dental Council of New Zealand website at: http://www.dentalcouncil.org.nz/Documents/DCNZ_ConditionsOfPracticeHandbook.pdf.
[27] Cephalometric analysis is the study of the dental and skeletal relationships in the head.

102. Dr D stated that he reviewed Miss A again in November 2008 and June 2009, and noted no further significant findings regarding tooth 36. Dr D took a panoramic radiograph in January 2010 for another purpose. Although the radiograph was of poor quality, he decided not to repeat it as he considered it adequate for the current purpose. In June 2010, tooth 36 was diagnosed as having an abscess.

103. Dr F and Dr E reviewed the January 2010 radiograph and identified radiolucency beneath the restoration.

104. My expert advisors, Dr Tim Little and Dr Andrea Cayford, both advised that the panoramic radiograph taken on 11 January 2010 clearly showed cause for concern. Dr Little advised that while the panoramic radiograph is of poor quality, it shows very clearly extensive decay under the filling on tooth 36 and indicated that it was "very likely to involve the pulp". Dr Cayford advised that the quality of the panoramic radiograph was "good enough to determine that tooth 36 either has a very deep filling or more caries". A deep filling would be inconsistent with Dr D's advice that the filling he had placed in tooth 36 was small to moderate. I accept my experts' advice.

105. I do not accept that because the purpose of the radiograph was to identify and orient Miss A's erupting canines rather than to identify caries, Dr D was not responsible for identifying the caries in tooth 36 at that time. Dr D took a radiograph on 11 January 2010, and he had a responsibility to read that radiograph thoroughly and accurately, identify any pathology, and advise on treatment options. Dr D failed to do so. Accordingly, Dr D failed to provide services to Miss A with reasonable care and skill and breached Right 4(1) of the Code.

106. It is difficult, on the evidence, to establish whether the abscess to tooth 36 was the result of inadequate care and treatment by Dr D. Dr Little comments that the extent of decay in tooth 36 only one and a half years after it had been restored (June 2008) is surprising. However, as Dr Little also explains, it is difficult to pick the most likely cause of the caries in tooth 36. No X-rays were taken prior to the restoration to tooth 36, and therefore it is hard to know the extent of the decay at that stage, although Dr D's description of the caries as small to moderate is not consistent with Dr E's finding of a large restoration.

107. In his response to my provisional opinion, Dr D notes his concern that no one appears to have considered that perhaps the caries was not present at the time of the examinations on 17 November 2008 and 29 June 2009. Consequently, Dr D considers that the appointment he believes Mrs B cancelled on 14 December 2009 becomes "highly significant". He considers that had this appointment taken place, it is most likely that the caries would have been diagnosed during an examination and bite wing radiographs.

108. The basis on which Dr D indicates that he would have taken bite wing radiographs at that appointment, when he had not done so during previous examinations, is unclear.

109. Mrs B does not recall cancelling an appointment on 14 December 2009 and states that she would not have done this. She said that she would have expected Dr D to advise on which appointments were and were not necessary, and to determine what kind of

check-up was needed at any particular appointment. The appointment record states only "Appointment Not Required". Given the time that has elapsed since these events, I do not consider that I can establish whether there was an appointment scheduled and cancelled on 14 December 2009. In any event, I do not consider that speculation on what may or may not have been identified at appointment on 14 December 2009, had it proceeded, has any bearing on the standard of care Dr D provided prior to that date.

110. Although I am unable to determine whether Dr D treated tooth 36 adequately, I am concerned about Dr D's management of it prior to the panoramic radiograph being taken on 11 January 2010. Dr Little states that he would have expected an attempt to take intra-oral radiographs following the detection of the original caries in May 2008 and, at the very least, radiographs should have been taken at subsequent examinations. Examinations were undertaken in November 2008 and June 2009. Without radiographs, it is not possible to determine whether or not the caries was present at these times. For failing to monitor tooth 36 after the restoration in June 2008, I also find that Dr D breached Right 4(1) of the Code.

Record-keeping

111. The Dental Council of New Zealand and the New Zealand Dental Association's *Code of Practice: Patient Information and Records (2006)* states:

> "1.1 The patient's treatment record is legally regarded as 'health information' and is an integral part of the provision of dental care. A record of each encounter with a patient will improve diagnosis and treatment planning and will also assist with efficient, safe and complete delivery of care considering the often chronic nature of dental disease. The treatment record will also assist another clinician in assuming that patients care.
>
> …
>
> 2.12 The principles applying to records extend to computerized records. They should be of the same standard and identifiable to a specific clinician …"

112. It states further:

> "2.7 [The treatment] record **must** include:
>
> …
>
> (f) details of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon;
>
> (g) A concise description of any and all treatment or services provided;"

and that:

> "2.8 The record **should**, in the interests of best practice, also include:
>
> …
>
> (i) A description of any procedure, including any materials used, variation from any standard or usual technique, and any general comments on the procedure

undertaken. The detail of the description should reflect the complexity of the treatment or the seriousness of the potential outcomes;

(n) Estimates or quotes for fees involved; …"

113. I share my advisors' concerns about the adequacy of Dr D's documentation of his care and treatment of Miss A. Dr D did not document his examinations, findings, recommendations, or treatment plans.

114. As Dr Cayford states:

"The clinical notes don't give any information about the need for orthodontic work and inadequate information about some other treatment procedures done. There is no treatment plan, quote, informed consent or record of that discussion with a parent/caregiver.

…

The clinical notes don't indicate any details about the treatment on tooth 36 — whether local anaesthetic was used, if any lining was used, if all the decay was able to be removed, if there were any difficulties during the procedure …"

…

The clinical notes should include initial findings after the examination. After an orthodontic examination it should include the type of bite/occlusion, what the main problems and concerns are, treatment plan etc. They lack any information about this. In a letter from [Dr D] May 15 2012 he says he's not sure which teeth were in crossbite … It should all be written in the notes."

115. Dr Little notes that treatment was provided up until June 2009 without real comment. Although Dr Little states that the notes are generally "adequate", he also states that they are "obviously short of information as supplied by the 'remembered' information". Dr Little comments that there is insufficient information to determine the suitability of the treatment or the standard of that treatment, and that, in his view, there should be adequate information to determine this.

116. A full and accurate clinical record is vitally important for continuity of care. HDC has made numerous comments in previous reports stressing the importance of good record-keeping and the accuracy of the clinical record.[28]

117. In my view, Dr D failed to maintain records to the required standard, and breached Right 4(2) of the Code.

[28] For example: 10HDC00610, 09HDC01765, 08HDC10236, 06HDC12164, 04HDC17230.

Recommendations

118. Dr D has provided a written apology to Mrs B and Miss A.

119. I recommend that Dr D:

- obtain an independent review of his Information Booklet to ensure that it does not mislead consumers as to the nature of the treatment he provides, and clearly explains the difference between orthopaedic and orthodontic care, and provide evidence of that review to HDC by **28 May 2014**; and

- obtain an independent review of his record-keeping practices, and provide evidence of that review to HDC by **28 May 2014**.

Follow-up actions

120.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Dental Council of New Zealand. The Dental Council will be advised of Dr D's name and asked to consider whether an assessment of his competence is warranted.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Dental Association of New Zealand and the district health board, and they will be advised of Dr D's name.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent dental advice: Dr Andrea Cayford

The following expert advice was obtained from Dr Andrea Cayford:

"I have been asked to write a report to the Health and Disability Commission on case C11HDC01103.

I have read and agreed to follow the 'Guidelines for Independent Advisors'.

I am a General Dentist. I graduated from Otago University Dental School in 1983. In my first year I worked as a Dental House Surgeon in Christchurch Public Hospital. Since then I have been a general dentist. I have worked in several practices including London. For the last 20 years I have been part of a large group practice.

I have been asked to give advice on '... whether, from the information available, there are concerns about the care provided by [Dr D], which require formal investigation.'

The documents I have been given to read for this case are as follows:

[Deleted for brevity.]

Summary timeline of events

21 July 2004	[Miss A's] first appointment at [the dental clinic] Age 6
31 Aug 2004	First orthodontic appliance fitted
20 Sept 2006	Fissure sealants done
4 Oct 2006	Second orthodontic appliance fitted (Clark twin wear)
16 July 2007	First fillings done (on four teeth including tooth 36)
12 Sept 2007	'Blue trainer' fitted
6 Feb 2008	'Pink trainer' fitted
9 June 2008	Composite distal occlusal filling done tooth 36
27 July 2009	Three fillings done
19 Oct 2009	'Upper tranverse' orthodontic plate fitted
11 Jan 2010	Panex radiograph to determine position teeth 13 23
15 Mar 2010	[Dr D] recommends removal teeth 53 63 to allow for eruption teeth 13 23 into correct position
29 June 2010	[Miss A] presented with toothache tooth 36 to dentist [Dr F]
16 Aug 2010	[Miss A] saw [Dr E] specialist paediatric dentist
7 Sept 2010	[Miss A] had tooth 36 removed and other work (removal baby teeth 53 63, some fillings, fissure sealants) under a GA
Nov 2010	Under the care of [orthodontist] for orthodontic treatment

In the next section of this report I will divide the discussion into two sections; Treatment done on tooth 36 and the orthopaedic/orthodontic care.

Treatment done on tooth 36

Tooth 36 is the first permanent molar on the patient's lower left side. It generally erupts into position about the age of 5 or 6.

During the time [Miss A] had dental care with [Dr D] this tooth received the following treatment:

20/9/06 Fissure sealant
16/7/07 Buccal filling
9/6/08 Distal occlusal filling

A fissure sealant is a non-invasive plastic sealant placed on top of a tooth to prevent decay. A buccal filling is on the outside surface of the tooth. A distal occlusal (DO) filling is between this tooth and the one behind it. These treatment procedures are standard and acceptable. However, the quantity of fillings [Miss A] has had done indicate a slightly higher than average decay rate.

Usually a 'DO' filling would be diagnosed from a bite wing radiograph. I have no radiographs of this tooth prior to the filling. The bite wings and panex radiograph, I have viewed, both show a moderately large and deep filling which may indicate the decay was quite advanced prior to the filling being done.

The clinical notes do not give any detail about the filling:

— whether it was deep
— whether all the decay was removed
— what/if any lining was used
— was local anaesthetic used.

About 18 months after the filling was done on 36 [Dr D] had a panex radiograph taken to determine position of teeth 13 23. On this panex, tooth 36 shows a radiolucent area underneath the filling suggesting dental caries. This was the first time this tooth was x-rayed post treatment and therefore contained valuable information.

A medical/dental practitioner is taught to read all information possible on a radiograph. Usually an x-ray is taken for a specific piece of information, but it should be examined thoroughly for any other problems. Although the panex was taken for orthodontic reasons the entire mouth is involved when trying to straighten teeth and therefore all the teeth are important. It would be difficult not to observe the filling on tooth 36 as it is so much larger than any other fillings the patient has. It would also appear the panex may also have been viewed by '[Ms H's first name]' who may be a hygienist.

About two years after the filling was done [Miss A] had toothache with this tooth. The clinical notes from [Dr F] say the tooth was very 'ttp', meaning tender to percussion. This test together with radiographs indicated that tooth 36 had an acute abscess. The radiographs taken by [Dr F] 29/6/2010 confirm tooth 36 had a defective filling on it (probably dental caries under the filling) and a dental abscess

at the base of the tooth. In this situation the tooth can only be retained by doing a root filling. The other option is to remove the tooth.

In the letter from [Dr E] (5 Dec 2011) she describes [Miss A] as very phobic about dental treatment and the extent of her dental anxiety was 'severe'. This description is of a girl who just two years previously had a reasonably large filling placed. The clinical notes don't suggest any difficulties at the time of placement of the filling. However, the panex radiograph does show a large radiolucent area under the filling which could indicate decay had been left behind. It is not always necessary to remove all the decay depending on clinical findings and type of decay etc. Sometimes the ideal treatment cannot always be provided and decay may be left behind. If decay is intentionally left behind this needs to be documented, explained to the patient/caregiver and monitored.

It would be difficult to imagine from the notes that [Miss A] would have tolerated getting such a filling done without local anaesthetic. However, there are also a few remarks about how she doesn't tolerate needles. The other fillings she has had done may not have required anaesthetic as they were small. The DO filling on tooth 36 was however very large.

When the panex radiograph was taken, the defective filling should have been found and redone. Or the patient referred to for example a paediatric dentist for care possibly to have the filling redone with sedation.

Orthopaedic/Orthodontic Treatment

[Dr D] was also treating [Miss A] for orthodontic treatment. During the few years he treated [Miss A] he used about 4 different appliances with a variety of compliance by [Miss A].

The clinical notes do not describe the reason for this treatment and there is no diagnosis or treatment plan. There is also no suggestion of how long the treatment would take, what it would involve or cost. No informed consent was documented. There does not appear to be a photographic record.

A letter from [Dr D] describes the initial problem as a crossbite.[29] However this is not explained in the notes and there is no mention of which teeth were in crossbite.

[Miss A] was 6 when the orthopaedic/orthodontic treatment was started. It is common at this age to correct crossbites and also try to modify any habits eg thumb sucking. This 'basic' type of treatment can be carried out by general dentists or orthodontists. It may not exclude the need for full orthodontic work in the future.

[Dr D] describes the treatment he provided as orthopaedic treatment. I had not heard this term previously. I asked for advice from an orthodontist colleague who I had read the information I was given. The treatment concept was explained to me as follows: orthopaedic treatment aims to help develop jaws in order to avoid

[29] This was contained in a letter from Dr D to HDC.

extraction and possibly full orthodontic treatment in the future. However, there is no evidence based research to indicate you can make jaws grow faster/bigger. This type of dentistry is not advocated or taught by Otago University Dental School orthodontists.

A letter from [Dr D] April 25 2011 to [Ms C] says that in a period of around 6 years [Miss A] attended for orthopaedic assessment 28 times. This seems to be very time consuming and costly for a young child who attended the clinic 'under a cloud of poor oral hygiene and a low tolerance to dental procedures'. (Letter dated April 25 2011).

Most orthodontic treatment is carried out on children about the age of 13 (apart from correcting crossbite, thumb sucking as previously described). At this time most permanent teeth have erupted and the jaws are reaching full size. The children are also mature enough to understand the importance of oral hygiene diet etc.

Discussion and Concerns

[Miss A] was age 6 when she started her care with [Dr D]. The care provided included prevention, oral hygiene, restorative work and orthopaedic/orthodontic work. She had some dental phobias and her oral hygiene was not always adequate. Compliance was at times an issue.

The orthodontic work was complicated and involved a large number of visits over many years. [Miss A] was possibly a poor candidate for extended orthodontic work at this age with poor oral hygiene and low tolerance to dental procedures. It appears there was some confusion about whether [Dr D] was an orthodontist or general dentist according to [Miss A's] grandmother. There may also have been some confusion about whether he was the primary dental caregiver.

The orthopaedic treatment does not follow what is generally accepted as standard practice in New Zealand. Conventional orthodontic treatment around the age of 13 following evidenced based guidelines would seem more appropriate for [Miss A].

It would appear that [Miss A's] grandmother was not fully informed about the treatment given. She assumed that the orthopaedic treatment provided would mean [Miss A] would not have to wear braces in the future. The costs, length of treatment time and expected outcomes were not fully discussed or understood.

The clinical notes don't give any information about the need for orthodontic work and inadequate information about some other treatment procedures done. There is no treatment plan, quote, informed consent or record of that discussion with a parent/caregiver.

[Miss A] had a moderate decay rate and was given oral hygiene instruction. There is no indication she was given dietary advice. An inappropriate diet is often the cause of decay.

A letter from [Dr D] states that he hasn't examined [Miss A] since June 2009 but he had done fillings on her July 2009 and saw her for an orthodontic consultation Nov and Dec 2009. He also had taken a panex radiograph in January 2010.

The clinical notes don't indicate any details about the treatment on tooth 36 — whether local anaesthetic was used, if any lining was used, if all the decay was able to be removed, if there were any difficulties during the procedure. The extraction of a permanent tooth on a 12 year old who has been a regular attender of a dentist is an unfortunate and unexpected outcome. The notes do not help to justify why this may have been inevitable.

There were few radiographs taken but the panex taken for orthodontic reasons indicates the filling on tooth 36 was inadequate with probable decay under it. It would be negligent not to look at all the teeth and supporting structures on this panex especially of a child who hadn't had many radiographs done previously. The tooth should have been identified on the panex as needing more attention and some further treatment planned for it at that stage in consultation with caregivers. If the tooth had been retreated at that time it may, however, still have required a root filling in the future due to size of the filling.

Few bite wing radiographs have been taken due to low tolerance. However [Dr F] managed to successfully take some at the time of toothache with tooth 36.

The clinical notes lack detail required. The notes are inadequate in describing the treatment for tooth 36. The notes are inadequate in describing any details about the orthodontic treatment. Few clinical records have been taken including radiographs and photographs.

Conclusion

[Miss A's] rights as a consumer may have differed in a moderate way from what should be acceptable treatment. It appears she may not have received services of an appropriate standard and she (her caregiver) may not have been fully informed throughout the treatment.

It is unusual for a child who has been under the regular care of a dentist to have a permanent tooth extracted due to a dental abscess.

The orthodontic/orthopaedic treatment provided seems inappropriate for [Miss A] and with few documents it is difficult to assess the effectiveness of it.

The clinical notes lack detail and it is difficult to understand the need for some aspects of the care given and how procedures were carried out."

Further advice

In January 2013, Dr Cayford provided further advice as follows:

"I have been asked to respond in this case having received additional information in particular the 'Right of Response' letter from [Dr D] dated August 9 2012.

I have read and reviewed all the original data, letters and information. Additionally I have read all the information in the folder marked 'Additional supporting documents (post notification)'.

The information I have recently read provides more detail on the treatment provided for [Miss A].

I will set out this report as I have set out my original one dated May 2012. I expect this report to be read in conjunction with the May report as it is not comprehensive on its own. Some explanations in the original report still stand and I wish not to repeat them. Therefore this is not a standalone document.

Documents

[Deleted for brevity.]

Summary timeline of events

This remains the same as in previous report. In addition to this I now have been provided with a list of the patient's appointments (including the ones cancelled).

Treatment done on tooth 36

[Dr D] has provided a further detailed explanation of the treatment on tooth 36 which was carried out 9/6/08. He says that the filling was done with no local anaesthesia (due to the patient's needle phobia). He felt at the time it was a 'routine' (my word) filling ... not out of the ordinary. It didn't need any special care and he felt he had removed all the caries (decay). We have both explained (myself and [Dr D]) sometimes if there is very deep decay some may be left in order to avoid 'going near the nerve of the tooth'. This can be acceptable as long as the tooth is monitored and the patient is informed. However, [Dr D] was confident he had removed all the caries. I say the appointment was 'routine' with the exception of not using local anaesthesia. Most patients would have local anaesthesia for this procedure. [Dr D] explains that although [Miss A] was 'nervous and fragile' she '...in the end coped well'.

There are a variety of different notes about the treatment of tooth 36 on 9/6/08.

1. The clinical notes are as follows: C 36 00, composite filling 36.

2. Letter to [ACC clinical advisor] Oct 4 2010 states '…a 2 surface distal occlusal restoration was placed due to presence of interproximal caries…'.

3. In [Dr D's] Right of Reply letter he states 'The original caries was small to moderate and visible from the buccal aspect of the tooth. The caries was removed from the distal as well as to a slight degree from the buccal surface. I can confirm that caries was not intentionally left behind…'

Usually interproximal caries (between teeth) as in this tooth is diagnosed from a bite wing x-ray. To see interproximal caries clinically i.e. from an examination

(rather than an x-ray) it is usually at a more advanced stage. Not necessarily very deep, but would be of a moderate size.

Tooth 36 abscessed and required removal two years later. [Dr D] has described the original caries as small to moderate. For a tooth to abscess the decay has to get near the nerve of the tooth. This can happen if some decay is left and continues to develop or the filling fails (breaks or loses its bond to surrounding tooth structure). [Dr D] states that all the decay was removed. Therefore we should consider the possibility that the filling failed. The type of filling placed was a composite filling. This is one of the main filling materials used however they can fail from time to time. Obviously this is part of a routine examination to determine integrity of all dental work. There are no comments from subsequent dentists about the state of the actual filling. All we know is that the tooth had an abscess and there was a gap (radiolucency) under the filling both showing on the x ray.

However I do refer you back to a letter from [Dr E] 4 Dec 2011 stating that the tooth had a large restoration (not small to moderate). The radiograph she took shows a 'radiolucency beneath the existing filling (which would indicate decay beneath the filling)'.

Please refer back to my report May 2010 regarding the panex radiograph. I remain of the view that had tooth 36 been looked at on the panex, [Dr D] may have decided to examine tooth 36 clinically. The panex quality was good enough to determine that tooth 36 either has a very deep filling or more caries. Both scenarios differing from his placed small to moderate filling. We do not usually make judgements about restorations on a panex radiograph (we prefer the detail of a bite wing x ray) but it can be useful especially in the absence of other x rays.

After clinical examination he could have given options and information about tooth 36 to [Miss A's] grandmother. She may have decided as there were no symptoms at that stage to continue to monitor it. Ideally, however, as I stated in the previous report it should have been considered to redo this filling. A reasonable option would have been to use local anaesthesia and some kind of sedation. This appointment could have also included removing the two baby teeth which was scheduled.

Dentists take as few radiographs as possible. However, as with any medical procedure, it is a case of weighing up the risks and the benefits. In this case I consider another radiograph would have been appropriate. Indeed this was tolerated 29/6/10.

On 14/12/09 it appears [Miss A] had two appointments scheduled that day. It appears one was an exam and one was a regular 'ortho' follow up. However, the second one was cancelled as 'Appointment not required'. It seems unusual that everything would not have been scheduled to do at one appointment. The last full exam was done by [Dr D] on 29/6/09. This was confusing as on the clinical notes it has [Ms G] listed as the clinician. [Dr D] has clarified he was the clinician at that appointment. Since that appointment until 15/3/10 [Miss A] was seen 8 times. [Dr D] says that at each appointment [Miss A] was always seen by him and often by

the hygienist. It is fair to say that a full examination is not carried out at each visit. Indeed in this case of orthodontic/paedic work often the exams are quite quick and a full exam is not necessary. However, it does appear that a full nine months went past without a full examination ('CHILDSCAPEX') when there were opportunities to have done this.

Orthopaedic work

I understand another practitioner is being asked to do a report on this aspect of [Miss A's] care. However, I would like to make a few comments.

The term 'orthodontic' treatment is widely used in dental care to cover all aspects of jaw and tooth position, development and care. When I use this term it is all encompassing. [Dr D] states that you do not do orthodontic care on 6 year olds it is 'orthopaedic' care. It is just terminology rather than a different type of care. I do this type of care on for example 6 year old patients and I call it orthodontic care. Patients and the general public understand the term and what it means. I am not inexperienced in this area of dentistry.

Clinical notes

I do not consider the clinical documentation [Dr D] has provided for the care of [Miss A] is adequate. In [Dr D's] right of reply conclusion number 1 paragraph 4 he comments on my concern in this area. The clinical notes should include initial findings after the examination. After an orthodontic examination it should include the type of bite/occlusion, what the main problems and concerns are, treatment plan etc. They lack any information about this. In a letter from [Dr D] May 15 2012 he says he's not sure which teeth were in crossbite… It should all be written in the notes.

I agree with [Dr D] that other radiographs are not needed at this early intervention stage. Photographs would have been a useful means of recording information. [Dr D] confuses my unfamiliarity with the term 'orthopaedic' treatment with inexperience. I was not looking for 'understanding' in his clinical notes, rather I was looking for a detailed description of [Miss A's] teeth as she presented to him and a subsequent treatment plan.

I accept the minimal clinical notes about the DO filling placed on tooth 36 9/6/08 — it appears it was 'routine' and no additional notes were required.

Concerns

[Miss A's] grandmother is concerned about:

— The fact that [Miss A] still had to have braces. In a letter/email to [HDC] 8/5/12 [Mrs B] states that the expected outcome was to avoid braces.
— She does not remember getting an information booklet or signing anything like informed consent (see letter 8/5/12)
— She thought [Dr D] was an orthodontist (8/5/12)
— [Miss A] has had to have a permanent tooth removed

There are some communication irregularities between [Dr D] and [Miss A's] grandmother. The hygienists both say in their supporting letters that [Dr D] always explained the treatment very well to [Miss A] and her grandmother. However the grandmother appears to disagree.

Conclusions

The clinical notes lack detail.

Removal of tooth 36 may have been avoided if an examination and subsequent retreatment of this tooth was carried out earlier. It appears there were opportunities for an oral examination of this tooth.

Useful information on the panex radiograph was not considered or responded to in some way regarding tooth 36. There were opportunities to have orally checked tooth 36 had the panex prompted this.

The orthopaedic/orthodontic treatment is to be commented on by another dentist."

Appendix B — Independent dental advice: Dr Tim Little

The following expert advice was obtained from Dr Tim Little:

> "I am replying with regard to providing independent expert advice to the Commissioner as you requested, with regards to whether [Dr D] provided an appropriate standard of care to [Miss A]. (Ref HDC01103)
>
> My name is Timothy David Little. I am a registered dental general practitioner having graduated from Otago Dental School in 1980. I have a BDS Otago. I have been in full time general practice in Auckland since 1984. I have over this time included some orthopedic and orthodontic treatment in my practice. I have had 4 years on the ADA peer review Committee with one as the Chairman. I have also been a past president of the ADA.
>
> I have reviewed the material that has been provided to me.
>
> (This includes the background, complaint and supporting information as attached.)
>
> When assessing generally the standard of care provided, especially over the extended period of time from 2004 and 2010 the most important material I have received is the dental notes (which include treatment history, statement of accounts, appointment history, including the time put aside for appointments, radiography models and any consults etc from that time period.) I am aware that some of these records may have been lost in the transfer of records to [Miss A's] grandmother, [Mrs B]. For the purpose of this review I will comment on the orthopaedic treatment of [Miss A] first then comment on the treatment of tooth 36. When considering the complaint, especially due to the length of time between initiating the orthopaedic treatment and the laying of the complaint, 'Remembered information' that is not significantly backed by the notes is very hard to corroborate.
>
> From the notes it would appear that [Miss A] was seen initially on 21/07/2004 by [Mr I] for 40 minutes for a consultation, X-rays and models were made for appliances to be made. On the history of appointment time there appears to be a 20 minute appointment with [Dr D] on 18/08/2004, however this is not recorded on treatment history notes, so it is difficult to assess what initial consultations went on.
>
> It appears that the only records taken to start treatment were the initial study models and panoramic X-ray. The quality of the panoramic X-ray and its development is extremely poor. Due to this, it is of limited use diagnostically other than to assess that on all probability all teeth are present. The models are trimmed in such a way that it is difficult to assess the original 'bite'. Without an accurate bite registration or trimming in such a way to show the bite and assuming that there is a Class II Div II occlusion, there would appear to be a significant over jet, but no apparent crossbite. There is crowding of the lower incisors and the appearance of a classic bite that would be consistent of a 'Thumb sucker'.

I realise that while the contents of [Miss A's] folder were given to her grandmother, [Mrs B], there is no mention in the notes of a consultation with regards to informed consent forms being given, or possible fees and projected treatment duration. I do note that fees of $875.00 on 31/08/2004 and $2170.00 on 04/10/2006 were paid toward treatment and would imagine that some discussion would have gone on as to what these covered. I also note that on 19/10/2009 that a fee of $425.00 was paid towards a further appliance and wonder if this is the cause of concern by [Mrs B] as to what further fees she may have to pay. Generally reading the notes there are references to a number of scale and polishes with a note on 20/09/2006 that more attention needs to be taken as far as oral hygiene and a note on the 18/01/2007 that there was a gum infection. (I note that in the remembered information that [Dr D] mentions he recommended a rest period with appliances, but in the notes only mentions to soak the appliances in steradent every day.) There also appears to be almost a year between visits to [Dr D] for orthopaedic treatment from 04/08/2008 till he saw [Miss A] for fillings on 27/07/2009 and then for orthopaedic treatment on 05/10/2009.

There is considerable clinical information that shows that expansion appliances followed by clark twin block treatment can deliver a very good result in someone with a Class II Div II malocclusion. However in summary I find that [Dr D's] diagnostic evidence very limited. Photographs showing facial profiles, lateral profiles from both left and right of the occlusion of the teeth, also full front photos of the face and teeth in occlusion would have been very useful. Cephalometric Analysis would have been significantly more important than a panoramic X-ray. Models that occluded (either by the way they were trimmed or with an occlusal bite or both) would have been useful as well. The Panoramic x-ray taken 21/07/2004 should have been retaken and developed properly if it was going to be of much use.

With such limited diagnostic information it is very hard to comment on whether the treatment recommended for [Miss A] was suitable. There are no other models or Cephalometric analysis taken or available during the treatment process to be able to comment on whether the treatment was carried out to an acceptable standard, up till when [Miss A] transferred on for treatment.

The duration of treatment without real comment till 29/06/2009 should have been of concern. Generally the notes are adequate but obviously short of information as supplied by the 'remembered' information. As already mentioned there is no note of a consultation with regard to informed consent fees or treatment duration. I do note that in [Dr D's] information about his team he mentioned that he is not a registered specialist orthodontist but I could also see that a patient reading that information could easily not register that fact. Much of the description of what the team does is revolved around orthodontic treatment. Likewise reading the information sheets on orthdontic and orthopaedic perspectives it would be easy for a patient to believe they were undergoing orthodontic treatment due to mention of orthodontic appliances rather than orthopaedic appliances.

In conclusion I find that due to lack of information it very difficult to comment on the suitability of treatment recommended for [Miss A] nor on the standard of such treatment. I feel that there should be adequate information to be able to determine this. Likewise there is no written evidence of any treatment plan, informed consent or financial outline being provided to [Miss A's] payee or [Mrs B]. However the initial payments imply that the level of fees and treatment were discussed to some degree. It appears that [Dr D] has now changed his methods of providing information with regard to his treatment, he now has an extensive if not overwhelming consent process. He also has a form for information about fees for treatment. I would hope that a more personalized treatment plan is provided to each patient outlining their individual orthodontic or orthopaedic problem and the sequences of treatment to correct this. Due to the lack of adequate records and diagnostic information it is difficult for me to assess [Miss A's] presenting situation. I do feel that [Dr D] has not obtained sufficient diagnostic information to adequately assess the problem and therefore commence his initial treatment. I feel that in relation to adequate records and diagnostic information which leads on to correct assessment of [Miss A's] treatment that there has been a moderate departure from the expected standards by [Dr D].

Treatment of tooth 36:

[Miss A's] general dental treatment under [Dr D] started 13/07/2005 just over a year from when orthopaedic treatment began on 21/07/2004. Treatment notes are incomplete as they do not mention [Miss A's] resistance to taking bite wing X-rays nor her degree of apprehension having dental work. The notes show that following her 3rd examination (all done by [Mr I]) a fissure sealant was placed on tooth 36 by [Mr I] on 20/09/2006. Then following an examination by [Ms G] on 27/06/2007 a buccal composite filling was placed in tooth 36 by [Dr D]. Again following an examination by [Ms G] on 28/05/2008 a DO composite filling was placed in tooth 36. Following this there were examinations on 17/11/2008, 29/06/2009 and a panoramic X-ray taken 11/01/2010. On 16/08/2010 [Miss A] was seen by [Dr F] for tooth ache with tooth 36. Two small lesions were found on the buccal of the 37 and 47. [Dr F] assessed the current restoration on the 36 as a large, poor, leaking restoration that looked like Fuji IX.

The Panoramic X-ray taken 11/01/2010 is of poor quality, appearing to be over developed, and very dark. It can be read on a light box and does show the unerupted 23 and 13. It also shows very clearly extensive decay under the filling on the 36 and would give the appearance of being very likely to involve the pulp.

[Miss A's] mouth has generally been decay free other than some small buccal areas on molars. The extent of the decay present in the tooth 36 only 1½ years following being restored is surprising. [Miss A] has had two examinations during the period between the placing of the restoration and the panoramic X-ray being taken. There would be a normal expectation for a restoration to last a good deal longer than 1½ years, but as there are no X-rays prior to the restoration being placed it is hard to know the extent of decay at that stage. It is hard to pick what the most likely cause of the caries in the tooth, but it is somewhat surprising that this had not been picked up in either of the subsequent examinations. There is a

responsibility for a dentist who takes x-rays to be able to read them and advise patients on any pathology. Clearly the caries present on the 36 was easily identified and the patient should have been advised. There is every likelihood that due to the extent of the decay in that tooth the outcome would have been the same as later on.

I would have expected that following the initial caries detected on 28/05/2008 that there would have been an attempt at taking intra-oral radiographs. At the very least I would have thought they should have been taken at subsequent examinations. Unlike the panoramic X-ray in 2004 that should have been retaken, the panoramic X-ray of 2010, poor as it was, does show most features. However observing the caries present in 36 there should have been a follow up intra-oral X-ray and treatment advised. I find it surprising that [Dr D] does not feel that he needed to read all pathology on this X-ray. I feel that there has again been a moderate departure from the expected standard by [Dr D].

Regards

Dr Tim Little (BDS)"

Appendix C — Clinical records

Printed On 09/06/2012 09:11am
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Patient Details

Code:
School:
Dentist:
Infectious Notes:
Med History:
Address:

Name:
Date of Birth:
Recall Date:

Work Address:

Phone:
Paying Pat.:

Work Phone:

Patient Notes

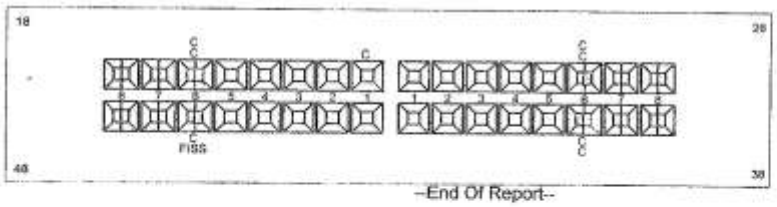
Treatment History	Details	Done	Debit	Credit
Historical				
21/07/04	S/M, study models		83.00	
	Clinical Notes: double pour for appliance			
21/07/04	XRPAN, panoramic xray		62.00	
31/08/04	ORAPPL, orthodontic appliance		875.00	
	Clinical Notes: Mn schwarz, wear & care, see 4wks			
07/10/04	ORTX, orthodontic treatment			
	Clinical Notes: see 4 wk			
03/11/04	ORTX, orthodontic treatment			
	Clinical Notes: see 4 wk			
06/12/04	ORTX, orthodontic treatment			
	Clinical Notes: for three weeks then stop turning - see Feb			
09/02/05	ORTX, orthodontic treatment			
	Clinical Notes: told to wear night time only see 3 mon.			
04/05/05	ORTX, orthodontic treatment			
	Clinical Notes: instructed to continue wearing appliance night only, wiating for 42/32 to erupt, childscapex and ortho check in 3/12. would not co-operate to day promised she would let me polish her teeth next time...			
13/07/05	CHILDSCAPEX, Private Child Exam And Clean		65.00	
	Invoice Notes: Private child exam and scale/ polish			
13/07/05	NOTES, refer to notes			
	Clinical Notes: used her own ELTB and prophy cup to polish with today, removed moderate lingual build-up form 31 41. Doesn't like suction tips, just let her rinse out. instructed to wear appliance night time only, see in 3months for ortho check and to review calc build-up...			
05/10/05	NOTES, refer to notes			
	Clinical Notes: was very co-opperative today, removed light lingual calc 31/41 and prophy, instructed to continue wearing plate night time only and review in 3 months...			
05/10/05	CHILDSCAPEX, Private Child Exam And Clean		65.00	
	Invoice Notes: Private child exam and scale/ polish			
23/01/06	ORTX, orthodontic treatment			
	Clinical Notes: told to wear night time only see 6 mon.			
09/08/06	CHILDSCAPEX, Private Child Exam And Clean		65.00	
	Invoice Notes: Private child exam and scale/ polish			
09/08/06	NOTES, refer to notes			
	Clinical Notes: turn lower 1/5day wear everyday ,allday see 4wks time			
20/09/06	NOTES, refer to notes			
	Clinical Notes: OHI given quick clean also done ,plus demo disclosing tab /where to pay more attn /floss			
20/09/06	FISS 36 O, fissure sealant			
20/09/06	FISS 26 O, fissure sealant		40.00	
20/09/06	FISS 46 O, fissure sealant		40.00	

20/09/06	FISS 16 O, fissure sealant	
	Clinical Notes: 1 + 1 free	
20/09/06	IMPS, impressions	
	Clinical Notes: upper and lower + sealants	
04/10/06	ORTX, orthodontic treatment	2170.00
	Clinical Notes: insert clark twin wear and care see 4 wk 2170 for prepayment	
01/11/06	ORMON, monthly orthodontic fee	
	Clinical Notes: see 4 wk	
29/11/06	ORMON, monthly orthodontic fee	
	Clinical Notes: will stop turning Mn next visit Mx 2-3 mon	
08/01/07	ORMON, monthly orthodontic fee	
08/01/07	ORMON, monthly orthodontic fee	
	Clinical Notes: told t stop turning Mn Mx will stop next month or march	
18/01/07	ESP, specific consultation	
	Clinical Notes: re mild case of nug. Told to brush teeth 3-4 x?day mouth wash before and after brushing, soften TB under hot water and brush gums, soak appls in stearadent every day. Should be gone week to 10 days	
26/02/07	ORMON, monthly orthodontic fee	
	Clinical Notes: told to wear night time only see 3 mon.	
09/03/07	FAILED, failed appointment	
	Clinical Notes: failed appt on 7/2/07	
16/05/07	FAILED, failed appointment	
	Clinical Notes: FAILED APPT ON 14/5	
27/06/07	CHILDSCAPEX, Private Child Exam And Clean	65.00
	Invoice Notes: Private child exam and scale/ polish	
27/06/07	NOTES, refer to notes	
	Clinical Notes: Light calc ling 32-42, rec to start flossing these teeth	
27/06/07	ORTX, orthodontic treatment	
	Clinical Notes: wearing night time only - waiting for more permanent teeth	
16/07/07	C 16 P, composite filling	60.00
16/07/07	C 26 P, composite filling	60.00
16/07/07	C 36 B, composite filling	60.00
16/07/07	C 46 B, composite filling	60.00
12/09/07	ORTX, orthodontic treatment	150.00
	Clinical Notes: insert blue trainer, wear & care see 4wks	
17/10/07	ORTX, orthodontic treatment	
	Clinical Notes: doing well but not staying in all night every night told to war more during the day. see 4 wk	
14/11/07	ORTX, orthodontic treatment	
	Clinical Notes: she found old acrylic appls and started wearing !!!! Told her to stop abd continue wearing trainer. see 4 wk	
12/12/07	ORTX, orthodontic treatment	
	Clinical Notes: wearing well but still comes out during bouts of hay fever see Jan to go on to pink appl.	
06/02/08	ORTX, orthodontic treatment	
	Clinical Notes: graduate to pink see 8 wk.	
02/04/08	ORTX, orthodontic treatment	
	Clinical Notes: issue ph 1 see 8 wk	
28/05/08	ORTX, orthodontic treatment	
	Clinical Notes: not staying in at night at all, not wearing duaring day time. Reinforced need to wear day time, finding time is hard for them but adv even 10-20mins at a time is a help, doing homework, making bed etc.. Rec taping lips at night also, see 4wks	
28/05/08	CHILDSCAPEX, Private Child Exam And Clean	65.00
	Invoice Notes: Private child exam and scale/ polish	
09/06/08	C 36 DO, composite filling	80.00
04/08/08	ORTX, orthodontic treatment	
	Clinical Notes: weawring patern is improving but return in 12 weeks	
17/11/08	CHILDSCAPEX, Private Child Exam And Clean	72.00
	Invoice Notes: Private child exam and scale/ polish	
17/11/08	ORTX, orthodontic treatment	
	Clinical Notes: see in 12 weeks may go to red trainer.	
29/06/09	CHILDSCAPEX, Private Child Exam And Clean	72.00

	Clinical Notes:	Reinforced twice daily brushing for 2mins. Ensuring getting all surfaces. Explained why nightly brushing is most important.
	Invoice Notes:	Private child exam and scale/ polish
29/06/09	ORTX, orthodontic treatment	
	Clinical Notes:	Day time wear non-exsistant. Falls out at night. kept saying that she was doing well with the plates - explained that they will not work anymore - need to break the mouth breathing habit. Will review in 4mths, if no improvment may have to hold out for braces
27/07/09	C 16 O, composite filling	70.00
27/07/09	C 11 P, composite filling	70.00
27/07/09	C 26 P, composite filling	
05/10/09	IMPS, impressions	
	Clinical Notes:	to go to upper tranverse
19/10/09	ORAPPL, orthodontic appliance	425.00
	Clinical Notes:	wear and care see 4 wk
16/11/09	ORTX, orthodontic treatment	
	Clinical Notes:	making progress cai see 4 wk
14/12/09	ORTX, orthodontic treatment	
	Clinical Notes:	see Jan to take pan
11/01/10	XRPAN, panoramic xray	70.00
11/01/10	ORTX, orthodontic treatment	
	Clinical Notes:	Pan taken for position of 13/23. advised baby teeth may need to be extracted in a few more months if no movement. hates that Idea as she does not do well with needles. Told to continue turning screw in plate , see in 4 weeks..
15/02/10	ORTX, orthodontic treatment	
	Clinical Notes:	see 4wks - told to get a wriggle on the eye teeth..
15/03/10	ORTX, orthodontic treatment	
	Clinical Notes:	adv needs to have 53 & 63 ext'd ASAP to try & avoid braces & impaction of permanent canines. not happy with this. Discussed options of referral or having it done here. decided it should be done here. Rec Lorapam to calm her nerves.
06/07/10	NOTES, refer to notes	
	Clinical Notes:	phoned & requested records to be sent wouldn't say why just said to they were having a change she offered any help they may require she said she didn't want to discuss any issues.
06/09/10	NOTES, refer to notes	
	Clinical Notes:	rung today re: a statement of account with all that has been charged to her and that she has paid to date. She said that she thinks her insurance company was going to pay for treatment and this is why she needed this. I have printed it out and sent it to her but it sounded like a very odd request as insurance companies do not back pay.

Current Treatment Plan:

17/10/07	NOTES, refer to notes	
	Clinical Notes:	Grandma



--End Of Report--