Dr Bharath (Barry) Subramani

A Report by the
Deputy Health and Disability Commissioner

(Cases 22HDC00313 | 22HDC00347 | 22HDC00613)

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Contents

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received complaints from three separate consumers, Ms A, Mr B, and Mr C, about the care provided by a dentist, Dr Bharath Raja (Barry) Subramani, who was practising at Dental Practice 1 and Dental Practice 2.

2. The following issues were identified for investigation:

- *Whether Dr Bharath (Barry) Subramani provided [Mr C] with an appropriate standard of care in December 2021 and January 2022 in respect of dental services provided.*
- *Whether Dr Bharath (Barry) Subramani provided [Mr B] with an appropriate standard of care in April 2018 in respect of dental services provided.*
- *Whether Dr Bharath (Barry) Subramani provided [Ms A] with an appropriate standard of care in March and April 2018 in respect of dental services provided.*

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

4. The parties directly involved in the investigation were:

Ms A	Consumer
Mr B	Consumer
Mr C	Consumer
Dr Bharath Raja (Barry) Subramani	Provider/registered dentist (at the time of the complaints)

5. Further information was received from:

Dental Practice 1	Dental practice
Dental Council of New Zealand	Regulatory authority

6. Independent clinical advice was obtained from dentist Dr Angela McKeefry in relation to all three consumers (see Appendices A, B and D).

Complaint and Investigation

Background

7. This report relates to the dental care provided by Dr Subramani to three patients at both Dental Practice 1 (Practice 1), where he was contracted as a dentist, and at Dental Practice 2 (Practice 2), of which Dr Subramani remains a director and where he also practised as a dentist.

8. The complaints occurred during the periods 23 March 2018 to 4 April 2018 (Practice 1), 4 to 17 April 2018 (Practice 1), and 6 December 2021 to 29 January 2022 (Practice 2).

9. The complaints about Dr Subramani were received on 3 February 2022 (Mr C), 10 February 2022 (Mr B), and 8 March 2022 (Ms A). For ease of reference, I have outlined my provisional decision in relation to each complaint separately. The relevant standards referenced throughout my decision are included below.

Relevant standards and guidelines

Dental Council of New Zealand Standards Framework

10. The Dental Council of New Zealand (DCNZ) 'Standards Framework for Oral Health Practitioners'[1] (DCNZ Standards Framework) outlines the professional standards and ethical principles oral health practitioners must meet. The five ethical principles to which practitioners must always adhere are to put patients' interests first, ensure safe practice, communicate effectively, provide good care, and maintain public trust and confidence.

DCNZ Practice Standards

11. Practice Standards relate to specific areas of practice that require more detail to enable practitioners to meet the DCNZ Standards Framework. Relevant DCNZ Practice Standards referred to in this decision are as follows:

DCNZ Medical Emergencies in Dental Practice — Practice Standard[2]

12. The purpose of these practice standards is to set minimum standards for registered oral health practitioners for the level of resuscitation training; the recertification intervals; and the equipment and drugs that need to be available in the case of a medical emergency.

13. The standards state:

> 'An oral health practitioner has an ethical and legal obligation to attend to a medical emergency. Further, it is the public's expectation that a health professional will be in a position to assist them in a medical emergency situation.
>
> …
>
> [A] practitioner's ability to deal with medical emergencies that arise in practice is a significant aspect of meeting their responsibility to, and the expectations of, their patients.
>
> …
>
> Oral health practitioners need to have appropriate skills, training and equipment available to deal with potentially life threatening conditions …'

[1] Whilst the Standards Framework referenced applied from 7 July 2017 to 20 November 2019, there is no change to the five ethical principles referred to in the subsequent versions.
[2] Dated December 2016. Whilst the Medical Emergencies Practice Standards referenced applied from October 2017 to November 2019, the version that covered the period August 2021 to August 2023 is largely the same in relation to these paragraphs.

DCNZ Patient records and privacy of health information practice standard[3]

14. The purpose of this practice standard is to set minimum standards for oral health practitioners in creating and maintaining patient records and maintaining the privacy of patients' health information.

15. The standards outline that 'practitioners have a responsibility to ensure safe practice and put their patients' interests first by maintaining accurate, time-bound and up-to-date patient records and protecting the confidentiality of patients' health information'.

Provisional opinion: Dr Bharath Raja (Barry) Subramani — breach

16. First, I acknowledge the distress of all three patients, Ms A, Mr B, and Mr C, caused by the dental services provided by Dr Subramani.

17. My investigation focused on whether the care provided by Dr Subramani was appropriate and reasonable. I have combined my decision in relation to these three separate complaints owing to the similarities regarding the concerns raised. I have considered the clinical evidence of an experienced dental practitioner, Dr Angela McKeefry.

18. Having carried out a thorough assessment of the information gathered, I consider that Dr Subramani breached Rights 4(1), 4(2), 5(1), 6(1), and 7(1) of the Code of Health and Disability Services Consumers' Rights (the Code) when he provided dental services to all three consumers. I have set out below the care provided to each consumer, and the reasons for my decisions.

Care provided to Mr C — breach

19. Mr C attended eight dental appointments with Dr Subramani over a period from 6 December 2021 to 29 January 2022. At the time of the care provided to Mr C, Dr Subramani was a director of his own practice, Practice 2, where he also practised as a dentist.

20. I recognise at the outset that the complaint information received from Mr C does not reflect the information in the clinical notes made by Dr Subramani for these appointments; this was also highlighted by Dr McKeefry in her advice.[4]

[3] Dated 1 February 2018. Whilst the patient records and privacy of health information standard referenced applied from February 2018 to November 2020, there is no change to the current version.

[4] Dr McKeefry advised that Mr C stated that he showed Dr Subramani a piece of bone and had a clean at appointment three — this was appointment five; Mr C stated that a front cap was placed by Dr Subramani at appointment four — this was appointment seven; Mr C stated that the last appointment was on 27 January 2022 — however, there was another appointment after this on 29 January 2022. What Mr C stated happened on 27 January 2022 happened on 29 January 2022; Mr C stated that Dr Subramani prescribed him

21. I acknowledge the time that has passed from when Mr C was treated by Dr Subramani and when Mr C made his complaint to HDC. Mr C did not have the benefit of the clinical records to hand, and where possible I have referred to his concerns and his version of events when they appear to be the correct treatment dates.

Initial consultation — 6 December 2021

22. Mr C, aged 55 years at the time, first visited Dr Subramani at Practice 2 on 6 December 2021 for repair work on several of his teeth.

23. Dr Subramani provided HDC with a 'Patient Declaration Form' (the Patient Declaration) signed by Mr C at this appointment. The Patient Declaration states that it was explained to Mr C that Dr Subramani was under supervision, and that prior to treatment, any diagnosis and treatment plan would be discussed and approved by Dr Subramani's supervisor.[5] It was noted that Dr Subramani had limited practice and so would provide Mr C with only an initial check-up (consultation), and if the treatment plan was approved and consented to by Mr C, Dr Subramani might also provide specific treatment.[6] The Patient Declaration also stated that if Mr C did not consent to the treatment, he would be referred to another dentist. A general sentence at the end of the form stated: 'Understanding the above, I confirm that I consent to Dr Subramani providing me with treatment and discussing my treatment plan with his supervising dentist.'

24. Mr C told HDC that during his first visit, Dr Subramani carried out an examination of his teeth and advised him that he needed an extraction. Mr C stated that he agreed to this because Dr Subramani had told him that if a root canal was required, he would have to go to another city. Mr C also said that he accepted Dr Subramani's word that having an extraction would not cause him problems chewing on the right-hand side of his mouth because there would be no teeth meeting top and bottom.

25. In response to the provisional opinion, Dr Subramani stated that at this consultation, he 'gave [Mr C] treatment options of "no treatment, a root canal or extraction"'. Dr Subramani also stated that he 'clearly explained all available treatment options to [Mr C]' so that he had 'a complete understanding of his choices before proceeding with extraction', including:

a) 'Root Canal Treatment (RCT) to preserve the tooth and maintain its function.'

b) 'Do the initiate emergency dressing to relieve the patient's pain and referral to a specialist for further evaluation and management.'

c) 'The functional impact and long-term plan if he chose [root canal treatment].'

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antibiotics for his dry socket on 8 December 2021 — however, according to the clinical notes, antibiotics were not given until 14 January 2022 and were for a separate issue.

[5] A measure put in place by the Dental Council in 2020 following various complaints received about Dr Subramani.

[6] Such as clean, composite fillings, extractions, a removable prosthesis, and/or emergency endodontic dressings.

26. In response to the provisional opinion, Dr Subramani stated that he 'clearly explained the impact of extractions on chewing efficiency' and felt that 'Informed consent was carried out'. Dr Subramani provided HDC with a consent workflow sheet and said that he followed the steps in the sheet.

27. Dr Subramani documented that Mr C had 'had trouble eating on the [right-hand side] bottom tooth for a couple years and [was] very sensitive' and 'had pain on [the right-hand side] Lower'.

28. Dr Subramani told HDC that his treatment planning rationale for Mr C was that he proposed to do the urgent things first, followed by the less urgent things as set out below, until the treatment plan was completed. Dr Subramani's clinical records for 6 December 2022 list the following management and treatment plan:

> 'a. Extraction of tooth 46 (urgent care)[7]
>
> b. Fillings of teeth 47 and 44 (primary care)[8]
>
> c. Comprehensive exam/43 buccal[9] early decay — watch (follow up)[10]
>
> d. In patient's best interest extract 46 and repair 44, 47/smoking cessation programme option given (Reflection)'

29. Dr Subramani advised that at comprehensive check-up examinations, bitewings[11] are taken, as well as photographs, and he confirmed that this is what Mr C had at his initial examination. Dr Subramani said that he discussed the following with Mr C:

> '[T]he oral hygiene instructions with the patient, showing brushing techniques the patient can use to support a better oral home-care regime and, additionally, smoking cessation advice if the patient is ready. We also go through our findings with him and make a plan, which is then preapproved by [Dr Subramani's] supervisor …'

Dental treatment provided to Mr C

6 December 2021 — first treatment

30. Mr C's first treatment was carried out at the initial consultation with Dr Subramani, being the urgent extraction of tooth 46.

31. Mr C told HDC that following the first appointment he had no 'chew ability'. He said that the advice Dr Subramani gave him at the initial appointment — that it would not ruin

[7] Subsequent information provided by Dr Subramani described this as 'Emergency Care'.
[8] Subsequent information provided by Dr Subramani described this as 'Urgent care', which included filling of tooth 36.
[9] The surface of the tooth that faces the cheek.
[10] Subsequent information provided by Dr Subramani described this as 'Urgent care'.
[11] Referring to how the film, or sensor in the case of a digital X-ray, is positioned in the mouth; the patient bites down on a tab or 'wing' that holds the apparatus in place. One bitewing is taken for each side to assess the posterior teeth. They are taken for preventative purposes to see any decay between the teeth or below the gumline.

chewing on that side of his mouth because there were no teeth meeting top and bottom — was 'extremely inaccurate'. Mr C also said that after the extraction he developed an infection.

32. Dr Subramani's clinical notes for this date record: 'Uncomplicated extraction; since it roots were curved took little time to retrieve the whole tooth …' There is no reference to any discussion about chew ability, and Dr Subramani has not denied that such a discussion took place.

33. In response to the provisional opinion, Dr Subramani stated that he accepted that he 'did not expressly say [that Mr C's] chewing ability would be affected by the extraction' as he 'mistakenly, assumed that he would be aware that losing a tooth would impact chewing'. Dr Subramani acknowledged that he should have been 'expressly clear about this' and apologised. However, Dr Subramani said that he was confident that he 'did not tell [Mr C] that the extraction would not affect his chewing ability due to the absence of opposing teeth,' although he recognised that his clinical records do not specifically document this discussion.

34. Dr Subramani provided HDC with an 'Aftercare Instructions for Extractions' leaflet, which he said was provided to Mr C before the extraction. The first sentence in the leaflet is: 'Please read carefully: 24 hours after tooth extraction it is important to control the bleeding.' Dr Subramani stated: 'The staff and I go through this form with the patient, to make sure that they understand the complications that could occur.'

35. In response to the provisional opinion, Dr Subramani stated that he provided the standard postoperative care instructions to minimise the risk of complications. Dr Subramani said that 'as with any surgical procedure, there is always a possibility of infection despite all necessary precautions being taken'.

36. Dr Subramani also provided HDC with an 'Informed Consent for Oral Surgery and Dental Extractions' form signed by Mr C at this appointment, which listed 'inherent risks'[12] of such treatment.

8 December 2021 — second treatment

37. On 8 December 2021 Mr C returned to see Dr Subramani because of the 'rot and smell and taste' from the cavity infection, and because there was a large lump in the cheek of his mouth. Mr C described the lump as 'excessively painful' and said he believed it to be a piece of tooth he could feel with his tongue.

38. Mr C said that at this appointment, Dr Subramani reassured him that there was nothing to worry about and prescribed antibiotics to clear the infection.

[12] Such as bleeding, bruising and/or swelling, injury to the nerves, dry socket, sinus involvement, infection, fractured jaw, roots, bone fragments or instruments, injury to adjacent teeth or fillings, bacterial endocarditis (an infection of the heart) and adverse reactions to medications given or prescribed.

39. Dr Subramani's clinical records for this appointment noted that Mr C had a 'Dry socket'[13] at tooth 46 and recorded the treatment as: 'Flushed socket with Savacol[14] dressed socket with Alveogyl.[15]' Mr C was advised not to rinse his mouth for a day. Dr Subramani's records note:

> '[U]nable to locate any bone. If I explore for it … risk of disturbing the healing socket. Reassured unwanted piece of bone body will [throw] it away. Given Monojet syringe[16] to get rid of food from the extracted socket from tomorrow.'

40. Dr Subramani told HDC that his rationale for the treatment of the dry socket at tooth 46 and Mr C's concern over the piece of tooth/bone in his gum was that he wanted to reassure Mr C that 'although extremely painful, this condition does not signify any serious consequence of the extraction'. Dr Subramani said that he advised Mr C that the socket was healing normally, but slowly, and that treatment could be given during the healing period to relieve the pain. Dr Subramani stated:

> 'Larger pieces may delay healing and sometimes sequestrate[17] through the alveolar ridge mucosa[18] many weeks after extraction, although they are not usually associated with significant pain. If the sequestra are associated with symptoms and are not shed, surgical removal may become necessary. In practice, this intervention is extremely rarely required, and sequestra are usually small and lost without being noticed.'

41. Dr Subramani told HDC that he was 'unable to identify any bone pieces on the x-ray either'. However, no X-rays have been provided to HDC, and the clinical records for this date do not note that an X-ray was taken.

42. In response to the provisional opinion, Dr Subramani said that he made the clinical decision not to perform an X-ray at this time explaining that 'X-rays are not routinely indicated for the management of a dry socket'.

43. Mr C told HDC that he was given antibiotics at this appointment. However, Dr Subramani's clinical records and script details provided to HDC do not show that Mr C was prescribed antibiotics on this date.

44. In response to the provisional opinion, Dr Subramani stated that the literature generally advises against prescribing antibiotics for dry socket unless there is a clear infection

[13] A dry socket is a painful dental condition that sometimes occurs when a blood clot at the site of a tooth extraction does not form, or it comes out or dissolves before the wound has healed.
[14] An antiseptic mouthwash.
[15] A product used for the prevention and management of alveolar osteitis/dry socket. Its active ingredients are iodoform (antiseptic) and butamben (anaesthetic).
[16] A syringe used for several different medical procedures.
[17] 'Sequestra' refers to dead bone fragments that separate from healthy bone, usually after tooth extraction. Bone sequestra are most commonly associated with osteomyelitis (an infection of the bone).
[18] The mucous membranes covering the alveolar ridge (the bony ridge or raised thickened border of the upper or lower jaw that contains the socket of the teeth).

present, and he judged them not to be necessary at this appointment and therefore did not prescribe them.

13 December 2021 — third treatment

45. Mr C continued to be in 'extreme pain' from the lump in his mouth, and he returned to see Dr Subramani on 13 December 2021. Mr C told HDC that he asked Dr Subramani if the lump was a 'floating piece of tooth' but was told: '[N]o that's your jawbone.' Mr C stated that Dr Subramani reassured him that it was healing well and said that it was best not to touch it.

46. In contrast, Dr Subramani told HDC that he was unable to retrieve 'any bone pieces' or 'bit of tooth' during the dressing appointment and was also unable to 'identify any bone pieces on the x-ray either'. Dr Subramani stated that he advised Mr C that 'the piece of bone would come off by itself'.

47. In response to the provisional opinion, Dr Subramani noted that whilst Mr C stated that he was in 'extreme pain', he considered that this did not accord with Mr C's presentation at that appointment and also was not reflected in the follow-up correspondence. However, Dr Subramani's clinical records for this date also note 'TMJ-no click, tender potentially from clenching' and that there was 'slight inflammation [of the] oropharynx[19]'.

48. Dr Subramani's clinical notes for this date (relevant section attached as Appendix C) record that he carried out a '[c]omprehensive oral examination' and that Mr C was '[h]ealing well'. Dr Subramani also recorded the status of teeth 15, 17, 18, 25, 26, 28, and 38 as 'Missing' and noted various concerns and options for Mr C about teeth 12, 13, 14, 21, 22, 24, 27, 33, 35, 36, 37, 43, 44, and 47 (see Appendix E). Dr Subramani also noted, '[O]ngoing care/wait/review in 3 months time,' for teeth 12, 22, 33, 35, and 43. Dr Subramani's subsequent 'Reflection' notes for this treatment state:

> 'In P[atient]'s best interest repair (Do the worst first, and adjacent repairs, so that the cost can be spread out) and perio[20] fix — later option replacement can be discussed with patient.'

49. Dr Subramani noted the urgent treatment required and recorded that Mr C 'opted for' fillings for teeth 47, 44, and 36 (with 47 and 44 stated as 'already approved is there to fill'). Other dental work is noted for a scale, polish and re-contouring of existing restoration(s) for teeth 24, 27, 13, 14, 21, and 37. At this appointment, Dr Subramani noted in his clinical records that metallic and adhesive restoration was required on Mr C's teeth 12, 14, 16, 22, 23, 27, 34, 35, 37, 44, 47, and 48. He said that this metallic and adhesive restoration was not carried out, but was included as a base charge for the comprehensive examination of these teeth. It was also noted that a need for future hygienist treatment was discussed.

[19] The middle part of the throat, directly posterior to the oral cavity.
[20] Periodontal — dental treatment for people with severe gum disease.

50. Mr C stated that following the appointment on 13 December 2021, he was 'still with extreme pain', and that what Dr Subramani had told him was his jawbone, 'came out, [and] it was a large piece of tooth'.

51. Dr Subramani provided HDC with a screenshot of communication log notes for 14 December 2021 (the day after the treatment but with no time stamp) saying: '[Left message] for patient asking how they are. Left phone number to call if any trouble.'

52. In response to the provisional opinion, Dr Subramani provided HDC with a copy of an email sent by Practice 2 on 16 December 2021, which stated:

> '[Dr Subramani will] do as much as possible in one session. However it is very hard to guesstimate how many appointments he needs. He only knows how long a filling will take once he has opened it up. It all depends on how much decay there is.'

23 December 2021 — fourth treatment

53. Whilst Mr C does not discuss this appointment in his complaint, Dr Subramani's clinical notes reflect that adhesive restoration was carried out on Mr C's teeth 36, 44, and 47. Dr Subramani also noted: 'Demin dentin[21] left behind. Caries detector[22] used to remove infected dentin[23] from periphery … [Patient] happy.'

14 January 2022 — fifth treatment

54. On 14 January 2022 Mr C attended for his fifth treatment appointment. He stated that at this appointment, Dr Subramani only cleaned his teeth. Mr C told HDC that he showed Dr Subramani what he believed was a piece of tooth, and Dr Subramani 'laughed it off saying that's big don't know why your body didn't want to keep that'. Mr C said that at that time, he thought that Dr Subramani's failure to identify the tooth in his mouth was because of dentistry 'being a complex and unpredictable industry'.

55. Dr Subramani told HDC that he did smile when Mr C showed him what he noted was a piece of bone and said, 'that's big', but he said that he did not laugh at that moment.

56. Dr Subramani told HDC that before extracting a tooth, he gave patients options such as 'no treatment, root canal treatment, extraction' and let them choose the option best for them. He said he would then discuss the risks of the extraction and go through the extraction consent and aftercare, before taking out the tooth, 'to make sure that they underst[oo]d the complications that could occur'. Dr Subramani described one of these complications as 'breaking a bit of bone or leaving a bit of tooth behind' and said that this would have been explained to Mr C prior to tooth 46 being extracted on 6 December 2021.

57. Dr Subramani's clinical records for 14 January 2022 note that Mr C raised concern about the filling in tooth 36 being sensitive and giving him toothache and headaches.

[21] Demineralised dentin is a synthetic material used as a substitute for human bone.
[22] A dye used for conservative dentistry to assist excavation of the infected carious dentin layer.
[23] The hard tissue that lies immediately underneath the enamel of the tooth.

Dr Subramani said that he advised Mr C to 'wait and watch' and prescribed amoxycillin[24] as a 'back up' in case Mr C's pain got worse and in case of infection. Dr Subramani also noted that he carried out 'Removal of calculus[25]', scaling, and '[r]econtouring[26] of pre-existing restoration for teeth 11, 22, 14, 15, 26, 25, 24 and 13'.

58. Dr Subramani provided HDC with a screenshot of patient script details for this date,[27] which showed a prescription for 20 amoxycillin 500mg capsules and the instructions: 'Take 2 caps to start, then one caps 3 times daily, for 5 days. Take probiotics or live [yoghurt] and [fermented] veggies 2 hours after the medication …'

22 January 2022 — sixth treatment

59. Dr Subramani's clinical records for 22 January 2022 note that Mr C informed him that '36 ha[d] settled down now after the course of [antibiotics]'. Dr Subramani also recorded that he carried out adhesive restoration to five surfaces of posterior tooth 24 and two surfaces of another posterior tooth (27), as well as enamel bevelling[28] and sand blasting.[29] Dr Subramani again[30] recorded: 'Demin dentin left behind. Caries detector used to remove infected dentin from periphery.'

27 January 2022 — seventh treatment

60. Mr C told HDC that he returned to see Dr Subramani on 27 January 2022[31] and was expecting to have some fillings and a broken tooth repaired. However, he said that when he returned home and regained feeling in his tongue, he noticed that a front tooth cap had been put on.

61. Dr Subramani's clinical records for 27 January 2022 note that Mr C informed him that the '[u]pper [left-hand side] fillings that were put in place on 22/01/2022 were a bit tender for a couple of days after they were put in place' and '[p]atient said they [were] settling down'. Dr Subramani noted the treatment he carried out on Mr C as: 'Recontouring of pre-existing restoration(s)' (tooth 14), 'Adhesive restoration — two surfaces — anterior tooth — direct' (teeth 13 and 21).

62. In his response to the provisional opinion, Dr Subramani stated that he did 'not accept that a front tooth cap was placed at the appointment on 27 January 2022' and that only composite fillings were provided that day.

[24] An antibiotic medication used to treat bacterial infections.
[25] Also described as 'tartar' (hardened plaque on the surface of the tooth).
[26] Removal of small amounts of tooth enamel to alter the length, shape, and surface of a tooth.
[27] With no patient name recorded.
[28] Removing a part of the tooth structure at an angle.
[29] A dental procedure that blasts a stream of sand projected by compressed air to remove surface discolouration from teeth.
[30] This was also recorded in the clinical notes for 23 December 2021.
[31] Mr C refers to this treatment as the fourth visit, but Dr McKeefry noted that from the clinical records, this was the seventh treatment.

29 January 2022 — eighth and final treatment

63. Mr C told HDC that at this treatment appointment[32] on 29 January 2022, before any work was done, he raised his concern with Dr Subramani that he had been unaware of a cap being placed on his tooth at the previous appointment on 27 January 2022.

64. However, Mr C told HDC that as he thought the cap 'was nice', he took it no further, although he made it clear to Dr Subramani that he did not want any further cosmetic work going forward. Mr C said that Dr Subramani confirmed that he would finish all his fillings at the next treatment appointment. Mr C stated that he told Dr Subramani that apart from his broken teeth, all he wanted treated were three black cavities at the front, as they were in the 'smile zone'.

65. Dr Subramani told HDC that the 'cap' referred to by Mr C was a 'composite filling, which surface/s, [which is] why the carious[33] fillings were prioritised'.

66. Mr C told HDC that when he attended this final appointment,[34] he was under the assumption that the teeth being treated were the three black cavities as set out above. However, he stated that after Dr Subramani gave him a local injection at the top and bottom of his mouth, he noticed that Dr Subramani did 'other work' and put 'bands' on the top and bottom.

67. Mr C said that once the treatment had finished, Dr Subramani told him that he had been unable to do the three black teeth at the front[35] because his gums needed three months to heal after the cleaning 'weeks earlier'. Mr C said that Dr Subramani then explained that he had 'built up more teeth' during that appointment, and asked if he would like to make a further appointment in three months' time.

68. Dr Subramani's clinical records confirm the advice to Mr C that 'since gum was bleeding during the filling procedure', he should return in three months' time. Dr Subramani told HDC that the reason he deferred the treatment for tooth 23 was because Mr C's '23 tooth distal gum was inflamed from the treatment done' on 22 January 2022.

69. Dr Subramani recorded the treatment carried out on Mr C as: 'Adhesive restoration — four surfaces — posterior tooth — direct'[36] (tooth 37). Dr Subramani again recorded: 'Demin dentin left behind. Caries detector used to remove infected dentin from periphery.'

Other information

70. Mr C stated that he was 'very disappointed in the whole experience' with Dr Subramani. However, he liked the 'better bite' and did not take issue with the treatment done that

[32] Mr C refers to this treatment as the fifth appointment, but Dr McKeefry noted that this was the eighth and final treatment.
[33] Decayed.
[34] Whilst Mr C recalled that this was on 27 January 2022, on viewing the clinical records it appears that the final appointment was on 29 January 2022.
[35] Noted in Dr Subramani's clinical records to be two teeth — 23 and 24.
[36] A filling.

had not been agreed to at that time. Mr C said that it was when he became aware of Dr Subramani's history in the media that he realised that what had happened to other past patients of Dr Subramani had happened to him. Mr C said that he made his complaint to HDC to prevent this happening to anyone else.

71. In contrast, Dr Subramani considers that Mr C was given adequate information about the procedures he underwent. Dr Subramani told HDC that Mr C 'had large and complex composite fillings'.

72. Dr Subramani stated that both he and his assistant gave Mr C follow-up care verbally, and Mr C signed the consent forms.

73. Dr Subramani stated that Practice 2 called all its patients the day after their appointment to see how they were doing after their dental treatment and to ask whether they had any concerns or questions. Dr Subramani said that when Mr C was called, he stated that he 'was doing well with all treatments'. Dr Subramani also told HDC that a follow-up appointment was made with Mr C in April 2022 to review his 'periodontal health after the initial scalings and fillings placed recently'.

74. In response to the provisional opinion, Dr Subramani also stated that he had no reason to believe that Mr C was unhappy with his treatment. Dr Subramani said that a five-star review of the practice was left by Mr C on 8 December 2021.

75. Dr Subramani provided HDC with unsigned statements from his dental assistant and receptionist at Practice 2 as part of his response. The statements indicate that Mr C did not seem unhappy with the treatment provided, and that they were surprised to hear of the complaint. However, they said that he 'did express some concern regarding his extraction site' and 'did express some concerns regarding a tooth that had been giving him pain' and that '[a] filling was put in place on the tooth one month prior … at [Practice 2]'.

Changes made since events

76. In response to the provisional opinion, Dr Subramani said that he recognised the importance of clearly recording all communication regarding treatment outcomes. He stated that he has made the following changes to his practice:

> '(a) Updated consents for extractions. The form for extractions was updated to provide more detailed information about potential risks and complications.
>
> (b) Updated post-operative care instructions given to patients were updated to ensure clearer guidance and improved patient understanding.
>
> (c) All prescriptions were updated to specify the exact number of tablets for Amoxicillin.
>
> (d) I implemented more robust record-keeping methods to ensure accurate and comprehensive documentation of patient interactions and treatments.'

Responses to provisional opinion

Mr C

77. Mr C was given an opportunity to respond to the 'Complaint and Investigation', 'Changes made since events' and 'Further information and DCNZ involvement' sections of the provisional opinion. He stated that he had no additional comments.

Dr Subramani

78. Dr Subramani was given an opportunity to respond to the provisional opinion, and his comments have been incorporated into this opinion where relevant and appropriate.

79. Dr Subramani stated that he always aimed to provide 'accurate and comprehensive information to [his] patients to help them make informed decisions about their dental care'.

80. Dr Subramani advised that all components of the treatment plan, including the management of the dry socket visit, were discussed thoroughly with his clinical supervisor, prior to initiation. Dr Subramani said that he adhered closely to the advice and guidance provided throughout the duration of the treatment.

81. In relation to consent for the appointments on 14, 22 and 27 January 2022, Dr Subramani stated that verbal consent was obtained from Mr C for all these appointments, and the treatment options were explained thoroughly to him, but these discussions were not documented in the clinical notes, which he acknowledged was crucial. Dr Subramani acknowledged and accepted the criticisms regarding his clinical notes for Mr C, and that the 'decision making processes, treatment plans, verbal consent etc all need to be recorded in writing'. Dr Subramani confirmed that he made these changes to his practice shortly after the complaint and that he recognised the importance of accurate record-keeping.

82. In conclusion, Dr Subramani stated that he acknowledged the feedback provided in the provisional opinion regarding the care he provided to Mr C. Dr Subramani also said that he recognised that it is important to ensure that the patient's concerns and preferences are discussed fully and prioritised in the treatment plan. Dr Subramani stated:

> 'While I did consider what I believed to be the most urgent and necessary treatments, I understand that clearer communication with [Mr C] would have been beneficial.'

Opinion

83. Mr C visited Dr Subramani for eight appointments between 6 December 2021 and 29 January 2022, during which a significant amount of treatment was carried out. I commend Mr C for bringing this complaint to '[protect] others in the future'.

84. To determine whether the care provided by Dr Subramani was reasonable, I considered the independent clinical advice from dentist Dr Angela McKeefry, who reviewed the clinical records and all other relevant information in relation to this complaint. I have

outlined Dr McKeefry's advice for each appointment before discussing my opinion on the care provided to Mr C.

Dental treatment provided

6 December 2021 — initial consultation and first treatment

85. In relation to the initial consultation and first treatment of Mr C on 6 December 2021, Dr McKeefry considered that the treatments and options provided by Dr Subramani to Mr C, given his presenting concerns, were necessary and appropriate. However, she was critical that Dr Subramani reassured Mr C that there would be 'no impact on chewing ability due to the problem tooth being unopposed'.

8 December 2021 — second treatment

86. In relation to Dr Subramani's comments in his clinical records for this date (referred to in paragraph 39 above), Dr McKeefry advised that Dr Subramani's treatment was inappropriate, and standard practice would be to carry out a clinical examination, and sometimes a radiograph would be advisable. Dr McKeefry said:

> 'I would expect if there was a large painful lump an x-ray would have been ideal to ascertain any foreign body or large fractured piece of bone (I assume there would not be any tooth remaining as the clinical notes from 2 days prior said the tooth was whole when extracted).'

87. I also note that Dr Subramani told HDC that he 'was unable to identify any bone pieces on the x-ray either'.

88. In his response to the provisional opinion, Dr Subramani confirmed that no X-ray was taken at this appointment and said that he made the clinical decision not to take one. I am critical that Dr Subramani did not suggest to Mr C that an X-ray be taken on this date, as this may have identified the issue and avoided further pain for him.

89. Dr McKeefry also questioned Dr Subramani's reasoning for not investigating the dry socket as being concern about disturbing the healing. Dr McKeefry explained that the socket is not healing if it is a dry socket. She advised that one of the treatments for a dry socket is to 'numb the patient and probe aggressively to stimulate bleeding and allow for a new blood clot to form', although 'flushing the socket, dressing it with alveogyl and prescribing a course of antibiotics is also an acceptable treatment to provide'.

90. In response to the provisional opinion, Dr Subramani disagreed with Dr McKeefry's method of probing aggressively to stimulate bleeding. Dr Subramani advised that according to the literature,[37] 'it is generally advised not to disturb the socket with aggressive probing. It is recommended that any remaining part of the clot should be retained — aggressive probing risks disturbing this.' Dr Subramani explained that this was

[37] Hupp JR, Tucker MR, and Ellis E, 'Postextraction Patient Management', in *Contemporary Oral and Maxillofacial Surgery* (7th edition) (2018), pp 185–203.

why he followed a more conservative approach to avoid unnecessary disturbance to the healing at the site.

91. Dr McKeefry recognised that often it is the case that where patients present with dry socket, 'they are squeezed into an already busy day and time can be limited'. Dr McKeefry noted that there is no reference in the clinical records to Dr Subramani having provided Mr C with antibiotics on this date, although Mr C said that this did occur.

92. The clinical records contain no script for antibiotics being provided to Mr C at this appointment (8 December 2021). In response to the provisional opinion, Dr Subramani confirmed that he judged them not to be necessary at this appointment, as no clear infection was present. I accept Dr McKeefry's advice that it would have been reasonable to provide antibiotics at this appointment.

93. I also accept Dr McKeefry's advice that the remainder of Dr Subramani's treatment of the dry socket was acceptable.

13 December 2021 — third treatment

94. Dr McKeefry considered that Dr Subramani's treatment at this appointment was appropriate apart from the clinical records, in that the three problem teeth and pain from the extraction are not mentioned (see paragraph 111 below).

23 December 2021 — fourth treatment

95. Dr McKeefry considered that Dr Subramani's treatment at this appointment also seemed 'reasonable' and noted that 'the three teeth which were filled display obvious and significant decay on the radiographs'. However, Dr McKeefry raised concerns about verbal consent for this treatment (see paragraph 115).

14, 22, and 27 January 2022 — fifth, sixth, and seventh treatments respectively

96. I accept Dr McKeefry's advice that the teeth cleaning at the fifth appointment was 'appropriate and justified' by the CPITN[38] probing chart, and the sixth and seventh treatments were 'appropriate'. However, I note her comments regarding the lack of consent and documentation in relation to all three appointments (see paragraphs 117–121 below).

29 January 2022 — eighth and final treatment

97. I accept Dr McKeefry's advice that the one filling done by Dr Subramani at this appointment was 'appropriate'. I note that as the clinical records contain no photographs from the day of treatment, it was not clear to Dr McKeefry whether the gums were too inflamed for treatment of the 'three black cavities' Mr C wanted to be treated. Dr McKeefry advised that 'it is always best practice to have healthy nonbleeding gums prior to doing any restorative treatment'. However, again I note Dr McKeefry's concerns

[38] Community Periodontal Index of Treatment Needs — an overview of a clinical assessment for the presence or absence of periodontal pockets, calculus, and gingival bleeding.

regarding the lack of informed consent and confusing/insufficient notes made by Dr Subramani (see paragraphs 125–127 below).

Informed consent — breach

98. Mr C had the right to receive the information that a reasonable person in his circumstances would expect to receive regarding his treatment, including an explanation of his condition and of the options available to him. Mr C said that he did not understand what treatment had been carried out and was surprised about some of the treatment performed. Whilst I acknowledge that Dr Subramani has told HDC that informed consent was carried out, in my view Dr Subramani did not explain what was happening to Mr C adequately. The clinical records also contain no reference to any discussions about consent. I consider that Mr C received insufficient information about his treatment options to make an informed choice, and therefore I find that Dr Subramani breached Right 6(1)[39] of the Code.

99. It follows that Mr C was not able to give informed consent for the majority of his treatments, and I consider that Dr Subramani failed to meet the requirements of the DCNZ Professional Standards in relation to legally and ethically obtaining a patient's informed consent before providing care. Accordingly, I find that Dr Subramani also breached Right 7(1)[40] of the Code.

Communication and documentation

100. The DCNZ Professional Standards require practitioners to communicate effectively by listening to their patients and considering their preferences and concerns. Practitioners must give patients the information they need or request, in a way they can understand, so that they can make informed decisions, and practitioners must ensure that informed consent remains valid at all times.

101. Dr McKeefry noted that Mr C said that at the initial consultation and first treatment appointment on 6 December 2021, he had a discussion with Dr Subramani around his concern about chewing ability if tooth 46 was extracted, but there is no reference of this in the clinical notes; nor is there reference to advice given about the potential effects of the extraction.

102. Whilst Mr C recollects that Dr Subramani gave advice that the extraction of tooth 46 would not ruin his chewing ability, Dr Subramani's clinical records make no reference to any such discussion, although he told HDC that Mr C was given adequate information about the

[39] 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 …
(e) any other information required by legal, professional, ethical, and other relevant standards …'

[40] 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 provision of this Code provides otherwise.'

procedures he underwent. However, Dr McKeefry advised that regardless of which tooth was being removed, it would be 'extremely unwise to advise a patient' that there would be no impact on chewing ability, and instead the patient should be informed that 'it is or isn't likely to impact chewing', as this would not be clear until the tooth had been removed.

103. Whilst in response to the provisional opinion Dr Subramani provided further information about how he explained clearly to Mr C the impact of extractions on his chewing efficiency, Dr Subramani also stated that he did not 'expressly' say that Mr C's chewing ability would be affected by the extraction, and he acknowledged that he should have been clear about this. Despite Dr Subramani's confidence in saying that he did not tell Mr C that the extraction would not affect his chewing ability due to the absence of opposing teeth, I remain of the view that Mr C understood that his chewing ability would not be affected. I am critical that Dr Subramani did not make fulsome notes or communicate appropriately with Mr C so that he could understand the impact of his tooth being removed and the likely effect on his chewing ability. In not doing so, Dr Subramani failed to give Mr C the information he required to make an informed choice and give informed consent, and I am critical of this.

104. Dr McKeefry advised that whilst the aftercare instructions on the extraction sheet leaflet[41] are appropriate, she considers that the first line, which reads '24 hours after tooth extraction it is important to control the bleeding', is confusing. Dr McKeefry said: 'I would say it is important to control the bleeding straight away, not just 24 hours after [extraction].'

105. The Informed Consent form dated 6 December 2021 signed by Mr C also highlights risks around bleeding. I agree with Dr McKeefry that if both forms were provided, this may have been confusing, and I am critical that this information may not have been clear for Mr C.

106. In relation to the appointment on 8 December 2021 (second treatment), Dr Subramani stated that Mr C had a 'dry socket' at tooth 46 and referred to the treatment noted in the clinical records. However, Dr McKeefry advised that there are 'no notes regarding the patient's symptoms or clinical findings to confirm the patient had a dry socket'.

107. Dr McKeefry also advised that there are no notes about Mr C's main complaint that he believed there was bone in the gum of his cheek, or that he was prescribed antibiotics, as Mr C suggested in his complaint.

108. Dr McKeefry also noted:

> '[Dr Subramani] [c]alling this bone "unwanted" is misleading as what it really is, is a piece of bone that was fractured during the extraction process, which no longer has a blood supply, and the body will expel it in due course.'

[41] Which Dr Subramani told HDC he gave to Mr C on 6 December 2021, although this is not recorded in the clinical notes at the time.

109. I accept Dr McKeefry's advice that the standard of care by Dr Subramani in relation to this second appointment was a mild departure from practice due to the 'less-than-ideal clinical records'.

110. I note Dr McKeefry's comment that Dr Subramani's aftercare instructions for the initial dry socket appointment on 8 December 2021 were appropriate.

111. In relation to Dr Subramani's clinical notes for 13 December 2021 (third treatment), Dr McKeefry described these as 'good'. However, she stated that 'no note is made of the teeth that are [Mr C's] main concern, "the three black ones right in the smile zone"'. Dr McKeefry also referred to Dr Subramani's clinical comment, which stated 'DH -> Exo at [Practice 2] Healing well', and said: 'According to the patient's complaint he still has extreme pain from the lump by the extraction site, no mention is made of this in the exam notes.'

112. I note that Dr Subramani's dental assistant/receptionist said that Mr C 'did express some concern regarding his extraction site', and I consider it more likely than not that this was also raised with Dr Subramani given the information provided by Mr C that at the second treatment on 8 December 2021 he had been reassured that there was nothing to worry about. I am critical that there is no reference to this in the clinical records.

113. Dr McKeefry also noted that Dr Subramani's records show that 'it [was] decided to wait and review in three months time five other teeth with issues' and, whilst Dr Subramani's subsequent 'Reflection' on the clinical notes for this treatment says that this was 'so that the cost can be spread out', it is not clear whether this was Mr C's or Dr Subramani's idea. Dr McKeefry advised:

> '[E]ven though the notes look comprehensive around discussing each problem and the potential treatment, the patient did not fully understand, or he would not have been surprised by the treatments delivered at later appointments.'

114. In relation to the communication log notes provided to HDC by Dr Subramani, I note that the entry dated 14 December 2021 refers to a message left for Mr C asking how he was and providing the surgery number for him to call if he had any trouble. However, as Dr McKeefry advised, there is 'no note of [Mr C] replying, so we don't know "they were doing well with all treatments" as Dr Subramani had previously stated'.

115. Whilst Dr McKeefry advised that Dr Subramani's treatment on 23 December 2021 was reasonable, she noted that 'there is no mention that verbal consent was gained at this appointment to do the treatment'.

116. Dr Subramani told HDC that he recalls giving Mr C 'adequate information about the procedures he underwent' and said that the clinical records show that adhesive restoration was carried out on three of Mr C's teeth, as well as the removal of infected dentin. Dr Subramani noted that Mr C was 'happy' at the end of the treatment.

117. In relation to the appointment on 14 January 2022 (fifth treatment), Mr C's understanding of this appointment was that only his teeth were cleaned, and he showed Dr Subramani the piece of tooth/bone that had finally worked its way out of the inner cheek of his mouth. Dr McKeefry advised that there is no record of this discussion about the tooth/bone in the clinical notes. Dr McKeefry found this 'unusual since there have been previous notes about the problem this was causing in the past'.

118. Dr McKeefry also stated:

> 'This is also the appointment Dr Subramani records prescribing the antibiotics for a toothache on the opposite side to where the extraction occurred. The notes only record the type of antibiotic, but not the dose or duration which is insufficient.'

119. I note that Dr Subramani provided HDC with a screenshot of a patient script for this date,[42] which contains no patient details. Dr McKeefry advised that there is an issue with this script in that Dr Subramani prescribed 20 capsules, but on his calculations for the instructions, this accounted for 16 capsules, and so there were four unnecessarily prescribed capsules. It is concerning that Dr Subramani did not calculate the correct amount of medication required in line with the instructions on the script.

120. I note Dr McKeefry's advice for the appointment on 22 January 2022 (sixth treatment) that there is no mention in the clinical records of verbal consent from Mr C prior to the fillings being done.

121. I have also considered Dr McKeefry's advice regarding the appointment on 27 January 2022 (seventh treatment) and note her comment that again there is no mention of verbal consent prior to the treatment being carried out. Dr McKeefry stated:

> '[This is] because [Mr C] clearly didn't understand what was going to happen until after he got home, and the numbness wore off. Then he was surprised by what had been completed.'

122. Again, Dr Subramani's general response to HDC was that he provided Mr C with adequate information about the procedures he underwent. However, Dr McKeefry's advice highlights that there is no reference to discussions that took place and verbal consent being obtained from Mr C for either of the treatments on 22 and 27 January 2022.

123. I note that Mr C's recollection of the discussion on 29 January 2022 is that he raised concern with Dr Subramani about being unaware that a 'cap'[43] had been placed on his tooth on 27 January 2022. Mr C also recalled that he told Dr Subramani that he did not want any further cosmetic work going forward, only the three black cavities in the 'smile zone' (see paragraph 64 above). Dr Subramani confirmed to him that he would finish all his fillings at the next appointment.

[42] 14 January 2022.
[43] Which Dr Subramani subsequently advised was in fact a 'composite filling'.

124. However, Dr Subramani recorded in the clinical records that on 22 and 27 January 2022 he carried out various treatments on Mr C (as detailed in paragraphs 59 and 61 above). Having regard to all the evidence before me, I consider it more likely than not that Mr C did not provide consent for the specific treatment provided on 14, 22, and 27 January 2022, and the lack of information in the notes supports this. I am extremely critical that adequate informed consent for the treatment provided was not obtained by Dr Subramani.

125. Dr McKeefry advised that for the eighth and final appointment on 29 January 2022, there is no mention in the clinical records of Mr C's complaint to Dr Subramani that he had not understood that a 'cap' was going to be placed on the front tooth at the previous appointment. Dr McKeefry stated:

> 'I would expect notes about this and then for Dr Subramani to be extra certain [Mr C] understood what was going to happen at this appointment, which clearly, he didn't as [Mr C] came away surprised and disappointed.'

126. Dr McKeefry also advised that Dr Subramani's clinical notes for the final appointment on 29 January 2024 are hard to understand. Dr McKeefry said she assumed that Dr Subramani's notes of '23 Distal & (24 since gum was bleeding during the filling procedure) mesial Defective filling recheck in 3 months' alluded to fillings that Mr C wanted done, which Dr Subramani stated could not be done because Mr C's gums were bleeding. However, Dr McKeefry advised:

> '[T]his only mentions two teeth and the patient was talking about three black cavities. The other issue is the 24 restoration was done by Dr Subramani on 22/01/2022, so could not be one of the three the patient still wanted completing.'

127. Dr McKeefry said that she failed to understand 'why the gums were healthy enough to do the other eight fillings and not the three the patient really wanted doing'. Again, she emphasised that Dr Subramani's clinical notes were not clear enough and stated:

> '[Mr C] wanted three specific teeth fixed and nowhere in the clinical notes was this noted. There was no specific diagnosis of these teeth or a summary of the discussion around them. There was no real clear explanation of why these teeth weren't treated, just a vague reference to tooth 23 and bleeding gums. I fail to see how the gums were healthy enough to restore the other eight fillings and not these three.'

128. I accept Dr McKeefry's advice and am critical that Dr Subramani's communication was inappropriate and the information in the clinical notes was incomplete, not clear, and confusing. I am also critical that again the clinical notes for this appointment contain no reference to verbal consent having been obtained from Mr C prior to the fillings being done. In my view, there is no evidence to demonstrate that consent was given.

129. Dr McKeefry advised that the standard of care provided by Dr Subramani to Mr C represents a moderate to severe departure from the accepted standard of care. Dr McKeefry stated:

> 'While Dr Subramani completed the treatments he felt were in the best interest of the patient, he failed to obtain proper informed consent. Clearly the discussions held at the examination appointment 13/12/2021 were insufficient as the patient was not expecting the treatment he received. There [were] also second chances to obtain informed consent at each subsequent treatment appointment which Dr Subramani failed to do, even after [Mr C] raised this with him directly …
>
> If the patient did consent or at least failed to raise issues with Dr Subramani then the departure from the standard of care is mild to moderate due to less-than-optimal clinical notes and a possible failure to ensure continued informed consent across all appointments.'

130. I note that whilst Dr McKeefry considers that Dr Subramani 'failed to obtain proper informed consent', HDC must reach its own conclusions on whether there was informed consent based on the evidence.

131. I also note Dr McKeefry's comment that Dr Subramani's clinical notes are not as complete as the notes provided to HDC once he was aware of the complaint. Dr McKeefry gave examples of this[44] and, in relation to Mr C's concern that his fillings were not prioritised in Dr Subramani's response to HDC, she stated:

> 'Dr Subramani talks about his treatment plan process, discussing with the patient about future prevention and prioritizing "the urgent things first, followed by the less urgent things, until we have gone through the plan". This is all very appropriate except there is no mention of the patient's chief complaints or what he wanted prioritized. If you don't think the patient is making a wise decision, you should try and educate them as to why, document these discussions and record the agreed upon outcome. It seems Dr Subramani decided what was best for [Mr C] and went ahead and did this, possibly without [Mr C] fully understanding/consenting.'

132. In relation to the aftercare provided, I note that Dr Subramani stated that at the initial appointment on 6 December 2021 he provided Mr C with aftercare instructions for extractions. The clinical records also show that Dr Subramani provided Mr C with aftercare advice for the dry socket on 8 December 2021. Other than at these appointments, there seems to have been little other postoperative instruction given by Dr Subramani for any of the filling or scaling appointments. I agree with Dr McKeefry that this was inadequate.

[44] Dr Subramani subsequently told HDC that '[Mr C] said a piece of bone came out to us'. There is no mention of this in the contemporaneous notes. Dr Subramani also stated: '[W]e call all patients (including [Mr C]) after the day of the appointment to see how they are doing after the dental treatment and whether they have any concerns or any questions staff did call [Mr C] he was doing well with all treatments.' There is also no mention of any of these calls in the clinical notes.

133. Dr McKeefry advised that appropriate information on what to expect, and how to care for himself following any clinical treatment, should have been provided to Mr C and recorded in the clinical notes. Dr McKeefry considers this to have been a mild departure from the standard of care. I agree with her advice and am critical that this was not done for the majority of Mr C's appointments.

134. Dr Subramani told HDC that as with all patients, follow-up calls were made to Mr C on the day after appointments to see how he was doing after the dental treatment and to check whether there were any concerns or questions. Dr Subramani stated that staff said that Mr C was 'doing well with all treatments'.

135. However, as Dr McKeefry noted, there is no mention of any of these calls or discussions in the contemporaneous clinical notes other than the unanswered call on 14 December 2021 when a message was left. I consider that Dr Subramani had overall responsibility to ensure that these calls were made and noted in the clinical records, and I am critical that he did not do so.

136. I also note that in Dr Subramani's response to the provisional opinion, he stated that he discussed all components of the treatment plan thoroughly with his clinical supervisor and adhered closely to the advice and guidance provided. However, there is also no reference to these discussions in the clinical notes.

Conclusion

137. It is clear that Mr C and Dr Subramani have differing recollections of events, and some time has elapsed since the treatments took place.

138. Dr Subramani's clinical notes lack information, and although he has since provided further information in his response to HDC, it has been difficult to determine exactly what took place. However, I have reached my decision based on all the available evidence and the advice received from Dr McKeefry.

Care provided to Mr C — breach

139. Dr Subramani had a responsibility to provide services to Mr C with reasonable care and skill. I consider that Dr Subramani did not do this, for the following reasons:

- On 6 December 2021 Dr Subramani failed to provide appropriate advice to Mr C about the potential effects on his chewing ability prior to extracting tooth 46.
- On 8 December 2021 Dr Subramani failed to carry out a clinical examination or suggest that an X-ray be done for Mr C in relation to his concern over the large painful lump in his cheek.
- On 8 December 2021 Dr Subramani failed to provide appropriate advice or treatment for Mr C's dry socket.

140. Accordingly, I find that Dr Subramani breached Right 4(1)[45] of the Code.

Communication — breach

141. I consider that Dr Subramani failed to communicate effectively with Mr C and did not meet the requirements set out in the DCNZ Professional Standards to put a patient first and always treat patients with dignity and respect, for the following reasons:

- Dr Subramani failed to be sensitive to Mr C's preferences and concerns, including prioritising the needs of the work he wanted done on his teeth.
- Dr Subramani failed to provide appropriate aftercare instructions to Mr C after the majority of the filling or scaling appointments or ensure that follow-up calls after treatments were made.

142. Accordingly, I find that Dr Subramani breached Right 4(2)[46] of the Code.

Clinical documentation — breach

143. Dr Subramani did not comply with his professional responsibility to keep adequate records. I consider that Dr Subramani did not meet the requirements outlined in the DCNZ Professional Standards in relation to safe practice by failing to maintain accurate, time-bound, and up-to-date patient records for the following reasons:

- Dr Subramani failed to make appropriate notes regarding Mr C's concerns/symptoms and what discussions took place at the treatment appointments on 6, 8, and 13 December 2021, and 14, 27, and 29 January 2022.
- Dr Subramani failed to make appropriate notes regarding his clinical findings at the treatment appointments for Mr C on 8 December 2021, and 14 and 29 January 2022.
- Dr Subramani failed to record accurate information on 14 January 2021 by not noting in the clinical records that antibiotics had been prescribed for a toothache on the opposite side to where the extraction occurred, not stating the correct number of capsules on the script for the antibiotics, and not including the patient details on the script.
- Dr Subramani failed to record whether verbal consent was obtained at the treatment appointments on 13 and 23 December 2021, and 22, 27, and 29 January 2022.
- Dr Subramani failed to record whether any aftercare instructions were provided post treatment after any of the filling or scaling appointments.
- Dr Subramani failed to ensure that post-treatment follow-up calls with Mr C were recorded after all appointments.

144. Accordingly, I find that Dr Subramani breached Right 4(2) of the Code.

[45] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[46] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

Care provided to Mr B — breach

Treatment provided

145. On 4 April 2018 Mr B, aged 35 years at the time of treatment, first visited Dr Subramani at Practice 1. The clinical records for the treatments referred to below were provided by Practice 1.

4 April 2018 — initial consultation and first treatment

146. Mr B told HDC that he needed to see a dentist urgently as he believed a filling had fallen out and he was in some pain. Mr B said that he arranged to see Dr Subramani as he was the only dentist available at short notice.

147. Mr B stated that whilst only one tooth had been bothering him, which Dr Subramani fixed, three other teeth on the same side of his mouth were 'worked on', which Dr Subramani told him required attention. Mr B said that Dr Subramani also made a 'type of mouthguard', which Dr Subramani said was required, at a total cost of $1,300.00.[47]

148. Dr Subramani's clinical records for this treatment note that Mr B had a 'dull ache all the time', a 'cracked tooth', and was a 'grinder'. Dr Subramani took X-rays and carried out three composite fillings[48] for teeth 16, 14, and 17, as well as 'Splints for Bruxism[49]'.

149. Dr Subramani told HDC that the dull ache related to the 'upper right top teeth region' and the cracked tooth was on 'the right side of the top teeth', although these specific areas do not appear to be noted in the clinical records. Dr Subramani recorded that he prescribed Mr B Codalgin[50] and metronidazole[51] and that a 'post night guard'[52] should be sent to Mr B's address.

150. In his response to Dr McKeefry's advice, Dr Subramani apologised for having not recorded in the clinical notes his detailed reasoning for his diagnosis of Mr B's grinding of his teeth.

151. In relation to the Codalgin and metronidazole prescribed at this appointment, Dr Subramani told HDC: '[T]he prescription was made as a backup if the tooth which had filling plays up or goes non vital; as the patient lives in remote area 2 hours 30 minutes from the dental clinic.' Dr Subramani said that he advised Mr B of this. However, this advice is not recorded in the clinical notes from Practice 1, and instead it was documented for Mr B to take the Codalgin every four hours as needed, and the metronidazole every eight hours with a note for him to finish the full course.

[47] The clinical records show a total payment of $1,321.00 for the first treatment on 4 April 2018.
[48] A filling made of a mixture of powered glass and resin designed to match the colour of the teeth.
[49] The habit of unconsciously gritting or grinding the teeth, especially in situations of stress or during sleep.
[50] Paracetamol 500mg and codeine phosphate 8mg.
[51] Metronidazole 200mg (an antibiotic used to treat bacterial infections).
[52] An appliance that covers the teeth and the upper and lower dental arches of the mouth to provide protection from teeth grinding.

152. Dr Subramani told HDC that he was able to relay detailed information regarding his diagnosis of Mr B being a 'grinder' five years on after seeing the documented evidence in the clinical records, namely: 'Enamel wear pattern can be seen on the PA[53] of the anterior teeth; Parafunctional[54] habit wear has similar effect on the teeth and filling.'

153. Dr McKeefry reviewed the X-rays provided to HDC by Dr Subramani and advised that these are of poor quality. In response, Dr Subramani accepted that the X-rays are of 'inferior quality' and told HDC that 'the sensors were scratched and one of the sensors was not put through the [X-]ray scanner. Due to that the x-ray appears as being double exposed.'

154. In response to the provisional opinion, Dr Subramani provided further clarification in relation to the quality of the X-ray, stating:

> 'The inferior quality of the X-rays was due to a technical issue where, on occasion, the repeat X-ray image was taken and displayed on the scanner but did not save correctly to the software. This issue occurred when the image was displaced on the scanner. This system problem was present at the time when I was working with [Practice 1]. I also informed [Practice 1] management about this issue at that time.'

155. In response to the provisional opinion, Dr Subramani also stated that he acknowledged the importance of maintaining high-quality diagnostic images and explained that the reason for the missing X-ray on this occasion was due to the images 'not being stored properly in the system'.

156. Mr B stated that at this appointment (4 April 2018) Dr Subramani informed him that he required more fillings on the other side of his mouth and could book in for this in two weeks' time and quoted $400.00 for the treatment. Mr B said he decided to go ahead with this proposed treatment so that his teeth 'would be all sorted for a long time'.

157. Dr Subramani told HDC that his rationale behind the proposed treatment for Mr B was 'tooth conservative care and to sequence that care to improve outcomes for the patient and to address the most urgent problems first'. In response to the complaint, Dr Subramani provided HDC with a copy of the proposed treatment plan for Mr B, which is included as Appendix C.

158. Dr Subramani also provided typed educational information titled 'The Ultimate Guide to TMJD[55] for Patients'. He told HDC that he gave this to Mr B at the time of the appointment and obtained verbal consent.

17 April 2018 — second treatment

159. Mr B stated that despite quoting him $400.00 for the treatment on 4 April 2018, at this appointment Dr Subramani charged him $1,400.00.[56] Mr B said that after the

[53] Periapical X-ray (which shows the whole tooth, including the root and the area around it).
[54] An abnormal function, for example unconscious teeth grinding.
[55] Temporomandibular joint (located where the jawbone connects to the skull (in front of the ears). Common complaints include teeth grinding and damage to the teeth (from grinding and clenching).

appointment, Dr Subramani advised him that he should return to get the enamel of his teeth re-done, which Mr B suggested Dr Subramani had gone 'around [his] mouth grinding off'.

160. Dr Subramani's clinical records for this date (17 April 2018) document that an examination, X-rays, full mouth scale and polish, and five composite fillings for teeth 37, 27, 24, 25, and 44 were carried out for Mr B. Dr Subramani also noted: '[G]eneralised chronic marginal gingivitis with generalised tobacco stains. Adv[ised] p[atien]t full mouth scale and polish. Informed consent taken.'

161. The clinical records show that Dr Subramani gave the following advice to Mr B at this second treatment:

> '[Patient] advised to brush 3 x daily with quality fluoride toothpaste and a very soft brush. better to brush more regularly with gentle brushing than once or twice hard.
>
> Advised flossing/tepes[57] and to attend regularly to maintain periodontium.[58]
>
> P[atien]t advised that they have to maintain mouth in between visits and tca[59] if any bleeding/discomfort as gum cannot grow back.'

162. Dr Subramani also recorded in the clinical records that he 'gave post-op oral hygiene instructions' to Mr B. Dr Subramani told HDC that he also provided verbal and typed educational information to Mr B at the time of the appointment, namely 'Information sheets for patients receiving resin composite restorations for treatment of tooth wear …'. However, Dr Subramani acknowledged that this was not documented and apologised for this.

163. Dr Subramani told HDC that he considered that '[a]ll fillings were necessary, additionally anterior fillings and other fillings planned was one of the options to protect the tooth structure'. He stated that the first option given to Mr B was 'no treatment'.

164. In relation to the treatment estimates, Dr Subramani told HDC that these were printed out and given to Mr B during the examination appointment, and the 'patient knew the plan'.

Other information

165. On 22 January 2019 Mr B advised Practice 1 that since his treatment with Dr Subramani in April 2018 he had had ongoing pain on the side of his mouth. Practice 1 offered a consultation to address this. On 9 February 2022, after reading about Dr Subramani's poor

[56] The clinical records show that the total paid for the second treatment on 17 April 2018 was $1,425.00.
[57] Small brushes designed to clean the gaps between the teeth.
[58] The supporting structures of the teeth.
[59] Trichloracetic acid — a chemical used to stop minor bleeding in the oral cavity.

dentistry in the media,[60] Mr B contacted Practice 1 again to complain about the dental treatment he had received. In his email, Mr B stated:

> 'I have had nothing but trouble since he did this work in 2018, spent thousands of dollars, seen [four] different dentists at different times resulting in [two] of the teeth he worked on ultimately being removed.'

Changes made since events

166. Dr Subramani told HDC that he would provide '[a] more thorough explanation of the treatment plan and advantages/disadvantages of each option, so the patient understands it without any doubts'.

167. Dr Subramani also told HDC that he had attended the following training sessions since the complaint:

- 7 continuing professional development courses
- The 'When is a consent form not enough' Dental Protection course
- A Dental Protection Dental Records course to improve his record-keeping
- A course on creative composite solutions
- A splint course

Responses to provisional opinion

Mr B

168. Mr B was given an opportunity to respond to the 'Complaint and Investigation', 'Changes made since events' and 'Further information and DCNZ involvement' sections of the provisional opinion and stated he had nothing further to add.

Dr Subramani

169. Dr Subramani was given an opportunity to respond to the provisional opinion and his comments have been incorporated into this opinion where relevant and appropriate.

170. Dr Subramani stated that when he was practising at Practice 1, the signed consent forms and patient information leaflets were saved under the contact section of Exact.[61]

Opinion

171. Mr B visited Dr Subramani for two appointments, on 4 and 17 April 2018. First, I acknowledge the difficulties Mr B encountered following the treatment by Dr Subramani, which resulted in further expense to him. I commend Mr B for bringing this complaint to HDC's attention.

[60] https://www.stuff.co.nz/national/127649238/dentist-botched-work-charged-excessive-fees-put-a-filling-in-perfect-tooth-tribunal-hears
[61] Dental software.

172. To determine whether the care provided by Dr Subramani was reasonable, I considered the independent clinical advice of dentist Dr Angela McKeefry, who reviewed the clinical records from Practice 1 and all other information relevant to this complaint.

Dental treatment provided

4 April 2018 — initial consultation and first treatment

173. In relation to the initial consultation and first treatment of Mr B on 4 April 2018, Dr McKeefry advised that the X-rays taken for this appointment 'are of poor quality, and it is impossible to tell from them alone what treatment needed doing'. I note that Dr Subramani acknowledged that the X-rays are of 'inferior quality'. Whilst Dr Subramani has since stated that he informed Practice 1 management about this issue at the time, nonetheless it is concerning that he knew about this issue and yet chose to continue to diagnose and treat Mr B using poor quality X-rays, and I am critical of this.

174. Dr McKeefry provided further advice around Dr Subramani's poor clinical records, which I have referred to in paragraphs 183–184 below. Dr McKeefry advised that because the clinical records fall so far short of the required standard, she cannot say whether or not the treatments provided by Dr Subramani at this appointment were appropriate.

175. Dr McKeefry also advised that there is no indication from the clinical records to justify a prescription for the pain relief and antibiotics prescribed by Dr Subramani on 4 April 2018, and she considers this to be a severe departure from accepted practice.

176. Dr Subramani told HDC that he prescribed the medication to Mr B on 4 April 2018 only as a back-up due to the distance of Mr B's home from Practice 1's practice, and he advised Mr B not to take the medication unless it was necessary. However, this is not documented anywhere in the clinical records, and in fact the records note that Mr B was advised to take two tablets of Codalgin every four hours as needed and to take one tablet of metronidazole with food every eight hours and to finish the full course. I note that Mr B has not provided comment on this aspect of his care.

177. The information in the clinical records differs from that provided by Dr Subramani five years later, and I am minded to rely more on the contemporaneous clinical records, which clearly state that the medication was to be taken immediately. I accept Dr McKeefry's advice that prescribing antibiotics with no stated reason in the clinical records is a severe departure from accepted practice.

17 April 2018 — second treatment

178. In relation to the second treatment of Mr B on 17 April 2018, Dr McKeefry noted: 'Mr B thought this appointment was for $400 of fillings. It turned out to be an exam, scale and polish plus five fillings for $1425.'

179. Dr McKeefry advised that she could only presume that the bite splint was also fitted at this appointment, because again there are no notes in the clinical records to clarify this. Dr McKeefry said that Dr Subramani's treatment would be viewed very poorly by her

peers. She stated: '[I]f it turned out some or all of the fillings were unnecessary, then our peers would be absolutely shocked.'

180. Dr McKeefry was asked whether the recommendations made by Dr Subramani to Mr B regarding his diagnosed 'generalised gingivitis' were appropriate. Dr McKeefry advised that it was not possible to make an accurate diagnosis as there were no periodontal probing depths charted. Dr McKeefry confirmed that the advice around gentle soft brushing was correct and that the postoperative oral hygiene instructions were good. However, Dr McKeefry advised that it would have been better for Dr Subramani to have suggested flossing once a day rather than just saying 'regularly', and that the three-month review seemed 'excessive' if Mr B had only generalised gingivitis.[62]

181. Dr McKeefry advised that '[n]ot recording any pocket probing depths on a patient who had a "foul smell from the mouth for the past week" and [Dr Subramani] then diagnos[ing] [Mr B] with generalized gingivitis' would be viewed poorly by her peers, especially for an adult smoker. Dr McKeefry considered that this was a moderate departure from the standard of care, and I accept this advice.

182. Dr McKeefry considered that there was no departure by Dr Subramani in not raising the defective/worn fillings and defective tooth structure until the second appointment on 17 April 2018, provided 'there was better communication than indicated in the clinical notes'. Dr McKeefry stated:

> 'It is normal to see a patient for relief of pain and then get them to return for a thorough examination. It is less usual to get them to return for that, a full mouth scale and polish, five fillings and a bite splint fit. However in this case the patient did have to travel [a considerable distance] so perhaps this is why.'

Communication and documentation

183. In relation to the clinical records completed at the treatment on 4 April 2018, Dr McKeefry advised:

> 'The clinical records are also very poor not specifying the severity or history of the symptoms. The notes say the tooth chipped due to grinding, but how does Dr Subramani know this? He states the patient is a grinder but gives no real reason for this diagnosis. He doesn't explain the size of the chip (which can't be seen on the poor x-rays) or why he has to place a four-surface filling (when from the x-ray, the tooth seems previously unrestored, but again, they are hard to read).'

184. Dr McKeefry advised that the clinical records for the appointment on 17 April 2018 were also insufficient and described them as 'terrible'.

185. Dr Subramani acknowledged that he failed to record his detailed reasoning for diagnosing Mr B as a 'Grinder', or to record that he gave postoperative care instructions to Mr B, and

[62] The normal recall period would be six months.

Dr Subramani apologised for this. Having regard to Dr McKeefry's advice, I consider it more likely than not that this information was not given to Mr B.

186. I accept Dr McKeefry's advice that Dr Subramani's clinical records are inadequate and lacking in detail. He had a responsibility to ensure that his clinical records were robust and supported his clinical view, but clearly this was lacking. I am critical of this and accept Dr McKeefry's view that this is a severe departure from accepted practice.

187. In relation to Mr B's concerns over the cost of the treatment, Dr McKeefry advised that this fell within the range for the region and, as such, there was no departure from accepted practice.

Informed consent

188. In relation to the communication on 17 April 2018, Mr B stated that Dr Subramani had given him an estimate of $400.00 for the treatment, but the total cost was $1,425.00. This was substantially more than Mr B had been expecting, and I agree with Dr McKeefry's advice that '[i]t would certainly not be appropriate to give a $400 estimate and then charge $1425 without further consultation and notes about why'.

189. Dr McKeefry advised that whilst Dr Subramani stated that Mr B was told about risks and benefits verbally, and he signed a consent form for both appointments, no signed consent forms have been provided for either appointment on 4 or 17 April 2018. Dr McKeefry noted that the only reference to consent in the original clinical records received from Practice 1 is for the treatment on 17 April 2018, which stated '… informed consent taken', which appears to be for the scale and polish.

190. I note that in Dr Subramani's response to the provisional opinion, he stated that signed consent forms and patient information leaflets were saved under the contact section of Practice 1's dental software. However, Practice 1 was asked by HDC for all clinical records, specifically consent forms, and no consent forms were provided.

191. It is not clear whether Dr Subramani obtained informed consent from Mr B for all treatments on 4 and 17 April 2018 due to Dr Subramani's poor record-keeping and lack of detailed notes, and I note that Mr B has not provided comment on this. I accept Dr McKeefry's advice that as a result, this is a severe departure from accepted practice. In my view, a reasonable consumer in Mr B's circumstances would have expected to understand why the treatment was being provided and be given all appropriate options available, as well as a realistic estimate of the cost of the work to be carried out. Informed consent is an important part of the treatment process, and I am critical that Dr Subramani did not give Mr B appropriate information for him to make an informed choice to give consent for the treatment.

Post-treatment care and follow-up

192. When asked whether the aftercare instructions and follow-up by Dr Subramani was appropriate, Dr McKeefry referred to a three-sided document provided by Dr Subramani of

supposed verbal discussions around temporomandibular joint disorder (TMJD)[63] had with Mr B at the 17 April 2018 treatment. Dr McKeefry advised: 'This is only mentioned five years later and not in the clinical notes of 2018. Given there was no diagnosis of TMJD, this doesn't seem overly useful.'

193. In terms of the document for patients receiving resin composite restorations for treatment of tooth wear, which Dr Subramani told HDC he gave to Mr B, Dr McKeefry advised:

> 'While this is useful for [Mr B] to decide if he want[ed] that treatment or not, it doesn't give him any information regarding the fillings he actually had, i.e. no discussion around taking care not to bite your lips/cheeks/tongue while still numb, or to return if any of the fillings feel too high once the numbness wears off, or that some temperature sensitivity for a few weeks can be normal following fillings.'

194. Dr McKeefry stated that patients need to be advised on 'what to expect following treatment, how to care for themselves post treatment and when to return if there are any problems', and that '[t]his should all be documented'.

195. Mr B's complaint makes no mention of having received any post-treatment care and follow-up instructions from Dr Subramani. It is not clear from Dr Subramani's clinical records at the time of the treatments that post-treatment care and appropriate follow-up instructions were given to Mr B. I consider it more likely than not that this was not provided to Mr B at the time, and I am critical of this. Dr McKeefry advised that Dr Subramani's failure to do this was a moderate departure from the standard of care, and I accept this advice.

Conclusion

Care provided to Mr B — breach

196. Dr Subramani had a responsibility to provide services to Mr B with reasonable care and skill. I consider that Dr Subramani did not do this for the following reasons:

- Dr Subramani relied on poor quality X-rays to diagnose and treat Mr B on 4 and 17 April 2018.
- Dr Subramani failed to provide any reasoning for prescribing antibiotics to Mr B on 4 April 2018.
- Dr Subramani failed to provide an accurate diagnosis of generalised gingivitis for Mr B, as Dr Subramani did not chart the periodontal probing depths (where clinical attachment loss would have been able to be ascertained).
- Dr Subramani failed to provide appropriate advice to Mr B after the fillings undertaken on 17 April 2018.

[63] A condition that can cause pain and tenderness in the jaw joints and in the surrounding muscles that control jaw movement.

197. Accordingly, I find that Dr Subramani failed to provide services to Mr B with reasonable care and skill and breached Right 4(1)[64] of the Code.

Clinical documentation — breach

198. Adequate documentation is an integral part of clinical practice, and Dr Subramani's clinical notes lack information. In my view, Dr Subramani's deficient clinical documentation did not meet DCNZ's professional standards in relation to ensuring safe practice by maintaining accurate, time-bound, and up-to-date patient records, for the following reasons:

- Dr Subramani failed to make comprehensive or appropriate notes by not specifying the severity or history of Mr B's symptoms on 4 April 2018.
- Dr Subramani failed to document the reasoning behind his diagnosis that Mr B was a 'teeth grinder'.
- Dr Subramani failed to document his reasoning and justification for the treatment carried out, and medication prescribed, on 4 April 2018.
- Dr Subramani failed to note that a bite splint was fitted at the appointment on 17 April 2018.
- Dr Subramani failed to make accurate records of why the charge for the treatment on 17 April 2018 had increased substantially from the estimate provided on 4 April 2018.
- Dr Subramani failed to record any periodontal pocket probing depths.
- Dr Subramani failed to record whether verbal consent was obtained at the treatment appointments on 4 and 17 April 2018.
- Dr Subramani failed to record the post-treatment advice he stated was given to Mr B on 4 and 17 April 2018.

199. Accordingly, I find that Dr Subramani breached Right 4(2)[65] of the Code.

Informed consent — breach

200. In the absence of evidence to demonstrate otherwise, I find that Dr Subramani failed to provide Mr B with information that a reasonable consumer in his circumstances would expect to receive regarding his treatment, including failing to provide explanations for the treatments carried out on 4 and 17 April 2018 and failing to provide reasoning for the increase in cost of treatment for the appointment on 17 April 2018, which was substantially more than the estimate provided to Mr B. It also appears that no consent forms were provided to HDC for the 4 and 17 April 2018 appointments, only reference to a discussion around consent for the scale and polish treatment on 17 April 2018. I consider that Mr B had insufficient information about the treatment being provided and the options

[64] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[65] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

available and the cost of these, and therefore I find that Dr Subramani breached Right 6(1)[66] of the Code.

201. It follows that Mr B was not able to give informed consent for the majority of his treatments, and I consider that Dr Subramani failed to meet the requirements of the DCNZ Professional Standards in relation to legally and ethically obtaining a patient's informed consent before providing care. Accordingly, I find that Dr Subramani also breached Right 7(1)[67] of the Code.

Care provided to Ms A — breach

Treatment provided

202. During the period 23 March 2018 to 4 April 2018, Ms A, aged 75 years at the time, visited Dr Subramani at Practice 1 for dental treatment. The clinical records referred to below were provided by Practice 1.

Initial consultation

23 March 2018 — first consultation and treatment

203. Ms A told HDC that she had had a lot of pain and so attended for a consultation and treatment with Dr Subramani at Practice 1 on 23 March 2018. Ms A said that at this visit she had an extraction of tooth 18.[68]

204. Dr Subramani told HDC that his rationale behind the proposed course of treatment following his findings on examination at this appointment 'led to 28 tooth diagnosis as pulp necrosis[69] with apical periodontitis[70]' and teeth 24 and 26 requiring fillings.

205. Dr Subramani said that at the time, he gave Ms A treatment options for the pain in tooth 18, namely, no treatment, extraction, or root canal treatment, and for the fillings the options of no treatment or placement of fillings. Dr Subramani stated that Ms A considered the options and chose tooth extraction and for fillings to be undertaken whilst she was anaesthetised for the extraction of tooth 28.

[66] 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 —
(c) an explanation of his or her condition; and
(d) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and …
(e) any other information required by legal, professional, ethical, and other relevant standards …'

[67] 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 provision of this Code provides otherwise.'

[68] Whilst Ms A stated that tooth 18 was extracted, Dr Subramani stated that it was tooth 28.

[69] An irreversible condition that occurs when the soft pulp tissue inside a tooth dies.

[70] Inflammation of the periodontium — the tissue that surrounds teeth.

206. Ms A told HDC that after the extraction, she was given a treatment plan by Dr Subramani and he informed her, '[Y]ou grind your teeth,' and told her that she needed something for this. Ms A said she informed Dr Subramani that she did not grind her teeth, but he said, 'I can tell you grind your teeth,' and was quite insistent. Ms A stated that Dr Subramani said he would make a fixture for her, and she described him as 'very confrontational'.

207. Dr Subramani's clinical notes of his discussion with Ms A state:

> '[T]ooth pain just o[n]g[o]ing tooth aches on top teeth, taken Panadol and this morning early and take some just now, twice a day brushing doesn't floss. Haven't been able to clean teeth properly bec[aus]e it hurts so much.'

208. Dr Subramani recorded that on this date he carried out an X-ray, extraction of tooth 28, and composite fillings of teeth 24 and 26. The clinical records also note that Ms A was prescribed Amoxil[71] and Codalgin[72] at this appointment.

209. In response to Dr McKeefry's advice, Dr Subramani acknowledged that he did have a discussion with Ms A regarding 'parafunctional[73] habits' and seeing wear signs in her teeth. Dr Subramani recognised that perhaps he did not frame the question correctly to Ms A and apologised for this.

4 April 2018 — second treatment

210. On 4 April 2018 Ms A returned to see Dr Subramani at Practice 1 for a scale and polish. Dr Subramani's clinical records are attached as Appendix E. The notes completed by Dr Subramani confirm the treatment as a 'Scale & Polish' and four composite fillings for teeth 27, 36, 14, and 15.

211. In response to the provisional opinion, Ms A noted that she had arranged an appointment for fillings, not 'for a scale and polish'. Ms A also stated:

> 'When I first sat down in the treatment room I noticed another lady at reception and a discussion took place. I realised there had been a double booking. When Dr Subramani reentered the treatment room he said [t]he fillings would be done at a later date and today he would just do a clean. He proceeded to prepare for that.'

212. Dr Subramani told HDC that he carried out a clinical examination and discussed the following findings and options with Ms A:

> 'Staining present lingual lower incisors and mild gingivitis — so the treatment options given, included no treatment or scaling or scaling with [airflow polisher].

[71] An antibiotic, with the instructions: '500mg capsules, SEND: 16, LABEL: Take 2 caps to start then 1 every 8 hours, until finished.'
[72] A painkiller, with the instructions: 'Paracetamol 500mg & Codeine Phosphate 8mg, TAKE 2 TABLETS EVERY FOUR HOURS, AS NEEDED, SEND: 12.'
[73] Repetitive behaviour that targets the oral structures.

Other restorative treatments, so the treatment options given, included no treatment or repairs.'

213. Dr Subramani said that Ms A considered these options and chose scaling with air polishing, and he informed her of the possible risks and benefits[74] prior to the treatment. Dr Subramani told HDC that he received Ms A's 'verbal consent' for the treatment.

214. In response to the provisional opinion, Ms A stated that Dr Subramani did not offer any options of treatment at any point. Ms A also advised that she did not choose to have scaling with air polishing, was not informed of the risks or benefits, and subsequently did not give her verbal consent for this treatment.

215. Ms A told HDC that Dr Subramani took an X-ray and tried to polish her teeth using the airflow polisher, but it slipped and pierced the tissue of her cheek. She said that she 'shot upright and could not breathe,' and it felt like a 'choking sensation', which caused her throat, cheek, and neck to swell.

216. Ms A stated that after this happened, Dr Subramani went to speak to his assistant, and another assistant stood by looking 'shocked'. She said that she started to hyperventilate,[75] at which time Dr Subramani turned off the lights in the treatment room and left her there on her own for a few moments and then returned. Ms A told HDC that by this time, she felt flushed, and Dr Subramani asked her if he could call an ambulance for her, which he did.

217. In response to the provisional opinion, Ms A stated that when Dr Subramani turned off the lights in the treatment room, there was light from a window. However, she stated that he 'did withdraw from the room, as did his two assistants and closed the door' leaving her alone.

218. Ms A said that she tried to lie back and breathe whilst Dr Subramani called an emergency contact, who arrived at Practice 1 within a short time. The contact took Ms A to the Accident and Emergency Department (A&E). Ms A said that when she left, the Practice 1 receptionist looked 'shocked'.

219. In response to the provisional opinion, Ms A also advised that when Dr Subramani re-entered the room, he asked her if she was all right, at which point she replied 'No'. Ms A said that Dr Subramani then said she could call an ambulance or a friend, but he did use the phone. Ms A clarified that it was Dr Subramani's receptionist who called her friend, and that Dr Subramani went back into the treatment room with his next patient, whilst

[74] 'Risks[:] There is a risk of sensitivity. Sodium Bicarbonate powder may cause damage to the hard and soft periodontal tissues when used subgingivally. The use of sodium bicarbonate for air polishing has been considered safe for enamel but can contribute to root surface defects.
Benefits[:] Switching to an air polisher routine prior to hand scaling can improve your efficiency and shorten appointments. The microscopic particles used in air polishing access grooves, fissures, and subgingival surfaces are better than a rubber polishing cup. Air polishing is a useful option.'

[75] Breathe at an abnormally rapid rate.

Ms A sat in the reception area 'very upset and frightened' until her friend arrived and took her to A&E.

220. Dr Subramani told HDC that Practice 1 was very small and after the incident happened, the 'door was left open and [he] and [his] dental assistant were standing at the entrance of the door to talk to the doctors at the Emergency hospital department GP'. He stated: 'I am sure lights were not turned off.' However, Dr Subramani accepted that he should have told his assistant to stay inside rather than stand with him at the entrance of the surgery. He said that the set-up meant that Ms A's dental chair was facing the window, rather than the door, which is why she may have believed they had left the surgery.

221. Dr Subramani told HDC that at the time of the incident he had been angling the airflow polisher 40 degrees towards the gum sulcus, which he 'typically and traditionally did'.

222. The clinical records document that Dr Subramani noted that Ms A had 'air [emphysema]' from the airflow polisher within the immediate tissues. He told HDC that 'unfortunately, the high-pressured air went under the gum'. He said that he informed Ms A of this and explained that 'this was one of the rare risks with [the airflow polisher]'.

223. In response to the provisional opinion, Ms A said that the use of the airflow polisher was never discussed with her, nor was she told of the high risk.

224. In response to questions raised by Dr McKeefry, Dr Subramani said that his order of treatment when undertaking a scale and polish was to use an ultrasonic scaler, followed by hand scaling, and then airflow polishing. He confirmed that the powder used in the airflow polisher at the time was bicarbonate of soda and that the tooth being treated at the time was '[a]round 47 tooth'.

225. However, in subsequent correspondence to HDC, Dr Subramani said that he used the airflow polisher at the start of Ms A's treatment.

226. In response to Dr McKeefry's query whether he had received any training from Practice 1 on how to use the airflow polisher whilst he was contracted there, Dr Subramani confirmed that he had.

227. Dr Subramani stated:

> 'Not sure the compressor pressure was correct and whether calibration was correctly, since that surgery was purchased by [Practice 1] company before I was asked to work in that location. After that incident I stop[ped] using it in the surgery at [Practice 1] clinic.'

228. Dr Subramani recorded in the clinical records that he advised Ms A to go to '[the Emergency Department] for reassurance' and told HDC that he 'sincerely apologised to her'. However, he also told HDC that he 'referred' Ms A to the local hospital to seek their opinion and care if required.

229. Ms A stated that she saw a doctor at the Accident & Emergency Department, who was 'quite concerned that it was surgical emphysema[76]' that was 'well up in her face'. Ms A described it as 'a strange crackling feeling in [her] face and neck'.

230. Ms A told HDC that she was observed for around 12 hours and sent home from hospital around 10–11pm that evening. She stated that she was 'ill for around 10 days' after the incident.

231. Dr Subramani noted in the clinical records that he called the general practitioner at the hospital and was told that Ms A had 'slight swelling at [the right-hand side] bottom of the jaw', they had given Ms A Augmentin[77] as a back-up, the air bubble was moving down, and she had been advised to use massage oil and a heat pack. The clinical records also note that Dr Subramani was told that Ms A 'was in shock, but now she is ok'.

232. Ms A stated that she emailed Practice 1 to complain about what had happened and received no reply to her message.

233. In subsequent correspondence to HDC around Dr McKeefry's comments about whether his clinical records were appropriate, Dr Subramani said that he was sorry his records were not updated, as he used a system called 'auto notes' at that time.

234. On 30 January 2019 Ms A returned to Practice 1 to discuss having tooth 18 removed and was seen by a different dentist. Practice 1's clinical records note that the previous dental treatment with Dr Subramani had made Ms A anxious about dentistry and other medical treatments, and she needed reassurance.

235. Ms A again returned to Practice 1 on 19 September 2019 for a consultation with another dentist. The clinical records note that Ms A wanted the extraction of tooth 18 to go ahead. The records also state:

> '[Ms A] has thoroughly talked us through today what she has experienced over the last couple years from Barry to [named dentist of Practice 1] and now [to] us, because of the trauma from Barry [Ms A] is a very scared and unsettled patient.'

Other information

236. Ms A told HDC that Dr Subramani's manner with her during the treatment on 4 April 2018 was 'very rough' and she had to explain to him that she was an older person and to 'be gentle'. Ms A said she had never had a medical consultant talk to her the way Dr Subramani had.

237. Ms A told HDC that this incident left her feeling traumatised, and she has been too fearful to visit a dentist since her last appointment at Practice 1 on 19 September 2019. Ms A said

[76] Introduction of gas into the subcutaneous tissue, which can cause face and neck swelling, leading to respiratory distress, patient discomfort, and chest pain.
[77] An antibiotic.

that she would like to have treatment, but emotionally it is too difficult for her, and it is a medical experience she never wants to go through again.

238. Ms A said that the reason for making her complaint to HDC was because of concerns at the time that Dr Subramani was still practising in the town, and she wanted to keep the community safe and stand up for other people.

Changes made since events

239. Dr Subramani advised that this 'unfortunate incident' caused him to alter his use of the air polisher tip. He stated: '[T]ypically, and traditionally inclined at 40 degrees towards the gum sulcus[78]; instead I now use the polishing tip at an incline of at 90 degrees to the tooth surface.'

240. In subsequent correspondence with HDC, Dr Subramani said that his previous correspondence had been incorrect, and that he points the nozzle 'away from the gum at 10–60 degrees'.

241. Dr Subramani also stated that as a result of this incident he attended courses[79] to improve his daily practice.

Responses to provisional opinion

Ms A

242. Ms A was given an opportunity to respond to the 'Complaint and Investigation', 'Changes made since events' and 'Further information and DCNZ involvement' sections of the provisional opinion. Ms A's comments have been incorporated into this opinion where relevant and appropriate.

243. Ms A stated that whilst Dr Subramani has apologised since, at no time during the incident did he apologise to her for his behaviour towards her.

[78] The point at which the tooth and gums meet.

[79] 'When is a consent form not enough? Dental Protection.
Dental records DPL > DPL Dental Records
Creative composite solutions Lecture and Handson
NZDA CONFERENCE 2022 > NZDA Conference: Silver fluoride, a silver bullet for dental caries?
NZDA CONFERENCE 2022 > NZDA Conference: Human Error and Dentolegal risk.
NZDA CONFERENCE 2022 > NZDA Conference: Minimal intervention smile design: creating beautiful composite restorations
Pre-treatment assessment — Case difficulty, Anatomy and Root canal access >
Pre-treatment assessment — Anatomy and Root canal access, Module 4 NZSE
Endodontic Symposia 2022
Deep caries and managing the vital pulp > Deep caries and managing the vital pulp, Module 3 NZSE Endodontic Symposia 2022
Diagnosis — clinical and radiographic > Diagnosis — clinical and radiographic, Module 2 NZSE Endodontic Symposia 2022 Capital Dental Endodontics
Pulpal and periapical disease > Pulpal and periapical disease — Module 1 NZSE Endodontic Symposia 2022.'

244. Ms A advised that she was almost 76 years old when this incident occurred, and now at 83 it has been very difficult for her to deal with this trauma, and it has had a big impact on her senior life.

Dr Subramani

245. Dr Subramani was given an opportunity to respond to the provisional opinion. In relation to the incident with the air flow polisher, he said that 'there was an unintentional spill-off of the nozzle's angulation [and] combined with the high-pressure air this led to the occurrence of surgical emphysema'. He stated that he used the nozzle at the recommended angle of 10–60 degrees away from the gum.

246. Dr Subramani also stated that he does regret this mistake, and any harm caused to Ms A.

Opinion

247. Ms A visited Dr Subramani at Practice 1 for two appointments, on 23 March and 4 April 2018. I commend Ms A's reason for making her complaint as wanting to keep her community safe, and I acknowledge her distress as a result of the dental services provided by Dr Subramani. I am extremely concerned that Dr Subramani's dental treatment has left Ms A in fear of visiting a dentist.

248. To determine whether the care provided by Dr Subramani was reasonable, I considered the external clinical advice from dentist Dr Angela McKeefry, who reviewed the clinical records and all other relevant information.

Dental treatment provided

<u>23 March 2018 — first treatment</u>

249. In relation to the first consultation and treatment, Dr McKeefry was asked whether the treatment plan for a fixture for Ms A was appropriate. Dr McKeefry noted that Dr Subramani does not mention 'grinding' or a 'fixture' in his response. However, the clinical notes for the 4 April 2018 appointment mention Ms A being a 'grinder' (see paragraph 266 below).

250. Dr McKeefry advised that she was unable to comment on whether or not there was a departure from the accepted standard of care, although according to the clinical notes, it appears that nothing came of the fixture in any event. However, Dr McKeefry commented on the breakdown in communication at this appointment (see paragraph 261 below).

<u>4 April 2018 — second treatment</u>

251. Dr McKeefry explained that what happened to Ms A during the scale and polish at this appointment was that 'some of the high-pressure air went down between the tooth and the gum and penetrated into the soft tissues'.

252. Dr McKeefry noted that different powders are used with the airflow polisher for different purposes. She said that in his response, Dr Subramani listed one of the 'Risks' he informs

patients of is that 'Sodium Bicarbonate may cause damage to the hard and soft periodontal tissues when used subgingivally[80]'. Dr McKeefry advised:

> 'Sodium Bicarbonate should NEVER be directed towards the gum, always away from the gum. In the user manual which Dr Subramani attached to his response, it clearly shows the nozzle pointing AWAY from the gum at 10–60 degrees. For him to aim it toward the gum sulcus at a 40-degree angle and even now when he says he uses it at 90 degrees to the tooth surface is not acceptable and likely to cause damage.'

253. Dr McKeefry also advised that 'whatever powder is being used, [the accepted protocol for the airflow polisher] is to use it FIRST, BEFORE ultra sonic and hand scaling' and not as Dr Subramani suggested in his initial response to HDC to use it after the ultrasonic scale and hand scale. She stated:

> '[Dr Subramani's practice in relation to this was] absolutely wrong and is likely the reason, when combined with the 40-degree angle of use, that surgical emphysema occurred. Both ultra sonic and hand scaling easily cause tears in the gingival sulcus, which is why Airflow should NEVER be used after them, especially with sodium bicarbonate which can do even more damage, opening up potential pathways for air to penetrate into the tissues.'

254. It appears that Dr Subramani was also unsure whether the compressor pressure or calibration were correct on the airflow polisher. I agree with Dr McKeefry that 'he should not have been using the device on any patient without knowing it was safe to do so', and I am critical that he did this.

255. Dr McKeefry advised that Dr Subramani's practice that caused Ms A's surgical emphysema is a 'very severe departure' from the standard of care. Dr McKeefry stated that her peers 'would view this very poorly'.

256. I accept Dr McKeefry's advice. Ms A entrusted Dr Subramani to provide her with dental treatment with reasonable care and skill, and it is clear that he fell well short of this when he provided treatment to Ms A on 4 April 2018. I am extremely critical of this.

257. Dr McKeefry advised that standard practice when an incident like this happens is 'to stop treatment, remain calm, maintain the patient's airway if required and determine if more advanced care is needed'.

258. Dr McKeefry advised that as Dr Subramani called both an ambulance and Ms A's friend to ensure that she was taken to hospital, and later followed up with the hospital, his conduct would be considered reasonable.

[80] Below the gums.

259. However, Dr McKeefry noted that Ms A stated that when she started to 'hyperventilate', Dr Subramani left her on her own for a few moments before he returned to the room. Dr McKeefry advised:

> 'If this actually happened, that would be terrible. The patient is panicked and frightened with possible airway issues. You would never leave her alone unless you were the only person on site, and you had to in order to call an ambulance.'

260. Dr Subramani acknowledged that both he and his assistant were out of sight of Ms A, and I note that he could not confirm whether the lights were turned off. Dr Subramani also acknowledged that he should have told his assistant to stay inside rather than stand with him at the entrance of the surgery door, and it is understandable that Ms A believed there was no one in the room with her. Ms A said that at this time she was flushed and hyperventilating. This would have been a very frightening experience for her, and I agree with Dr McKeefry that Ms A should not have been left alone.

Communication and manner

261. Dr McKeefry noted that at the appointment on 23 March 2018 there appeared to be a breakdown in communication between Dr Subramani and Ms A. Dr McKeefry said that Ms A 'seems quite adamant they had a disagreement over whether [Ms A] grinds her teeth or not'. However, the clinical records for 23 March contain no reference to Ms A grinding her teeth or of any discussion having taken place about this or a 'fixture'.

262. Dr Subramani subsequently told HDC that on 23 March 2018 he did have a discussion with Ms A regarding 'parafunctional habits', as he had seen wear signs in her teeth. Dr Subramani acknowledged that perhaps he may not have framed the question correctly to Ms A, and he apologised for this.

263. Whatever discussion was held on 23 March 2018, Ms A perceived it to be a 'disagreement', and Dr Subramani recognised that he may not have framed 'the question' to Ms A correctly. In the absence of notes to demonstrate otherwise, I accept that Dr Subramani's manner towards Ms A at this appointment was not acceptable to her.

264. Ms A also described Dr Subramani as being 'confrontational' and 'very rough' at the appointment on 4 April 2018. She said she had to explain to him that as she is an older person, he needed to be 'gentle'. Again, in the absence of detailed notes about the discussions at this appointment, I am minded to accept Ms A's view of what happened. I also note the information provided in the clinical records from Practice 1 about Ms A's experience of Dr Subramani and how 'scared and unsettled' she was because of the trauma from her treatments with him, and I am critical that she was left feeling this way.

265. Dr McKeefry advised that it would have been good practice for Dr Subramani to have followed up with Ms A in the days following the incident on 4 April 2018 to 'check up on her'. I agree, and I am critical that Dr Subramani did not do this.

Clinical documentation

266. Dr McKeefry noted that Dr Subramani did refer to Ms A being a 'grinder' in his clinical records for 4 April 2018, but the records for this appointment contain no mention of any discussion with Ms A about this or about a 'fixture'. I accept Dr McKeefry's advice that if Ms A did grind her teeth and needed protection, the normal fixture for this would be a nightguard/bitesplint, and this 'should not be undertaken without clearly documented evidence of this issue and consent from the patient'.

267. Dr McKeefry advised that in general, Dr Subramani's clinical records do not contain enough information and are, 'at least in part, inaccurate', for example:

> '23/03/2018 — two composite fillings and an extraction are performed
>
> Neither of the fillings have listed why they needed to be done, options discussed, type of composite, bond used, post op instructions etc …
>
> The extraction notes refer multiple times to the patient as "he" and "his". They also include the statement "options given to replace a single missing tooth, He expressed he can't afford other treatment at the moment". It is not normal to offer options to replace an extracted wisdom tooth, unless there are multiple other teeth missing, which isn't the case.
>
> At the examination appointment on 04/04/2018 in the comment under teeth, it says "Pocketting and dentition as charted (see charting)". It has been confirmed through both [Practice 1] and Dr Subramani that there are no available periodontal pocketing charts.'

268. I agree with Dr McKeefry that 'clear evidence' and accurate information needed to be noted in the clinical records about the discussions that took place with Ms A, and the reasoning behind the treatment. Dr Subramani did not do this on 23 March 2018 or 4 April 2018, and information is missing from the records. I accept Dr McKeefry's advice that this is a severe departure from the accepted standard of care.

Other information

269. Whilst Dr Subramani confirmed that he had received training from Practice 1 on the airflow polisher, he failed to use it appropriately. There is also no evidence to show that Dr Subramani did in fact receive training. In my view, if Dr Subramani had been trained on the airflow polisher, as stated, he did not follow the guidelines for use, and this was an individual failing.

Conclusion

Care provided to Ms A — breach

270. Dr Subramani had a responsibility to provide services to Ms A with reasonable care and skill. I consider that Dr Subramani's treatment fell well short of an acceptable standard for the following reasons:

- He failed to provide appropriate advice in relation to the extracted wisdom tooth on 23 March 2018.
- He failed to use the airflow polisher in an appropriate way on 4 April 2018, by directing the nozzle with sodium bicarbonate towards the gum instead of away from the gum.
- He failed to follow the accepted protocol for use of the airflow polisher with sodium bicarbonate, by using it first instead of last when he treated Ms A on 4 April 2018.
- He failed to check that the compressor pressure or calibration were correct on the airflow polisher prior to using it on 4 April 2018.
- He failed to ensure that someone remained with Ms A following the incident with the airflow polisher to ensure that she was being cared for.

271. Therefore, I find that Dr Subramani breached Right 4(1)[81] of the Code.

Clinical documentation — breach

272. Maintaining accurate clinical documentation is an integral part of clinical practice, and Dr Subramani's clinical notes were very poor. In my view, Dr Subramani's deficient clinical documentation did not meet DCNZ's professional standards in relation to ensuring safe practice by maintaining accurate, time-bound, and up-to-date patient records, for the following reasons:

- Dr Subramani failed to make detailed, comprehensive, and accurate clinical records on 23 March 2018 by not listing why fillings were required, the options discussed, the type of composite and bond used, and the postoperative instructions provided.
- He failed to make detailed, fulsome, and accurate records on 4 April 2018.
- His initial response to HDC and his clinical notes of 23 March 2018 failed to mention any discussion with Ms A about being a 'grinder' and her need for a 'fixture', or his reasoning behind this.
- On 4 April 2018 he failed to record discussions with Ms A about whether or not she grinds her teeth.
- On 4 April 2018 he failed to record discussions with Ms A about the risks he stated he advised her of prior to her scale and polish.
- He failed to record any periodontal pocketing charts for Ms A on 4 April 2018.

273. Accordingly, I find that Dr Subramani breached Right 4(2) of the Code.

[81] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Communication and manner — adverse comment

274. I consider that Dr Subramani's manner and communication with Ms A were extremely poor, and that this did not meet the Dental Council's required professional standard to put patients' interests first and always treat them with dignity and respect. I am critical for the following reasons:

- Ms A perceived Dr Subramani's communication about whether or not she was grinding her teeth as 'very confrontational', and Dr Subramani acknowledged that he may not have framed this well.
- Ms A described Dr Subramani's manner as 'very rough' during the treatments.
- Dr Subramani failed to follow up with Ms A to check how she was doing after she experienced surgical emphysema.

Practice 1 — other comment

275. Dr McKeefry suggested that it would be pertinent for dental practices to have registers of potentially hazardous equipment, as well as information about key points regarding extensive training prior to use, such as who conducted the training, who received the training, and records of signatures and dates. I encourage Practice 1 to reflect on this advice and consider developing such a register if one is not in place already.

Further information and DCNZ involvement

276. On 11 February 2019 the Dental Council referred Dr Subramani to a Professional Conduct Committee. The Committee decided that a charge should be brought against him before the Health Practitioners Disciplinary Tribunal (the Tribunal).

277. On 4 February 2022 Dr Subramani admitted, and was found guilty of, a charge of professional misconduct at the Tribunal hearing relating to his treatment of 11 patients between October 2017 and October 2018 at Practice 1. The charge included 39 incidents of misconduct (which did not include the three complaints referred to in this decision). As a result, Dr Subramani was fined and ordered to pay costs.

278. On 10 March 2022 HDC made public interest referrals to the DCNZ in relation to the further complaints by two of the complainants in this decision,[82] as HDC became aware that Dr Subramani was still able to practise subject to supervision by a dentist appointed by the Dental Council in 2020 until an appeal made by him to the High Court had been heard. At that time, HDC had not received the third complaint[83] in this decision, and this has since been referred.

[82] Mr C and Mr B.
[83] Ms A.

279. On 30 November 2023 the Dental Council confirmed that Dr Subramani's appeal had been heard and that the High Court had upheld the decision to deregister Dr Subramani and had ruled that he was not to practise for three years from 2 October 2023.

Recommendations

280. In light of the action already taken by the Dental Council, and as Dr Subramani is no longer practising, I recommend that Dr Subramani:

a) Reflect on the information given by all three complainants and provide meaningful formal written apologies to Ms A, Mr B, and Mr C for the deficiencies in care outlined in this report. The apologies are to be sent to HDC, for forwarding to each complainant, within three weeks of the date of this report.

b) Provide HDC with evidence of the training courses he has attended, as stated in the 'changes made' section of this report, within three weeks of the date of this report.

281. Should Dr Subramani again become registered with the DCNZ to practise, I recommend that prior to this he undertake further education and training on courses that cover the following:

a) Clinical records and documentation

b) Informed consent

c) Communication skills

d) Dry socket treatment

e) Clinical/radiographical diagnosis

f) Pharmacology on when it is appropriate to prescribe antibiotics

g) Periodontal disease and care

282. Should Dr Subramani apply to be registered with the DCNZ, I recommend that the DCNZ conduct a competence review.

Follow-up actions

283. In my provisional decision, I proposed to refer Dr Subramani to the Director of Proceedings as I considered the breaches of the Code serious enough to warrant this. However, following consultation with the complainants I have decided not to proceed with the referral.

284. A copy of the final report with details identifying the parties removed, except Dr Subramani and the independent advisor on this case, will be sent to the Dental Council of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner — Mr C

The following independent advice was obtained from Dr Angela McKeefry dated 17 December 2023:

'Complaint:	**Mr C/Provider — Dr Bharath Raja (Barry) Subramani**
Our ref:	**22HDC00313**
Independent Advisor:	**Dr Angela McKeefry (BDS)**

I have been asked to provide clinical advice to HDC on case number 22HDC00313. I have read and agree to follow HDC's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint. I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	• Bachelor of Dental Surgery (Otago) 1993 • Fellow of the International College of Continuing Dental Education (In Orthodontics) • Have been a general dentist doing a wide scope of dental procedures in the same practice for 29 years until I recently shifted to a new practice. • Have served on several dental committees over my career including running the Wellington branch of the recent graduate program for several years
Documents provided by HDC:	3 bundles of documents all including the following documents 1. Complaint dated 03 February 2022. 2. Dr Subramani's response received by HDC on 23 March 2022. 3. [Practice 2's] Complaint Management Policy. 4. Supervisor Declaration form. 5. Progress Notes. 6. After Care Instructions. 7. Extraction Consent form. 8. Clinical records and x-rays. 9. Google review ([Mr C]) 10. [Practice 2's] Complaint management policy.
Referral Instructions from HDC:	Dr Subramani 1. Whether the treatments provided by Dr Subramani and options provided to [Mr C] given his presenting concerns were necessary and appropriate for each appointment;

	2. What is standard practice for a patient who has [Mr C's] symptoms of "rot and smell and taste" from the cavity and a large painful lump. 3. Whether Dr Subramani's explanation about the piece of tooth on the inside of [Mr C's] mouth was appropriate. 4. Whether the treatment to put bands on the top and bottom of [Mr C's] teeth on 27 January 2022 was appropriate and of an acceptable standard. 5. Whether the explanation provided to [Mr C] at the appointment on 27 January 2022 regarding being unable to carry out the treatment on the cavities was appropriate. 6. Whether the aftercare instructions and follow up provided by Dr Subramani was appropriate. 7. Any other matters that you consider amount to a departure from accepted standards or warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	Patient's Complaint: • Unhappy that Dr Subramani said the extraction wouldn't affect his chewing ability, but it did. • The extraction was generally a bad experience because the socket became infected, very painful and eventually expelled some tooth or bone from it. • Feels fillings (particularly the "front cap") were done without his consent, while the three he really wanted done, were not completed. • Has heard about other similar complaints and feels Dr Subramani hasn't learnt from his mistakes and wants to stop this happening to others. Dr Subramani's Response: • Dr Subramani says everything that happened with the extraction was a known risk and discussed with the patient in advance of the treatment. THE CLINICAL NOTES AND SIGNED INFORMED CONSENT FORM BACK THIS UP, ALTHOUGH NO MENTION IS MADE ABOUT A POSSIBLE DISCUSSION AROUND THE POTENTIAL AFFECT ON CHEWING ABILITY • Dr Subramani says that the "front tooth cap" was a filling and was discussed and consented prior to treatment. THE CLINICAL NOTES SUPPORT THIS • Dr Subramani says he prioritized the fillings by need from a

	disease standpoint. He doesn't discuss in his response why he didn't attend to the fillings the patient wanted done. THE CLINICAL NOTES ARE VAGUE BUT PERHAPS TWO UPPER LEFT FILLINGS WERE NOT DONE DUE TO A BLEEDING GUM. NOWHERE IN THE CLINICAL NOTES DOES IT SAY THAT THE PATIENT SPECIFICALLY WANTED THREE FILLINGS DONE AND WHICH THEY WERE.
Question 1: Whether the treatments provided by Dr Subramani and options provided to [Mr C] given his presenting concerns were necessary and appropriate for each appointment;	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards
Advisor's opinion:	Appointment 6/12/2021: • Fully appropriate other than the patient saying Dr Subramani assured him there would be no impact on chewing ability due to the problem tooth being unopposed. This complaint of the patient's sounds like there was a discussion around this concern, but Dr Subramani makes no note of it. It is difficult to tell from the x-rays and photos if the problem tooth really had no contact with the upper teeth, it looks like it probably was contacting the upper first molar as you would expect in most patients (ie the upper and lower first molars contacting each other). Regardless, it would be extremely unwise to advise a patient (no matter which tooth was being removed) that there would be no impact on chewing ability. It would be better to say it is or isn't likely to impact chewing, but you won't fully know until the tooth is gone. From the clinical notes, we have no idea if this was discussed or not and what Dr Subramani may have advised. Appointment 8/12/2021: • There are no notes regarding the patient's symptoms or clinical findings to confirm the patient had a dry socket. • There are no notes about the patient's chief complaint other than to say "Advised unable to locate any bone, If I explore for it. risk of disturbing the healing socket. Reassured unwanted piece of bone body will throw it away." • This is inappropriate. • I would expect if there was a large painful lump, an x-ray would have been ideal to ascertain any foreign body or large fractured piece of bone (I assume there would not be any tooth remaining as the clinical notes from 2 days prior said the tooth was whole when extracted). • Calling this bone "unwanted" is misleading as what it really is, is a

	piece of bone that was fractured during the extraction process, which no longer has a blood supply, and the body will expel it in due course. • To say "If I explore for it … risk of disturbing the healing socket", is ridiculous. The socket is not healing as it has a dry socket and in fact, one of the treatments for a dry socket is to numb the patient and probe aggressively to stimulate bleeding and allow for a new blood clot to form. • However, flushing the socket, dressing it with alveogyl and prescribing a course of antibiotics is also an acceptable treatment to provide. • BUT we only THINK the patient was given antibiotics at this appointment because he states that in his complaint. There is no mention of this in Dr Subramani's notes. So, we don't know if antibiotics were in fact prescribed and what type or what dose was given. I note antibiotics were prescribed on 14/1/22 for a different tooth/reason, perhaps the patient was mixed up? Appointment 13/12/2021: • The clinical notes for this appointment are good and it seems all dental issues were identified and discussed with the patient. • However, no note is made of the teeth that are the patient's main concerns "the three black ones right in the smile zone". • Also, there is a clinical comment "DH > Exo at [Practice 2] Healing well". According to the patient's complaint he still has extreme pain from the lump by the extraction site, no mention is made of this in the exam notes. • At the exam, it is decided to wait and review in three months' time five other teeth with issues. In the reflection it says this is to spread the cost but doesn't say if this is at the patient's request or the Dr's idea. • I would suggest that even though the notes look comprehensive around discussing each problem and the potential treatments, the patient did not fully understand, or he would not have been surprised by the treatments delivered at later appointments. • This appointment was appropriate apart from the above points. Appointment 23/12/2021: • Three fillings were done at this appointment, one of which was very deep and later plays up, which is not out of the ordinary. • The patient doesn't discuss this appointment in his complaint. • The three teeth which were filled display obvious and significant decay on the radiographs. • There is no mention that verbal consent was gained at this appointment to do the treatment, other than that, this

	appointment seems reasonable. Appointment 14/01/2022: • Teeth cleaning appointment. This is appropriate and justified by the CPITN probing chart. • This is the appointment the patient says he showed the piece of tooth/bone to Dr Subramani that had finally worked its way out. There is nothing recorded about this in the clinical notes which I find unusual since there have been previous notes about the problem this was causing in the past. • This is also the appointment Dr Subramani records prescribing the antibiotics for a toothache on the opposite side to where the extraction occurred. The notes only record the type of antibiotic, but not the dose or duration which is insufficient. Appointment 22/01/2022: • Two fillings were completed, and Dr Subramani notes the toothache from the previous week has settled. • The two teeth which were filled display obvious decay on the radiographs. Appropriate treatment. • Again no mention of verbal consent prior to the fillings being done. Appointment 27/01/2022: • Two fillings were completed. • Both treated teeth are noted as having decay at the exam appointment and one is clearly obvious on the radiographs. Appropriate treatment. • I assume this is the appointment where the patient says the "front cap" was placed as this is the first appointment with any front teeth being treated. • Again, no mention of verbal consent prior to the fillings being done. This is a problem today because the patient clearly didn't understand what was going to happen until after he got home, and the numbness wore off. Then he was surprised by what had been completed. • The patient talks about the 27th being the last appointment, but actually the 29th was the last appointment so it is a little confusing, but I assume he just got his dates muddled. Appointment 29/01/2022: • This is when the patient complained to Dr Subramani that he hadn't understood that he was going to place a cap on the front tooth. The patient says he stressed that he really wanted the three black cavities at the front done. • One filling was done at this appointment on the lower left (decay

	visible on the radiograph — appropriate treatment) and the notes mention two teeth on the top left near the front. I don't understand the notes "23 Distal & (24 since gum was bleeding during the filling procedure) mesial Defective filling recheck in 3 months Close gap on 23 by doing DO filling". I assume this is alluding to the fillings the patient wanted done but Dr Subramani couldn't do due to bleeding. However, this only mentions two teeth and the patient was talking about three black cavities. The other issue is the 24 restoration was done by Dr Subramani on 22/01/2022, so could not be one of the three the patient still wanted completed. • Looking at the full mouth photos, the gums do not appear to be so inflamed that any bleeding couldn't be controlled enough to complete a filling. However, those photos weren't from the day of the attempted treatment, and I wasn't there. It is always best practice to have healthy nonbleeding gums prior to doing any restorative treatment. • Dr Subramani makes no mention of the patient's complaint about lack of informed consent at the previous appointment. I would expect notes about this and then for Dr Subramani to be extra certain the patient understood what was going to happen at this appointment, which clearly, he didn't as the patient again came away surprised and disappointed. Inappropriate treatment/ communication. • Again no mention of verbal consent prior to the fillings being done.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/ material.	Practitioners are legally and ethically obliged to obtain a patient's informed consent before providing care. The standards framework requires practitioners to put patients' interests first and communicate effectively by: giving patients the information they need, or request, in a way they can understand, so they can make informed decisions; ensuring informed consent remains valid at all times; and respecting the autonomy and freedom of choice of the patient. You must create and maintain patient records that are comprehensive, time-bound and up to date; and that represent an accurate and complete record of the care you have provided.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or	Moderate to severe departure from the standard of care. While Dr Subramani completed the treatments he felt were in the best interests of the patient, he failed to obtain proper informed consent. Clearly the discussions held at the examination appointment 13/12/2021 were insufficient as the patient was not expecting the treatment he received. There was also second chances to obtain informed consent at each subsequent treatment appointment which Dr Subramani failed to do, even after the patient raised this with him directly (provided what the patient is telling us is correct, the other

• Severe departure.	side of this is that none of what the patient said happened is correct and Dr Subramani genuinely believed the patient had understood and consented and had no issues raised with him). I note the patient gave the practice a 5-star review, but I also note this was after the second appointment, NOT after ALL the appointments. If the patient did consent or at least failed to raise issues with Dr Subramani then the departure from the standard of care is mild to moderate due to less-than-optimal clinical notes and a possible failure to ensure continued informed consent across all appointments.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Our peers would view the treatment provided to be acceptable, but the communication and potential lack of informed consent to fall short of acceptable practice.
Please outline any factors that may limit your assessment of the events.	This is very tricky as: • [Mr C's] version of events don't fully match all the appointments in the clinical notes (e.g. [Mr C] talks about appointment three being when he shows Dr Subramani the piece of bone and has a clean — this is actually appointment five; He says the fourth visit is when a front cap was placed, but this was actually appointment seven; He talks about the last appointment being on 27/01/2022 when there was another appointment after this on 29/01/2022, but what [Mr C] says happened on the 27/01/2022, actually happened on 29/01/2022; [Mr C] says Dr Subramani prescribed him antibiotics for his dry socket on 08/12/2021, when according to the clinical notes, antibiotics weren't given until 14/01/2022 for a separate issue entirely. • Dr Subramani's clinical notes are not as complete as his reply to the complaints assessor. Here he states "[Mr C] said a piece of bone came out to us". There is no mention of this in the timebound notes; Dr Subramani also states "we call all patients (including [Mr C]) after the day of the appointment to see how they are doing after the dental treatment and whether they have any concerns or any questions staff did call [Mr C] he was doing well with all treatments." There is no mention of any of these calls in the timebound notes. • Dr Subramani's response to the complaints assessor's question about "[Mr C's] concern that you did not prioritise his fillings" is very telling. Dr Subramani talks about his treatment plan process, discussing with the patient about future prevention and prioritizing "the urgent things first, followed by the less urgent things, until we have gone through the plan". This is all very appropriate except there is no mention of the patient's chief

	complaints or what he wanted prioritized. If you don't think the patient is making a wise decision, you should try and educate them as to why, document these discussions and record the agreed upon outcome. It seems Dr Subramani decided what was best for [Mr C] and went ahead and did this, possibly without [Mr C] fully understanding/consenting.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Dr Subramani could benefit from a clinical documentation course and an informed consent course. Also, probably an increase in communication skills would be advisable.
Question 2: What is standard practice for a patient who has [Mr C's] symptoms of "rot and smell and taste" from the cavity and a large painful lump.	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards NZDA Code of Ethics
Advisor's opinion:	A thorough collection of the history of the complaint and documentation of all symptoms. A clinical examination and sometimes a radiograph would be advisable. I repeat my comments from above about the appointment regarding this problem: • There are no notes regarding the patient's symptoms or clinical findings to confirm the patient had a dry socket. • There are no notes about the patient's chief complaint other than to say "Advised unable to locate any bone, If I explore for it … risk of disturbing the healing socket. Reassured unwanted piece of bone body will throw it away." • This is inappropriate. • I would expect if there was a large painful lump, an x-ray would have been ideal to ascertain any foreign body or large fractured piece of bone (I assume there would not be any tooth remaining as the clinical notes from 2 days prior said the tooth was whole when extracted). • Calling this bone "unwanted" is misleading as what it really is, is a piece of bone that was fractured during the extraction process, which no longer has a blood supply, and the body will expel it in due course. • To say "If I explore for it … risk of disturbing the healing socket", is ridiculous. The socket is not healing as it has a dry socket and in fact, one of the treatments for a dry socket is to numb the patient and probe aggressively to stimulate bleeding and allow for a new blood clot to form. • However, flushing the socket, dressing it with alveogyl and if

	needed, prescribing a course of antibiotics is also an acceptable treatment to provide. BUT we only THINK the patient was given antibiotics at this appointment because he states that in his complaint. There is no mention of this in Dr Subramani's notes. So, we don't know if antibiotics were in fact prescribed and what type or what dose was given. I note antibiotics were prescribed on 14/1/22 for a different tooth/reason, perhaps the patient was mixed up?
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	See above discussion. NZDA Code of Ethics — In all dealings with patients and colleagues, dentists must strive to be open, honest, courteous, empathetic and supportive. DCNZ Practice Standards — You must create and maintain patient records that are comprehensive, time-bound and up to date; and that represent an accurate and complete record of the care you have provided.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Mild departure due to less-than-ideal clinical records. Often when patients present with dry socket, they are squeezed into an already busy day and time can be limited. While Dr Subramani could have probed the socket to investigate the bony painful lump and stimulate bleeding to regain a blood clot, the treatment he provided was adequate.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I think many dentists would treat a dry socket the way Dr Subramani did and so would be viewed as very reasonable. I think many would be less than impressed by his supposed explanation of the painful lump, though we don't know for sure what he said.
Please outline any factors that may limit your assessment of the events.	Less than ideal clinical notes that don't fully match the patient's account (especially regarding the antibiotic prescription).
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Better communication skills, better record keeping and possibly more education around dry socket treatment (regarding the option of re-probing the socket to gain a fresh blood clot, which he may already know about and decided against, but the comment in his notes ("If I explore for it. risk of disturbing the healing socket") would make me think he doesn't know about this treatment option.

Question 3: Whether Dr Subramani's explanation about the piece of tooth on the inside of [Mr C's] mouth was appropriate.

List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards NZDA Code of Ethics
Advisor's opinion:	Dr Subramani's explanation in his response to the complaints assessor is completely appropriate, whereas his response in the clinical notes for appointment 08/12/2021 is not appropriate (see my comments in question one about this appointment). His explanation to the patient (as reported by [Mr C]) is inappropriate (e.g. to laugh and say "that's big don't know why your body didn't want to keep that" is both unprofessional and unhelpful). The informed consent document [Mr C] signed prior to the procedure is appropriate.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	DCNZ — Practitioners are legally and ethically obliged to obtain a patient's informed consent before providing care. The standards framework requires practitioners to put patients' interests first and communicate effectively by: giving patients the information they need, or request, in a way they can understand, so they can make informed decisions; ensuring informed consent remains valid at all times; and respecting the autonomy and freedom of choice of the patient. NZDA — In all dealings with patients and colleagues, dentists must strive to be open, honest, courteous, empathetic and supportive. It is not uncommon for small pieces of bone or tooth to be expelled from the healing socket after extraction. If bits of tooth or bone are broken during the tooth removal, they sometimes work their way to the surface and are lost, sometimes the body will dissolve away small amounts of dead bone and sometimes tooth fragments remain in situ with no problems for ever. Dr Subramani should have explained to [Mr C] that the removal of his tooth was somewhat difficult and took longer than expected. It is likely some bone from around the socket was fractured during this process and lost its blood supply. This is likely what the patient was experiencing with the large painful lump. Dr Subramani's explanation to the patient was misleading.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a mild departure from the standard of practice. Dr Subramani made it sound like the bit of bone being lost was totally up to the body. Perhaps this was a way to simplify things for the patient, but it could have been done more accurately.
How would the care	The care provided would be seen as acceptable, but the explanation

provided be viewed by your peers? Please reference the views of any peers who were consulted.	somewhat lacking and misleading. However, the informed consent document [Mr C] signed prior to treatment covers this.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Improve patient communication around this explanation. He has it right in the informed consent document.
Question 4: Whether the treatment to put bands on the top and bottom of [Mr C's] teeth on 27 January 2022 was appropriate and of an acceptable standard.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	I don't know what the bands that were supposedly put on the teeth are. I can only assume these were the rubber dam clamps and that is just part of the treatment process. The bands could also be the structures (matrix bands) placed around the teeth while they are being filled. Either way, they are totally appropriate and not permanent (removed before the end of the appointment).
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Whether the bands were rubber dam clamps or matrix bands, it is entirely appropriate to use them.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure at all.
How would the care provided be viewed by your peers? Please reference the views of any peers who were	Using a rubber dam is the optimal treatment. This aspect would be viewed as excellent.

consulted.	
Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	Explain to the patient what you are doing and why both before and during treatment, so no misunderstandings occur.
Question 5: Whether the explanation provided to [Mr C] at the appointment on 27 January 2022 regarding being unable to carry out the treatment on the cavities was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards NZDA Code of Ethics
Advisor's opinion:	Firstly — this explanation occurred on 29/01/2022 NOT 27/01/2022 as stated by [Mr C]. I refer back to my comments in question one for appointment 29/01/2022: • One filling was done at this appointment on the lower left (decay visible on the radiograph — appropriate treatment) and the notes mention two teeth on the top left near the front. I don't understand the notes "23 Distal & (24 since gum was bleeding during the filling procedure) mesial Defective filling recheck in 3 months Close gap on 23 by doing DO filling". I assume this is alluding to the fillings the patient wanted done but Dr Subramani couldn't do due to bleeding. However, this only mentions two teeth and the patient was talking about three black cavities. The other issue is the 24 restoration was done by Dr Subramani on 22/01/2022, so could not be one of the three the patient still wanted completed. • Looking at the full mouth photos, the gums do not appear to be so inflamed that any bleeding couldn't be controlled enough to complete a filling. However, those photos weren't from the day of the attempted treatment, and I wasn't there. It is always best practice to have healthy nonbleeding gums prior to doing any restorative treatment. • I fail to understand why the gums were healthy enough to do the other eight fillings and not the three the patient really wanted doing. The notes don't make any of this clear enough and I still don't know which teeth these black cavities were on.
What was the standard of care/accepted practice at the time of events? Please	DCNZ — Practitioners are legally and ethically obliged to obtain a patient's informed consent before providing care.

refer to relevant standards/material.	The standards framework requires practitioners to put patients' interests first and communicate effectively by: giving patients the information they need, or request, in a way they can understand, so they can make informed decisions; ensuring informed consent remains valid at all times; and respecting the autonomy and freedom of choice of the patient. NZDA — In all dealings with patients and colleagues, dentists must strive to be open, honest, courteous, empathetic and supportive.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was (if [Mr C's] version is correct) a moderate to severe departure from the standard of care. From what I can gather, the patient wanted three specific teeth fixed and nowhere in the clinical notes was this noted. There was no specific diagnosis of these teeth or a summary of the discussion around them. There was no real clear explanation of why these teeth weren't treated, just a vague reference to tooth 23 and bleeding gums. I fail to see how the gums were healthy enough to restore the other eight fillings and not these three.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed as confusing and inappropriate. If the teeth really couldn't be treated at that time, list them, explain why and make a forward plan. Yes, Dr Subramani tried to reappoint [Mr C] for April 2022, but much clearer documentation/justification should have accompanied that decision.
Please outline any factors that may limit your assessment of the events.	The limiting factor here is that I don't really understand the clinical notes for 29/01/2022.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Better record keeping and communication.
Question 6: Whether the aftercare instructions and follow-up provided by Dr Subramani was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	• The aftercare instructions for extraction sheet given to [Mr C] was appropriate (although the first line is confusing — "Please read carefully: 24 hours after tooth extraction it is important to control the bleeding" — I would say it is important to control the bleeding straight away, not just 24 hours after).

	• The instructions for after the initial dry socket appointment on 08/12/2021 were appropriate. • No other post op instructions seem to have been given after any of the filling or scaling appointments — so not appropriate. • Dr Subramani states in his response to the complaints assessor "we call all patients (including [Mr C]) after the day of the appointment to see how they are doing after the dental treatment and whether they have any concerns or any questions staff did call [Mr C] he was doing well with all treatments." There is no mention of any of these calls in the timebound notes.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The patient should be given all appropriate information on what to expect and how to care for themselves following any clinical treatment. This should all be recorded in the clinical notes.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There is a mild departure from the standard of care in the lack of advice after the filling and cleaning appointments. It may just be that this advice was given but not included in the clinical notes. The patient doesn't complain about lack of relevant information. All communications the dentist or staff have with the patient about clinical matters should be included in the time bound notes. If there were follow up phone calls, these were not recorded.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The care would be viewed as fine, so long as at least verbal instructions were given for post op filling/cleaning appointments. If no advice was given, then this would be viewed less favourably.
Please outline any factors that may limit your assessment of the events.	I don't know if verbal instructions were given and not noted, or not given at all.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Better clinical notes.
Signature:	
Name: Dr Angela McKeefry (BDS)	
Date of Advice: 17 December 2023'	

Further advice

The following further advice was provided by Dr McKeefry on 20 April 2024:

> 'Complaint: [Mr C] — ref 22HDC00313
>
> Dr Subramani's response to the comments in Question 1, a screen shot of a script written has now been provided. Unfortunately this has no patient name attached to it. The other issue is the instructions accompanying the "Dispensed 20" say "Take 2 caps to start and then one cap three times a day for 5 days". That accounts for 16 caps, what is the patient supposed to do with the remaining 4 caps?
>
> Also regarding Question 1, Dr Subramani now has provided a screen shot of the comm log notes (not time bound). This shows a message was left with the patient asking how they were. There is no note of the patient replying, so we don't know "they were doing well with all treatments" as Dr Subramani had previously stated.
>
> Dr Subramani's response to Question 2 doesn't change my comments at all.
>
> With regards Question 3, I am pleased to hear Dr Subramani states he did not laugh, but even to smile, when all the patient is feeling is shock and confusion is inappropriate.
>
> I don't want to make any other comments following Dr Subramani's response.'

Appendix B: Independent clinical advice to Commissioner — Mr B

The following independent advice was obtained from Dr Angela McKeefry dated 17 December 2023:

'Complaint:	**[Mr B] / Provider — Dr Bharath Raja (Barry) Subramani**
Our ref:	**22HDC00347**
Independent Advisor:	**Dr Angela McKeefry (BDS)**

I have been asked to provide clinical advice to HDC on case number 22HDC00347. I have read and agree to follow HDC's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint. I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	• Bachelor of Dental Surgery (Otago) 1993 • Fellow of the International College of Continuing Dental Education (In Orthodontics) • Have been a general dentist doing a wide scope of dental procedures in the same practice for 29 years until I recently shifted to a new practice • Have served on several dental committees over my career including running the Wellington branch of the recent graduate program for several years
Documents provided by HDC:	3 bundles of documents all including the following documents: 1. Complaint dated 10 February 2022 2. Copy emails between the dentist and [Mr B] dated 22 January 2019 3. Response and clinical records from [Practice 1] dated 14 March 2022 4. Response from Dr Subramani dated 30 August 2023 5. Complaint management provided by Dr Subramani
Referral Instructions from HDC:	Dr Subramani 1. Whether the treatments provided by Dr Subramani and options provided to [Mr B] given his presenting concerns were necessary and appropriate for each appointment; 2. Whether recommendations made by Dr Subramani to [Mr B] regarding his diagnosed "generalized gingivitis" were appropriate. 3. Whether you think it is appropriate that the defective/worn

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

	fillings, defective tooth structure were only noted at the second appointment on 17 April 2018, and not raised on the 4 April 2018. 4. Whether the aftercare instructions and follow up provided by Dr Subramani was appropriate. 5. Whether you consider the cost of the treatments provided was reasonable and in line with New Zealand Dental Association average fees for the work carried out. 6. Any other matters that you consider amount to a departure from accepted standards or warrant comment.

Factual summary of clinical care provided:

Brief summary of clinical events:	[Mr B's] Complaint: • Went to see Dr Subramani due to a single tooth problem. He fixed multiple teeth and made a mouthguard. He has had to have a lot of treatment since then on the teeth Dr Subramani treated, has had nothing but trouble and has lost two of the teeth worked on by Dr Subramani. • The charges were a lot more than the pre-treatment estimate. Dr Subramani Response: • He gave the patient all the necessary information and did appropriate treatment.
Question 1: Whether the treatments provided by Dr Subramani and options provided to [Mr B] given his presenting concerns were necessary and appropriate for each appointment	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards
Advisor's opinion:	Appointment 04/04/2018: • [Mr B] presented as he had pain from what he thought was a lost filling. • The x-rays are of poor quality, and it is impossible to tell from them alone what treatment needed doing. • The clinical records are also very poor not specifying the severity or history of the symptoms. The notes say the tooth chipped due to grinding, but how does Dr Subramani know this? He states the patient is a grinder but gives no real reason for this diagnosis. He doesn't explain the size of the chip (which can't be seen on the poor x-rays) or why he has to place a four-surface filling (when from the x-ray, the tooth seems previously unrestored, but again,

	they are hard to read). • The information Dr Subramani gives to the complaint assessor's questions is more thorough, but I find it hard to place much faith in a response written more than five years after the treatment was delivered. How would he remember? Regardless, it should have all been recorded on the day of treatment. To indicate this or that was said five years later is not useful or reliable information. • At this appointment scripts are written for pain relief and for Metronidazole antibiotics. There is zero indication from the notes to justify a prescription for antibiotics. Even in his comments five years later, Dr Subramani says in his opinion, the pain is coming from the muscles and not any teeth at all. "Pain is from myogenic origin, due to the parafunction habit." • For this appointment I cannot say if the treatments were appropriate or not because the clinical records fall so far short of the required standard. Appointment 17/04/2018: • [Mr B] thought this appointment was for $400 of fillings. It turned out to be an exam, scale and polish plus five fillings for $1425. • Presumably the bite splint was also fitted at this appointment, but no notes were written about this at all. • Again, from the x-rays provided and clinical notes, I cannot tell what was or was not appropriate. It certainly would not be appropriate to give a $400 estimate and then charge $1425 without further consultation and notes about why. • Dr Subramani says the patient was verbally told about risks and benefits and then signed a consent form for both appointments, but these signed consent forms have not been provided.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Practitioners are legally and ethically obliged to obtain a patient's informed consent before providing care. The standards framework requires practitioners to put patients' interests first and communicate effectively by: giving patients the information they need, or request, in a way they can understand, so they can make informed decisions; ensuring informed consent remains valid at all times; and respecting the autonomy and freedom of choice of the patient. You must create and maintain patient records that are comprehensive, time-bound and up to date; and that represent an accurate and complete record of the care you have provided.
Was there a departure from the standard of care	There is a severe departure from accepted practice with regards to the clinical notes and informed consent. There is a severe departure

or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	from accepted practice for prescribing Metronidazole antibiotics with no stated reason. As far as the actual treatment delivered at these appointments goes, I can't say if they are appropriate or not due to lack of clinical records.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed very poorly and if it turned out some or all of the fillings were unnecessary, then our peers would be absolutely shocked.
Please outline any factors that may limit your assessment of the events.	There are insufficient clinical records to say anything for certain other than the records are terrible.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Clinical records course. Informed consent course. Potentially clinical/radiographic diagnosis course. Pharmacology update as to when it is or isn't appropriate to prescribe antibiotics.
Question 2: Whether recommendations made by Dr Subramani to [Mr B] regarding his diagnosed "generalized gingivitis" were appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards
Advisor's opinion:	• There have not been any periodontal probing depths charted so it's not possible to make an accurate diagnosis. • It is correct that gentle soft brushing is better than hard brushing. Twice a day should be sufficient. • It would have been better had Dr Subramani specified to use floss or tepes once a day rather than just saying "regularly". • Post op oral hygiene instructions were given which is good. • Dr Subramani wanted to place the patient on a three-month review. This seems excessive if he really only had generalized gingivitis. The normal recall period would be six months.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Practitioners are legally and ethically obliged to obtain a patient's informed consent before providing care. The standards framework requires practitioners to put patients' interests first and communicate effectively by: giving patients the information they need, or request, in a way they can understand, so they can make informed decisions; ensuring informed consent

	remains valid at all times; and respecting the autonomy and freedom of choice of the patient. You must create and maintain patient records that are comprehensive, time-bound and up to date; and that represent an accurate and complete record of the care you have provided.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a moderate departure in standard of care when no pocket probing depths were recorded (so clinical attachment loss is not able to be ascertained) and a diagnosis made anyway.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Not recording any pocket depths on a patient who had a "foul smell from the mouth for the past week" and you then diagnosed with generalized gingivitis would be viewed poorly, especially on an adult smoker.
Please outline any factors that may limit your assessment of the events.	The lack of any measurable periodontal markers e.g. probing depth, % of sites bleeding, or recession makes it hard to comment further on the treatment and advice delivered.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Record keeping course. Further education around periodontal disease and care.
Question 3: Whether you think it is appropriate that the defective/worn fillings, defective tooth structure were only noted at the second appointment on 17 April 2018, and not raised on the 4 April 2018.	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards
Advisor's opinion:	This was appropriate as a full examination was not done until 17 April 2018. However, it is unclear if the patient realised he was returning for an examination and clean, the $400 worth of fillings detected PLUS any other fillings found at the examination.
What was the standard of care/accepted practice at the time of events? Please refer to relevant	Practitioners are legally and ethically obliged to obtain a patient's informed consent before providing care. The standards framework requires practitioners to put patients'

standards/material.	interests first and communicate effectively by: giving patients the information they need, or request, in a way they can understand, so they can make informed decisions; ensuring informed consent remains valid at all times; and respecting the autonomy and freedom of choice of the patient. You must create and maintain patient records that are comprehensive, time-bound and up to date; and that represent an accurate and complete record of the care you have provided.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure, provided there was better communication than indicated in the clinical notes.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It is normal to see a patient for relief of pain and then get them to return for a thorough examination. It is less usual to get them to return for that, a full mouth scale and polish, five fillings and a bite splint fit. However, in this case the patient did have to travel from … so perhaps this is why.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 4: Whether the aftercare instructions and follow up provided by Dr Subramani was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	• The clinical notes say post op oral hygiene instructions were given. As discussed earlier, I think brushing twice a day with a soft brush (rather than the advised three times) is sufficient and the interdental cleaning should be daily, not just regularly. • There is an attached three-sided document of the verbal discussion supposedly had with the patient around TMJD. This is only mentioned five years later and not in the clinical notes

	of 2018. Given there was no diagnosis of TMJD, this doesn't seem overly useful. • There is an attached document that Dr Subramani says he gave to [Mr B] for patients receiving resin composite restorations for treatment of tooth wear. While this is useful for [Mr B] to decide if he wants that treatment or not, it doesn't give him any information regarding the fillings he actually had, i.e. no discussion around taking care not to bite your lips/cheeks/ tongue while still numb, or to return if any of the fillings feel too high once the numbness wears off, or that some temperature sensitivity for a few weeks can be normal following fillings.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	You need to give patients advice on what to expect following treatment, how to care for themselves post treatment and when to return if there are any problems. This should all be documented.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This is a moderate departure from standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	If no advice was given, it would be viewed poorly, however, if it was given, but not recorded, this wouldn't be seen as that bad a departure.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Better record keeping.
Question 5: Whether you consider the cost of the treatments provided was reasonable and in line with New Zealand Dental Association average fees for the work carried out.	
List any sources of information reviewed other than the documents	NZDA 2020 Fee Survey NZDA Code of Ethics

provided by HDC:	
Advisor's opinion:	• All fees charged fall within the range for the region. • The only area I have a query about is at the appointment on 17/04/2018. Here it seems (going by the statement of account) there were fees as follows: o Exam & xrays + clean — $118.00 o Scale & Polish — $131.00 o Stain Removal — $49.00 All of these effectively involve a clean. Unfortunately, we don't know how much time Dr Subramani spent doing the scale and polish. The fee survey breaks up scaling to per quarter hour. Regardless, I think all the fees charged do fall within reasonableness for the area.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	NZDA Code of Ethics — In all dealings with patients and colleagues, dentists must strive to be open, honest, courteous, empathetic and supportive.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	They would have no problems.
Signature:	
Name: Dr Angela McKeefry (BDS)	
Date of Advice: 17 December 2023'	

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

Further advice

The following advice was provided by Dr McKeefry on 20 April 2024:

> 'Complaint: [Mr B] — ref 22HDC00347
>
> Based on Dr Subramani's response, I see no reason to change my comments. The clinical records are too incomplete to form another opinion.'

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

Appendix C: Dr Subramani's proposed treatment planning for [Mr B] provided in his response to HDC (30 August 2023)

The rationale behind the proposed course of treatment is tooth conservative care and to sequence that care to improve outcomes for the patient and to address the most urgent problems first.

The following steps were proposed:

Emergency care: 16-tooth broken (MODP part), 14 distal worn /broken old filling, and 17 O part of old GIC broken/worn due to parafunctional habit. The treatment options given were no treatment, or filling-the patient opted for fillings.

Signs of parafunction, habit, and tooth wear were noted. Pain is from myogenic origin, due to the parafunction habit.

Options: no treatment, jaw exercise, or night splint, and discussion of advantages and disadvantages of all the options given – Mr [redacted] opted for night splint / splints for bruxism.

Primary care

-comprehensive examination + preventive patient education ie after the emergency visit to then have Mr [redacted] return for an exam and a clean appointment. Defective/ worn fillings, defective tooth structure are noted in relation to 37OB, 27 O, 24DO, 25O,44 OL.

Secondary care:

Prevention of plaque related disease

Diagnosis is generalized gingivitis, provide scaling

Review in 3 months

Management of non threatening disease (dental caries)

24 d early decay: - recommend watch. + advised to use tooth mousse (remineralise enamel)

Maintenance and monitoring: already made an appointment in July

Review recall decision. Review effectiveness of preventive measures, Detection of new pathology and restorative failure, Determine progress and effectiveness of previous treatment, Maintain existing restorations.

Ongoing care / wait / review in 3 months time

13 to 23: enamel wear; option: no treatment, re-enamel with composite resin to protect the dentin.

I provided the written information as attached in Appendix 2.

Appendix D: Independent clinical advice to Commissioner ([Ms A])

The following independent advice was obtained from Dr Angela McKeefry dated 17 December 2023:

'**Complaint:**	**[Ms A]**
Our ref:	**22HDC00613**
Independent Advisor:	**Dr Angela McKeefry (BDS)**

I have been asked to provide clinical advice to HDC on case number 22HDC00613. I have read and agree to follow HDC's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint. I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	• Bachelor of Dental Surgery (Otago) 1993 • Fellow of the International College of Continuing Dental Education (In Orthodontics) • Have been a general dentist doing a wide scope of dental procedures in the same practice for 29 years until I recently shifted to a new practice • Have served on several dental committees over my career including running the Wellington branch of the recent graduate program for several years
Documents provided by HDC:	3 bundles of documents all including the following documents: 1. Complaint from [Ms A] 2. HDC notes of call with [Ms A] dated 29 June 2023 3. [Practice 1] patient clinical records and x-rays 4. Response from Dr Subramani dated 19 September 2023 5. Air polisher protocol as supplied by Dr Subramani
Referral Instructions from HDC:	1. Having regard to [Ms A's] assessment of her visit on 23 March 2018 whether the treatment plan for a fixture was appropriate. 2. What is standard practice for an incident of a dentist piercing the tissue of a patient's mouth whilst providing a Scale and Polish treatment? 3. Whether the actions of Dr Subramani were appropriate in the circumstances. 4. Whether Dr Subramani's wife visiting the hospital to see [Ms A] would be standard practice in the circumstances. 5. Whether the clinical records and notes made by Dr Subramani appear appropriate.

	6. Any other matters that you consider amount to a departure from accepted standards or warrant comment.

Factual summary of clinical care provided:

Brief summary of clinical events:	[Ms A's] Complaint: • Felt Dr Subramani was very confrontational around insisting she grinds her teeth and making a "fixture" for this. • Felt Dr Subramani's manner was very rough. • During Airflow cleaning air went under the gums and caused a surgical emphysema for which she had to go to hospital. • [Ms A] is now extremely anxious about any further dental treatment. • [Ms A] wants to keep the community safe from Dr Subramani who is still practising in town. Dr Subramani's Response: • It was an unfortunate incidence of the air going under [Ms A's] gum, but he had explained it was a rare recognized risk. He referred her to hospital after apologizing. • Dr Subramani makes no mention in his response or the clinical notes about providing [Ms A] with a "fixture" for grinding. The clinical notes do say "Grinder", but no mention of what this is based on.
Question 1: Having regard to [Ms A's] assessment of her visit on 23 March 2018 whether the treatment plan for a fixture was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	• There is no mention of grinding or a "fixture" in the clinical notes or Dr Subramani's response. • There is mention of [Ms A] being a grinder in the examination appointment on 04/04/2018, but again no mention of a "fixture". • [Ms A] seems quite adamant they had a disagreement over whether she grinds her teeth or not. • What I can say is — IF [Ms A] grinds her teeth and needs protection, the normal "fixture" for this would be a nightguard/bitesplint. This should not be undertaken without clearly documented evidence of this issue and consent from the patient.
What was the standard of care/accepted practice at the time of events? Please	

refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	I don't know if this happened, but nothing came of it so I can't say any standards were breached. If anything, there was a breakdown in communication.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I don't know. Patients can often be adamant they don't grind when they do. However, clear evidence needs to be noted, especially if they disagree.
Please outline any factors that may limit your assessment of the events.	This is just all too vague to really comment on.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Communication course.
Question 2: What is standard practice for an incident of a dentist piercing the tissue of a patient's mouth whilst providing a Scale and Polish treatment?	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Medical Emergencies Practice Standards
Advisor's opinion:	• To clarify what actually happened — the tissues were not pierced by the air polisher, but rather some of the high-pressure air went down between the tooth and the gum and penetrated into the soft tissues. Please see Question 3 for further discussion around this. • The standard practice is to stop treatment, remain calm, maintain the patient's airway if required and determine if more advanced care is needed. • Dr Subramani called both an ambulance and [Ms A's] friend and ensured she was taken to hospital. He later followed up with the doctor at the hospital. This is all very reasonable. • In [Ms A's] account of the incident, she says she started to hyperventilate and so he turned off the lights and left her there on

	her own for a few moments. If this actually happened, that would be terrible. The patient is panicked and frightened with possible airway issues. You would never leave her alone unless you were the only person on site, and you had to in order to call an ambulance.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	An oral health practitioner has an ethical and legal obligation to attend to a medical emergency. Further, it is the public's expectation that a health professional will be able to assist them in a medical emergency situation within their training and until an emergency response team arrives, when indicated. The HDC Code of Rights provides that every consumer has the right to services provided with reasonable care and skill, and that comply with legal, professional, ethical, and other relevant standards. The standards framework requires practitioners to put their patients' interests first, and to protect those interests by practising safely and providing good care. The practitioner's ability to deal with medical emergencies that arise in practice is a significant aspect of meeting their obligations to, and the expectations of, their patients.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Once the surgical emphysema had occurred, Dr Subramani did everything right (except leaving her alone, if that is what happened). If he did turn off the lights and leave her alone, that is a severe departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	If Dr Subramani left the patient alone on purpose, this would be viewed very poorly. Otherwise, everything was done well. I do think it would have been much better if Dr Subramani had followed up with [Ms A] over the next few days to check on her.
Please outline any factors that may limit your assessment of the events.	Was [Ms A] left alone? I don't know.
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Question 3: Whether the actions of Dr Subramani were appropriate in the circumstances.	
List any sources of information reviewed other than the documents	DCNZ Standards Framework for Oral Practitioners

provided by HDC:	
Advisor's opinion:	• Other than the issues mentioned above in Question 2, the cause of the surgical emphysema needs to be more thoroughly assessed. • In Dr Subramani's answers to my questions dated 13 December 2023 he confirms the following: o The order of treatment Dr Subramani performs when undertaking a scale and polish appointment is an ultra-sonic scaler, followed by a hand scaler, followed by Airflow. o The powder being used in the Airflow was sodium bicarbonate. • In Dr Subramani's response dated 19 September 2023 he lists the risks he informed [Ms A] of prior to treatment. These being: o There is a risk of sensitivity. o Sodium bicarbonate powder may cause damage to the hard and soft periodontal tissues when used subgingivally. o The use of sodium bicarbonate for air polishing has been considered safe for enamel but can contribute to root surface defects. • Dr Subramani also notes in his response that now he uses the Airflow angled to 90 degrees to the tooth surface instead of what he had been doing which was 40 degrees towards the gum sulcus. • When using Airflow, there are different powders for different purposes. For the reasons listed above in Dr Subramani's own risks that he informs patients of, Sodium Bicarbonate should NEVER be directed towards the gum, always away from the gum. In the user manual which Dr Subramani attached to his response, it clearly shows the nozzle pointing AWAY from the gum at 10–60 degrees. For him to aim it toward the gum sulcus at a 40-degree angle and even now when he says he uses it at 90 degrees to the tooth surface is not acceptable and likely to cause damage. • The accepted protocol for Airflow, whatever powder is being used, is to use it FIRST, BEFORE ultra sonic and hand scaling. Dr Subramani clearly states in his answers to my questions dated 13 December 2023 that his protocol in 2018 and still now in 2023 is to ultra sonic scale and then hand scale and only after that does he use Airflow. This is absolutely wrong and is likely the reason, when combined with the 40-degree angle of use, that surgical emphysema occurred. Both ultra sonic and hand scaling easily cause tears in the gingival sulcus, which is why Airflow should NEVER be used after them, especially with sodium bicarbonate which can do even more damage, opening up potential pathways for air to penetrate into the tissues.
What was the standard of care/accepted practice at the time of events? Please refer to relevant	Patients have the right to: • have services provided with reasonable care and skill; • have services provided that comply with legal, professional, ethical, and other relevant standards;

standards/material.	• have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer; • co-operation among providers to ensure quality and continuity of services. You must practise within your professional knowledge, skills and competence, or refer to another health practitioner.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This is a very severe departure from standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Our peers would view this very poorly and for him to have not even realized his mistakes some five years after such an event (causing a patient to be hospitalized) is shocking.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Further clinical training.
Question 4: Whether Dr Subramani's wife visiting the hospital to see [Ms A] would be standard practice in the circumstances.	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards
Advisor's opinion:	• When asked in December 2023, Dr Subramani says his wife did not visit [Ms A] in hospital. • We are left to conclude this was an unknown person. • If this person was a staff member of the practice, present at the time of the injury, then while not standard practice, it is acceptable.

	• If this person was not a staff member present in the surgery at the time of injury (or perhaps the practice manager), and they found out about the incident through the practice (which seems possible since the person was unknown to [Ms A]), then this is a severe breach of patient confidentiality.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	You must protect the confidentiality of patient information.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This is impossible to say as we don't know who visited [Ms A]. If the visitor was not a staff member present in the surgery at the time of injury (or perhaps the practice manager), and they found out about the incident through the practice (which seems possible since the person was unknown to [Ms A]), then this is a severe breach of patient confidentiality.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	If there was a breach of patient confidentiality, then this would be viewed VERY poorly.
Please outline any factors that may limit your assessment of the events.	The visitor to hospital is unknown.
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Question 5: Whether the clinical records and notes made by Dr Subramani appear appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	DCNZ Practice Standards
Advisor's opinion:	The clinical records and notes do not contain enough information generally and are, at least in part, inaccurate. An example of this can be seen in the notes from appointment 23/03/2018 — two composite fillings and an extraction are performed. • Neither of the fillings have listed why they needed to be done,

	options discussed, type of composite, bond used, post op instructions etc … • The extraction notes refer multiple times to the patient as "he" and "his". They also include the statement "Options given to replace a single missing tooth, He expressed he can't afford other treatment at the moment". It is not normal to offer options to replace an extracted wisdom tooth, unless there are multiple other teeth missing, which isn't the case. At the examination appointment on 04/04/2018 in the comment under teeth, it says "Pocketting and dentition as charted (see charting)". It has been confirmed through both [Practice 1] and Dr Subramani that there are no available periodontal pocketing charts.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	You must maintain accurate, time-bound and up-to-date patient records.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This is a severe departure from accepted standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed poorly by our peers.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Clinical records course.
Question 6: Any other matters that you consider amount to a departure from accepted standards or warrant comment.	
List any sources of information reviewed	

other than the documents provided by HDC:	
Advisor's opinion:	• The owner of the practice ([Practice 1]) which Dr Subramani was contracted to, must have some obligation to ensure practitioners are fully trained to use all the equipment they provide. • Did [Practice 1] give full training to Dr Subramani prior to allowing him to use a potentially dangerous compressed air device on their patients? • Did [Practice 1] ensure Dr Subramani understood the differences in Airflow powders and their specific uses? • Did [Practice 1] ensure Dr Subramani knew the Airflow should NEVER be used AFTER scaling, only before? • If [Practice 1] did all these things, did Dr Subramani disregard this training on purpose?
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	As concluded in previous questions, Dr Subramani must ensure he only performs procedures for which he is fully trained and competent in. I am unsure if there is any such obligation on the practice owner as unless they are a dentist, they don't fall under the jurisdiction of the DCNZ. Perhaps they come under the Certified Health Care Provider in the Health and Disabilities Services Act?
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I would think our peers would take a very dim view of any practice owner allowing an oral health practitioner to use equipment they provide and maintain, without adequate training, especially when it can have such an impact on the patient.
Please outline any factors that may limit your assessment of the events.	I am unsure of the legalities around this point, but felt it was worth raising.
Recommendations for improvement that may help to prevent a similar occurrence in future.	I would think practices should have registers of potentially hazardous equipment with the key points of the training, who conducted and who received the training with signatures and dates.

Signature:
Name: Dr Angela McKeefry (BDS)
Date of Advice: 18 December 2023’

Further advice

The following further advice was provided by Dr McKeefry on 20 April 2024:

> ‘Complaint: [Ms A] — ref 22HDC00613
>
> Response to Question 2. [Ms A] was not left alone, but FELT she had been.
>
> Response to Question 3. I think the detail Dr Subramani provided originally about the airflow in a report following a serious medical incident should be the wordings we take as accurate. These comments surely would have been thoroughly checked prior to submission. To now say he mentioned it incorrectly seems unlikely. Dr Subramani is now also saying that he used the air-prophy 1st at the start of the appointment, but previously he said he ultrasonic scales first. I really don’t know what happened except [Ms A] ended up with air emphysema.
>
> Dr Subramani has attached comments from a paper in 2017, however this is quite non-specific. There are different purposes to use an air prophy which have different techniques, guidelines and powders. If using sodium bicarbonate (which he was), you should not ultrasonic scale first and angle the nozzle towards the gum (which it seems he did).
>
> Dr Subramani also states in his response that he was unsure the compressor pressure or calibration were correct. He should not have been using the device on any patient without knowing it was safe to do so.’

Appendix E: Relevant parts of Dr Subramani's clinical records for treatment on 4 April 2018 ([Ms A])

Patient Details

	04/04/18	BS	S&P, Scale & Polish	*
	04/04/18	BS	POLISH, Polish	*
	04/04/18	BS	AUTONOTE, Note	*
		Clinical Notes:	air emfasima for air profex 3 - advised see E and D for reassurance called gp at hospital - slight swelling at rhs bottom of the jaw	
	Appointment 3			
	04/04/18	BS	AUTONOTE, Note	*
		Clinical Notes:	hospital given augmention as a back up air bubble is moving down/ doctor advised to use massage oil and heat pack [redacted] was in shock, but now she is ok	
Void	04/04/18	BS	AUTONOTE, Note	*
		Clinical Notes:	hospital given augmention as a back up air bubble is moving down/ doctor advised to use massage oil and heat pack	

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