

Dental Surgeon – Dr B

**A Report by the
Health and Disability Commissioner**

(Case 02HDC01805)



Health and Disability Commissioner
Te Toihamu Hamora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider / Dental Surgeon
Dr C	Oral & Maxillo-Facial Surgeon
Dr D	General Practitioner
Dr E	General Practitioner

Complaint

On 11 February 2002 the Commissioner received a complaint from Mrs A about Dr B. The complaint was summarised as follows:

Dr B did not provide services to Mrs A in accordance with appropriate standards. In particular, Dr B:

- *did not advise Mrs A as to the various treatment options that were available in respect of treatment to her tooth and did not provide a reasonable explanation to Mrs A as to his reasons for his recommended treatment;*
- *did not carry out the recommended treatment with reasonable care and skill resulting in unnecessary pain and suffering to Mrs A in the course of administering such treatment;*
- *extracted the wrong tooth;*
- *aggravated the tooth that Dr B recommended should have been extracted causing Mrs A to suffer blood poisoning.*

An investigation was commenced on 17 July 2002.

Information reviewed

- Letter of complaint, dated 31 January 2002
- Notes of interview with Dr B on 11 April 2003
- Information provided by Dr C, including:
 - a report to ACC, dated 22 May 2002
 - comments made during a telephone call on 11 December 2002
- Information provided by ACC, including:
 - Dr B's response, dated 22 February 2002
 - Dr B's clinical notes
 - expert reports by an oral and maxillo-facial surgeon and a dental surgeon
 - records from Medical Misadventure panel meeting on 29 October 2002
 - Medical Misadventure decision letter, dated 24 October 2002
- Notes taken by Mrs A's GP relating to her dental treatment
- Further information provided by Mrs A, via telephone interview, on 30 May 2002.

Independent expert advice was obtained from Dr Mark Goodhew, a dental surgeon.

Information gathered during investigation

There are several factual discrepancies between Dr B's account and Mrs A's account. I have carefully reviewed all of the evidence and the conclusions I have drawn are outlined below.

On 28 December 2001, Mrs A saw Dr B regarding an infected wisdom tooth (tooth 18) that she asked to have removed. Dr B took X-rays and advised Mrs A that tooth 18 should be extracted "sooner rather than later". Mrs A states that Dr B told her that she had a very bad infection and advised her to have the tooth out "pretty smartly". He told her that it was a straightforward procedure and that the extraction itself would take less than a minute. Mrs A agreed to have the tooth removed. Dr B put her on a course of antibiotics and arranged for her to return on 5 January 2002 for the extraction, once the infection had subsided.

On 5 January 2002, Mrs A returned to Dr B's surgery to have tooth 18 removed. Present during the procedure were Dr B, Mrs A and Dr B's assistant. I note that Dr B has been unable to provide me with the name or contact details of the dental assistant who assisted him with the procedure.

Mrs A states that the extraction took about 25 minutes, which was three times longer than Dr B had told her it would take, although he had told her that it would be difficult to get the tooth out.

After discussing the procedure Dr B anaesthetised Mrs A and began to use an elevator to subluxate, or loosen, tooth 18 in its socket. In doing so he used the neighbouring tooth (tooth 17) as a fulcrum, on which to lever the elevator.

Dr B states that, in using the elevator, he used the usual amount of pressure, which is a "large amount". Mrs A, in her letter of complaint of 31 January 2002, described the amount of pressure Dr B used as "immense". She subsequently described it to my staff as "considerable", noting that the force used was enough to split the sides of her mouth, although not enough to make them bleed. Mrs A also stated that during the procedure she "ended up being almost upside-down" and Dr B had to put one of his feet up on the chair, near her hip for leverage or balance. It is clear that Dr B used a great deal of pressure when removing Mrs A's tooth.

Dr B states that, while he was subluxating tooth 18, Mrs A suddenly flicked her head to one side. He believes that, as he was supporting Mrs A's head at the time, she must have given a "big shake" in order to move her head. When Mrs A did this Dr B stopped treatment and enquired if she was all right. Mrs A indicated that everything was fine and he continued. Mrs A then made another sudden head movement. Dr B heard a very audible noise and part of a tooth came out. Mrs A states that she did not move her head at any point during the procedure, except when Dr B moved it for her. I note that there is no record of this incident in Dr B's clinical notes or in his earlier correspondence with my Office or with ACC.

During an interview on 11 April 2003, Dr B stated that, after the tooth came out, Mrs A got out of the chair very quickly. This statement is disputed by Mrs A, who claims that she was "not in a position to do anything quickly". Mrs A was advised to bite down on a gauze square which was already in her mouth. Dr B stated that, having extracted the tooth, he was able to look at it and it looked very similar to tooth 18. He assumed that it was a piece of tooth 18. Mrs A stated that after the tooth came out Dr B told her something to the effect of "it is all over now". He then wrapped the tooth in a piece of gauze and gave it to her (in her letter of complaint Mrs A stated that it was Dr B's assistant who gave her the tooth). Dr B then placed a piece of cotton wool in her mouth in the gap where the tooth had come out. He did this with his finger. According to Mrs A, Dr B did not look in her mouth after removing the tooth.

Mrs A states that after the procedure Dr B wrote up his clinical notes. The notes for the consultation record:

"LA [local anaesthetic] x2 Exo 18 Buccally erupted. Informed R.S. [one word illegible] Will look at if symptomatic. Haemostasis. Paid."

Mrs A states that Dr B then gave her a list of instructions for aftercare and an account for payment. Dr B told her that he had left a few roots in, but that her body would discharge them over time.

Dr B recalls that, following the consultation, he felt that something might not be right and telephoned Mrs A to enquire as to her wellbeing and to suggest that she come back to see him for a further examination, which she agreed to do. According to Mrs A, following the procedure, she felt sore and weak, the corner of her mouth was torn and her face was very swollen and puffy. Mrs A submits that Dr B's following phone call amounts to an admission of negligence.

Mrs A did not discover that Dr B had removed tooth 17 until the next day. She decided not to see Dr B for further treatment. However, she did speak to Dr B on the telephone and told him that he had removed the wrong tooth.

On 7 January 2002, Mrs A saw Dr D, general practitioner, who noted that tooth 18 was "probably infected". She prescribed antibiotics and pain relief, and advised Mrs A to see a dentist the next day.

On 8 January 2002, Mrs A saw Dr C, an oral and maxillo-facial surgeon. Dr C stated that when he saw Mrs A she complained of pain and swelling in the region of the upper second and third molars. She referred to blood poisoning and having been very ill, although Dr C did not find any evidence of septicaemia or any significant general reaction. He noted that because tooth 17 appeared to have been in a buccal position it may have obstructed access to tooth 18. Dr C extracted Mrs A's tooth 18 on 10 January 2002. He noted that tooth 18 was unlikely to make contact with the opposing lower molar and thus was likely to be of little functional value. He also noted that it would have been very obvious to Dr B that he had removed tooth 17.

Mrs A saw her GP, Dr E, on 24 January, to facilitate an Accident Compensation Corporation (ACC) claim. Dr E noted that Mrs A had said that she had had the wrong tooth taken out on 5 January and had become "unwell soonafter".

In May 2002 Mrs A submitted a claim to the Medical Misadventure Unit of ACC. ACC obtained advice from an oral and maxillo-facial surgeon and a dental surgeon. The oral and maxillo-facial surgeon advised:

"I believe that the failure to remove the correct tooth and lack of appropriate follow-up does not meet a reasonable standard of care to be expected in the circumstances. Surgical removal of tooth 18 would not generally be a difficult procedure when performed by someone with adequate experience."

The dental surgeon advised:

"The patient management provided by [Dr B] was probably the best he could do under the circumstances. The fracture to tooth 17 was described as an unusual accident and, as things turned out, it would have been better to inform the patient then of the damage to tooth 17 rather than wait for the next appointment ... This mistake cannot be classed as negligent or reckless."

ACC medical error

By letter dated 24 October 2002, ACC accepted that the actions of Dr B constituted medical error.

Independent advice to Commissioner

The following independent expert advice was obtained from Dr Mark Goodhew, dental surgeon:

“I have been asked to provide advice with respect to complaint file 02/01805. I have considered all of the supporting information and material provided, as listed by the Commissioner, in arriving at my conclusions. The Commissioner has asked a number of specific questions related to [Dr B's] management of the removal of a wisdom tooth (tooth 18) for [Mrs A]. I note that there is some dispute between [Dr B] and [Mrs A] over whether a sudden movement by [Mrs A], that may have contributed to the subsequent fracture of tooth 17, took place. I have not attempted to determine whether or not this happened, but have laid out my advice to take account of any alternative versions of events.

Did [Dr B] give [Mrs A] all the information that she could reasonably expect to receive about the options for treating her infected wisdom tooth?

An extraction of this nature is the treatment of choice in this situation, and is usually a straightforward clinical procedure. A patient could reasonably expect to receive information related to complications common to all extractions, such as post-operative pain, swelling or prolonged bleeding, as part of the planning and consent process. As well, a prudent practitioner would assess the particular risks of this extraction, and mention these. They may include the possibility of a breach of the maxillary sinus floor. A possible fracture of the adjacent tooth is not something that would normally be mentioned, unless that tooth was weakened in some way, by being heavily restored for example.

I note that [Dr C] in his letter of 22 May, 2002, mentioned that tooth 17 ‘appeared to me to be in buccal position which may have obstructed access to’ tooth 18. In my opinion, if this was the case, it may have made the procedure more technically difficult, but not more likely to cause tooth 17 to fracture than would normally be the case. I would have expected [Dr B] to note this feature, and mention it to [Mrs A] at the time, if he anticipated that it could potentially make his clinical access to tooth 18 more difficult.

In this case there do not appear to be any risks so great that an extraction would be contra-indicated, or that another treatment option would even be considered. [Dr B's]

notes do not indicate that any options other than extraction were discussed, and in my opinion this is reasonable.

Was [Dr B's] plan for treating [Mrs A's] tooth appropriate and reasonable?

There is no question that tooth 18 required removal, and I consider that the treatment plan proposed for this was appropriate. It is reasonable to delay the extraction of an impacted wisdom tooth until a gum infection around the tooth (pericoronitis) has resolved, because local anaesthetic is often less effective in the presence of inflammation or infection. It is also completely reasonable for a general dental practitioner to remove a tooth such as this one with local anaesthetic only.

Does the accidental damage to tooth 17 show a lack of reasonable care and skill on the part of [Dr B]?

In order to remove an impacted upper wisdom tooth, it is reasonable and normal practice to use dental elevators. Simply put, these are levers designed to loosen (subluxate) the tooth in its socket. This is normally done prior to final removal of the tooth by dental forceps. A lever requires a fulcrum to be able to generate force, and in this situation the elevator would have been placed between the 18 and 17, at about the level of the alveolar crest, with the 17 acting as the fulcrum, and the 18 moved backwards by a small rotational movement of the elevator.

An elevator can potentially generate considerable force, so it is important that any movement be controlled and limited, to minimize damage to the soft tissues in the area, and damage to the fulcrum area. If the operator is right-handed, the left hand will normally be used to stabilize the area, to protect the soft tissue structures in the area, and retract the cheek to allow adequate vision. It also helps to control unexpected movement by the patient.

I have examined the fractured tooth crown, and it is unfilled and free of dental decay, so it would have taken a substantial amount of force to fracture this tooth. In the normal course of events, that is if there was no unexpected movement by the patient, this could only happen if uncontrolled and excessive force was used to attempt to remove a tooth; in other words, tooth 17 could only have fractured if [Dr B] did not use reasonable skill and care.

However, [Dr B] states that [Mrs A] moved her head suddenly. If this was the case, the operator's left hand should have been able to control and limit any such movement.

If [Mrs A] did somehow manage to suddenly move her head, and [Dr B] was unable to control this, for whatever reason, then it is possible to imagine that the elevator could have moved sufficiently to create the force required to fracture tooth 17. However, this would be such a singularly unusual event, and have such a major detrimental influence on the outcome of this routine procedure, that I am certain the large majority of dentists would have made mention of this complication in their patient records.

There is no note in the records to this effect, nor does [Dr B] mention it in his letter of 22 February, 2002, to the Medical Misadventure Claims Officer.

Having removed the tooth, was [Dr B's] examination of [Mrs A's] mouth reasonably adequate?

In order for [Dr B] to confirm that clotting (haemostasis) had taken place, and that tooth 18 had been extracted, as recorded in the patient notes and confirmed in the interview of 11 April, 2003, he would have had to look closely at the socket. He also states in this interview that he 'always push(es) something into the socket which the patient can bite down on and have the ... clot form'. In these situations there is no way an experienced dentist could miss the presence of another tooth behind the socket of the tooth that had fractured.

On the other hand, [Mrs A], in her telephone conversation with the investigation officer of 30/05/03, states that [Dr B] did not look in her mouth once the tooth had been extracted.

Given this, I have to conclude that either [Dr B] has wilfully recorded information he knew to be false in the patient records, or his post-extraction examination was of a very poor standard.

I am of the opinion that it is almost impossible that [Dr B] was not aware at the time of the attempted extraction of tooth 18 that it was tooth 17 that had fractured.

According to [Mrs A], [Dr B] advised her that he had 'left a few roots in', but that her body would discharge them over time. Was this accurate and reasonable advice in the circumstances? Would this course of action accord with normal practice?

Fractured and retained roots are a recognized complication of dental extractions. If retrieving them at the time of the extraction is not possible, then patients should at least be informed of their presence, which [Dr B] obviously did. If there are small tips or root fragments that have to be left, they will generally not cause ongoing problems, and can often be discharged, occasionally over long periods over time.

In this case there appears to be, on the panoramic radiograph supplied by [Dr C] and dated 8/01/02, a large amount of root material remaining, which I would expect to require removal in the short term. Leaving this quantity of tooth untreated for an extended period would not be normal practice in situations similar to this.

However, I note that [Dr B] did try to contact [Mrs A], and arranged a follow-up consultation, which is a reasonable course of action, if it was not possible to remove the tooth roots at the initial appointment.

Are [Dr B's] records of [Mrs A's] condition and treatment of a reasonable professional standard?

The patient records that I have viewed are concise, but very clear. However, the entry dated 05/01/02 is factually incorrect, in that it identifies tooth 18 as having been extracted. Therefore these records cannot be relied on as a complete and accurate record of [Mrs A's] treatment, and so cannot be regarded as being of a reasonable professional standard. Of course, if [Dr B] has wilfully entered incorrect information, this is completely unacceptable.

Are the x-rays taken by [Dr B] of a reasonable professional standard?

Two radiographs were supplied, dated 28/12/01, of the upper right and lower right posterior teeth. Both are of very poor technical quality. They are so badly stained and fogged, as a result of processing faults, that they are diagnostically useless.”

Dr Goodhew also gave the following verbal advice to the investigation officer:

If [Dr B] knew that he had fractured tooth 17 he would have been under some obligation to tell [Mrs A] what had happened, including that he had fractured the wrong tooth.

As the experience appears to have been quite traumatic for [Mrs A], [Dr B] would not necessarily have had to try and remove the roots straight away. However, he should either have arranged another appointment with [Mrs A] to remove the roots or offered to refer her to another dentist to have the roots removed.

If [Dr B] had told [Mrs A] that tooth 17 had been fractured, he could have eased her concerns by noting that, as tooth 17 was not in occlusion, losing it was not a complete disaster.

It is unlikely that taking the top off tooth 17 would have made the infection of the gum around tooth 18 worse. Even if the correct tooth had been removed, the outcome might still have been the same.

If [Dr B] wanted to check that haemostasis had occurred he would have had to look carefully in [Mrs A] mouth, pulling back the cheek and using a mirror. If he did not do this level of examination, his comment on this point must have been a guess.

An examination would have confirmed that haemostasis had occurred and would also have revealed that tooth 17 had been fractured.

In the usual course of events after an extraction, a dentist should definitely do a postoperative examination, which would include looking in the mouth.

If something had not gone right, such as [Mrs A] being distressed after the procedure, a prudent dentist should still make some attempt to do a postoperative examination.

Responses to Provisional Opinion

In response to my provisional opinion, Dr B stated that he viewed the outcome of his operation on Mrs A with regret and that it was accidental. He noted his willingness to “take on board” the comments of his peers, and comply with an audit of his radiograph technique, if necessary.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

- 1) *Every consumer has the right to have services provided with reasonable care and skill.*

RIGHT 6

Right to be Fully Informed

- 1) *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; ...*
-

Relevant standards

The New Zealand Dental Association's "Code of Practice – Patient Information and Records 1996" states:

"The information held about individual patients must be accurate, up to date, complete, relevant, and not misleading. Thus information which is subject to change over time should be checked for accuracy and updated at reasonable intervals."

Opinion: Breach

Excessive force in extracting tooth

I find Dr B's contention, that Mrs A moved her head, unconvincing. I note that Dr B did not record this head movement in his notes, nor did he raise it as an issue, either with ACC or with my Office, prior to his interview with my staff in April 2003. I also note my expert's advice that, even if Mrs A had moved her head, Dr B should have been able to control this movement.

I accept my expert advice that for Mrs A's tooth to have fractured Dr B must have used excessive and uncontrolled force when subluxating tooth 18. This resulted in the wrong tooth being extracted. Thus, in my opinion, Dr B did not use reasonable care and skill in attempting to remove Mrs A's tooth 18 and breached Right 4(1) of the Code.

Inadequate post-extraction examination

Following the extraction Dr B told Mrs A to bite down on some gauze that was already in her mouth. He also placed some cotton wool into the socket of tooth 17 with his finger. He examined the tooth he had extracted. Dr B did not look in Mrs A's mouth. This was the extent of his post-extraction examination.

Furthermore, Dr B recorded that, following the procedure, haemostasis had occurred (ie, a blood clot had formed). I accept my expert advice that in order to confirm that haemostasis had occurred Dr B would have had to look carefully in Mrs A's mouth, pulling back the cheek and using a mirror. I note that Dr B did not look in Mrs A's mouth at all after the procedure. In these circumstances, I accept that Dr B could not have known if haemostasis had occurred.

Dr B also recorded that he had extracted tooth 18. This is clearly inaccurate. Dr B states that after extracting tooth 17 he looked at it and it looked like tooth 18. He also states that he assumed that he had extracted the correct tooth. I note my expert advice that, having placed padding into the socket of tooth 17, it would have been almost impossible for Dr B not to have known which tooth he had extracted. I also note the comment made by Dr C,

the dental surgeon who treated Mrs A after Dr B, that it would have been “very obvious” to Dr B which tooth he had extracted.

In my view, whether Mrs A promptly stood up following the extraction is immaterial. A prudent dentist would have made some attempt to undertake a postoperative examination. An adequate postoperative examination would include looking in the patient's mouth.

Clearly Dr B did not undertake such an examination. If he had done an adequate examination he would have been left in no doubt that he had extracted the wrong tooth. In my opinion, in failing to conduct an adequate post-extraction examination, Dr B did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: No breach

Information prior to treatment

I accept my expert advice that the information Dr B provided to Mrs A prior to her treatment, about the options for treatment and the reasons for having tooth 18 extracted, was reasonable in the circumstances. I also accept my expert advice that extracting tooth 18 was the only reasonable treatment available and that damage to a neighbouring tooth during this procedure would usually be such a remote risk that it would not need to be explained to a patient prior to treatment. In my opinion, Dr B provided Mrs A with sufficient information about her condition, the options for treatment, and risks in the circumstances, and did not breach Right 6(1) of the Code.

Blood poisoning

I accept that Dr B's treatment did not lead to blood poisoning or septicaemia. While it appears that the treatment did aggravate Mrs A's tooth, there is no evidence that it led to more widespread or serious infection. There is no indication from either Dr C or Dr D that Mrs A was suffering a generalised infection. In my opinion, Dr B did not cause blood poisoning by treating Mrs A and thus did not breach Right 4(1) of the Code in relation to this matter.

Other comments

Record keeping

I bring to Dr B's attention the New Zealand Dental Association's comments that “the information held about individual patients must be accurate, up to date, complete, relevant, and not misleading”.

I note that the records provided by Dr B are inaccurate and incomplete. They give no indication that the procedure was anything other than a routine, successful extraction and are, in this respect, clearly misleading.

Radiographs

I note my expert's comments that the radiographs supplied were of a very poor standard and were diagnostically useless. As there were no other radiographs supplied, I can only conclude that they were the radiographs relied on by Dr B when treating Mrs A.

Follow-up actions

Referral to Director of Proceedings

I will refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken.

Referral to Dental Council of New Zealand

A copy of this report will be sent to the Dental Council of New Zealand, with a recommendation that they consider whether to audit Dr B's use of radiographs.

Anonymised opinions

A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Dental Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings laid a charge before the Dentists Disciplinary Tribunal. On 27 September 2004 the Tribunal found that Dr B's actions and omissions were detrimental to the welfare of the complainant pursuant to s 54(1)(b) of the Dental Act 1988, but did not consider that his conduct was sufficiently serious to attract disciplinary sanction. The Tribunal granted permanent name suppression.