



Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*

## **Dentist works outside scope in providing orthodontic treatment**

**21HDC00656**

Deputy Health and Disability Commissioner Dr Vanessa Caldwell has found a dentist breached the Code of Health and Disability Services Consumers' Rights (the Code) for orthodontic treatment provided over a two-year period to a 12-year-old girl.

The dentist fitted braces on the teen, which were subsequently removed and replaced with aligners. Three years after completion of the treatment, a specialist orthodontist expressed dissatisfaction with the orthodontic treatment undertaken by the dentist and recommended the teen have upper and lower braces and jaw advancement surgery.

Dr Caldwell found the dentist breached several Rights under the Code for failing to refer the teen to a specialist at the outset, and undertaking treatment he was not trained, or sufficiently experienced, to provide.

The Dental Council of New Zealand (DCNZ) standards, state that practitioners must practice within their professional knowledge, skills and competence, or refer to another health practitioner.

Dr Caldwell also found the dentist in breach for failing to keep full, accurate patient records that complied with the relevant professional and ethical standards.

The DCNZ practice standard on record keeping stipulates that practitioners must create and maintain comprehensive, time-bound and up-to-date patient records.

“The absence of clear, well documented clinical records hindered my investigation into the clinical aspects of this complaint,” Dr Caldwell said. “In addition, more fulsome, detailed clinical records would have assisted the dental practitioners who subsequently provided treatment.”

The dentist did not obtain adequate informed consent for the braces. Not only was documentation of the informed consent process lacking, but the informed consent discussion took place on the day the braces were fitted. This did not allow adequate time for the teen and her mother to consider the treatment and its risks.

Noting that the dentist had completed a detailed DCNZ education programme, Dr Caldwell made several recommendations, outlined in the report, including that he provide a written apology to the teen for the deficiencies in care identified in the report.

6 May 2024

**Editor's notes**

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's '[Latest Decisions](#)'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website [here](#).

HDC promotes and protects the rights of people using health and disability services as set out in the [Code of Health and Disability Services Consumers' Rights](#) (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

[Read our latest Annual Report 2023](#)

Health and disability service users can now access an [animated video](#) to help them understand their health and disability service rights under the Code.

Learn more: [Education Publications](#)

**For more information contact:**

*Communications team, Health and Disability Commissioner*

Email: [communications@hdc.org.nz](mailto:communications@hdc.org.nz), Mobile: +64 (0)27 432 6709