Dentist, Dr B

Dental Service

A Report by the

Health and Disability Commissioner

(Case 15HDC01402)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 17 April 2015, Ms A (aged 15 years at the time of the events in question) had an appointment at a dental service with dentist Dr B. The appointment with Dr B was for the extraction of Ms A's deciduous teeth[1] numbered 53, 63 and 65.

2. During the appointment, Dr B extracted deciduous teeth 53 and 63 but erroneously removed adult tooth 26 instead of the third deciduous tooth, 65. Immediately after removing tooth 26, Dr B realised he had extracted the incorrect tooth and reinserted tooth 26.

3. Dr B failed to identify the correct tooth for extraction and therefore removed the wrong tooth. In doing so, Dr B failed to provide services with reasonable care and skill and breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights.

4. Dr B's breach of the Code was the result of an individual clinical error and is not attributable to the dental service. Therefore, the dental service did not breach the Code.

Complaint and investigation

5. The Commissioner received a complaint from Mr and Mrs A about the services provided to their daughter, Ms A, by dentist Dr B.[3] The following issues were identified for investigation:

   - *Whether Dr B provided an appropriate standard of care to Ms A in April 2015 and May 2015.*
   - *Whether the dental service provided an appropriate standard of care to Ms A in April 2015 and May 2015.*

6. An investigation was commenced on 12 February 2016.

7. The parties directly involved in the investigation were:

Mr A	Complainant
Mrs A	Complainant
Dr B	Dentist, provider
Dental service	Provider

Other parties relevant to this report:

[1] Primary teeth, commonly known as baby teeth.
[2] Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.
[3] Ms A has confirmed that she supports the complaint.

Ms A	Consumer
Mr C	Orthodontist

8. Independent expert advice was obtained from dentist Dr Andrea Cayford (**Appendix A**).

Information gathered during investigation

Dental service

9. Dr B is a director and shareholder of the dental service. Dr B is the sole dentist at the dental service and is registered with the Dental Council of New Zealand in a general dental scope of practice.

Ms A

10. Ms A, aged 15 years at the time of the events in question, is a patient of orthodontist Mr C. Mr C advised HDC that Ms A is a "complicated multidisciplinary orthodontic case with multiple congenitally absent teeth[4]".

11. On 24 March 2015, Mr C wrote a referral letter for the extraction of Ms A's deciduous teeth[5] numbered 53, 63 and 65 as part of her orthodontic treatment. Mr A forwarded the referral letter to Dr B and arranged for teeth 53, 63 and 65 to be extracted.

12. Dr B was also provided with a panex radiograph[6] of Ms A's mouth, taken by Mr C, which identified the teeth to be extracted.

17 April 2015 appointment

13. On 17 April 2015, Ms A had an appointment with Dr B. Dr B had consent for the treatment plan, which included the extraction of teeth 53, 63 and 65.

14. Dr B extracted two of the deciduous teeth, 53 and 63, that were to be removed. However, he mistakenly identified adult tooth 26 as deciduous tooth 65 and erroneously extracted tooth 26 instead of tooth 65.

15. Dr B provided HDC with documentation he had sent to ACC, in which he stated:

> "[I]t was only upon its extraction that I then realised by the length of the root this mistake had occurred. My immediate response was to re-implant the tooth without delay."

16. In response to the provisional opinion, Dr B stated that the reason tooth 65 was not extracted at this stage was to provide support to reimplanted tooth 26. Dr B said that

[4] Teeth missing from birth.
[5] Primary teeth, commonly known as baby teeth.
[6] Commonly referred to as a full-mouth X-ray.

he informed Mr C of his decision not to extract tooth 65 at the time the decision was made.

Actions taken following the incorrect extraction of tooth 26

17. Mr and Mrs A told HDC that Ms A continued to experience pain in the incorrectly extracted tooth after Dr B had reinserted it. On 21 April 2015, Dr B carried out a pulpotomy[7] on the reimplanted tooth.

18. Dr B told HDC that he referred Ms A to an endodontist[8] to have tooth 26 reviewed. On 16 October 2015, an endodontist examined Ms A. Following the examination, the endodontist proceeded with endodontic treatment on tooth 26.[9]

19. Tooth 65 has not been extracted. Mr and Mrs A told HDC that Mr C has decided to re-evaluate what should be done with tooth 65 at a later stage.

Additional comment by Dr B

20. Dr B has "offered to co-pay along with ACC any cost associated with tooth 26". Dr B told HDC: "I very much regret that this occurred and that I am responsible for that occurrence." Dr B has apologised to Ms A and her parents.

Response to provisional opinion

21. Dr B was provided with an opportunity to respond to the provisional opinion. Dr B accepted the findings of the provisional opinion.

22. Mr and Mrs A were provided with a copy of the "information gathered" section of the provisional opinion and had no further information to add.

Opinion: Dr B — Breach

23. Mr C provided Mr and Mrs A with a referral letter for Ms A to have deciduous teeth 53, 63 and 65 removed as part of her orthodontic treatment. Mr A forwarded the referral letter to Dr B and engaged him to extract the teeth.

24. Dr B correctly extracted deciduous teeth 53 and 63, but mistakenly identified adult tooth 26 as deciduous tooth 65. As a result, he erroneously extracted tooth 26 instead of tooth 65.

25. My expert advisor, dentist Dr Andrea Cayford, advised:

[7] A pulpotomy is a procedure involving the removal of all or part of the soft inner tissue of the tooth, called the pulp. The procedure is often the first stage of root canal treatment.
[8] Endodontists are dentists who specialise in the study and treatment of the dental pulp.
[9] As part of his treatment, the endodontist completed the root canal work on tooth 26.

> "Given that a panex radiograph was available and all the teeth in a correct position it is straight forward, essential and basic dentistry to identify the correct tooth to be removed.
>
> …
>
> [Dr B] did not correctly identify the tooth to be removed. It was an error that could and should have easily been avoided if care and attention had been shown. The treatment did not follow [an] appropriate standard of care.
>
> The removal of the incorrect tooth would be viewed as a medium to severe departure from [the] accepted standard of care."

26. In my view, by failing to identify the correct tooth for extraction and therefore removing the wrong tooth, Dr B failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

27. In relation to the events following the extraction, Dr Cayford advised me that Dr B's decision to re-insert tooth 26 was a reasonable course of action and appropriate in the circumstances. She also advised that the decision to carry out root canal surgery on the tooth was appropriate in the circumstances. I accept that advice.

28. I note that Dr B has accepted his error, has apologised to Ms A and her parents, is aware of the outcome of his mistake, and has made an attempt to minimise the damage caused by his mistake. This is commendable.

Opinion: Dental service — No breach

29. Dr B is a director and shareholder of the dental service. The dental service is a healthcare provider and an employing authority for the purposes of the Health and Disability Commissioner Act 1994. As such, it may be held directly liable for the care provided to Ms A, and it may be held vicariously liable for any actions or omissions of its employees and/or agents who are found to be in breach of the Code.

30. Dr B was provided with Mr C's referral letter and a panex radiograph of Ms A's mouth, both of which identified the teeth to be extracted. As outlined above, Dr Cayford advised me that it would have been basic dentistry for Dr B to identify the correct tooth to be removed. Dr Cayford considered that the failure to identify the correct tooth for extraction was an error that could and should have been avoided easily if care and attention had been shown.

31. Guided by my expert's advice, I consider that Dr B's error was an individual clinical error. Accordingly, I conclude that the dental service did not breach the Code.

Recommendations

32. I recommend that Dr B provide a written apology to Ms A for his breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

33. I recommend that the Dental Council of New Zealand consider whether a review of Dr B's competence is warranted.

Follow-up actions

34.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Dental Council of New Zealand and the district health board, and they will be advised of Dr B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Dental Association, for educational purposes.

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

Appendix A — Independent dental advice to the Commissioner

The following expert advice was obtained from dentist Dr Andrea Cayford:

"I have been asked to provide an opinion to the Health and Disability Commission[er] on case C15HDC01402. Patient: [Ms A] /Dentist: [Dr B]. I have read and agree to follow the 'Guidelines for Independent Advisors'.

I am a General Dentist. I graduated from a university dental school in 1983. In my first year I worked as a Dental House Surgeon in a public hospital. Since then I have worked in several practices in London and New Zealand. For the last 24 years I have been part of a large group practice in New Zealand.

Documents Provided

— Letter of Complaint
— [Dr B]: Response and notes
— Orthodontist [Mr C]: Response and notes
— Radiographs from the orthodontist
— Study models from the orthodontist

Outline of Treatment Provided

[Ms A] has a dentition which requires some complicated orthodontic treatment. She has several congenitally missing teeth and an incorrect bite predominantly because she has a very small upper jaw compared to her lower jaw. Several of her teeth are much smaller than normal. The short to medium care plan for [Ms A] appears to be some orthodontic work, followed by possible jaw surgery, followed by probable implant work and composite or crown restorations to modify the shape and size of the smaller teeth.

As part of the ongoing plan the orthodontist required three deciduous (baby) teeth to be removed. These were teeth 53, 63 and 65. She returned to her family dentist for this treatment.

On April 17th 2015 [Dr B] removed teeth 53 and 63. However he removed tooth 26 by mistake instead of tooth 65. Tooth 26 is immediately behind tooth 65. He realised his error immediately and reinserted the tooth 26 back into the socket.

On April 21st [Dr B] started root canal treatment on tooth 26. [Dr B] has referred [Ms A] to a specialist endodontist to complete the root canal work on tooth 26.

Currently tooth 65 still has not been removed and the orthodontist is considering options.

ACC has been informed and have accepted the claim as a Treatment Injury.

[Dr B] has offered to pay any additional fees in the attempt to keep tooth 26 and if it becomes unsavable in the short or long term he has offered to pay the cost of an implant.

Issues Requiring a Response

1. **What is the incidence rate of removing a permanent tooth instead of a deciduous tooth in the context of orthodontic treatment, rather than general dental treatment?**

I found this question to be ambiguous so asked for clarification. The response was 'How easy is it to remove a baby tooth?'

Normally when we remove a tooth for orthodontic reasons (rather than a disease process) it is a permanent tooth. Most baby teeth fall out by themselves as the permanent teeth underneath them erupt. In fact the roots of the baby teeth generally get eroded away by the permanent teeth underneath them so that there is little left holding them in place. This makes it easy for them to come out naturally.

In this case tooth 65 was eroded away only a little. The permanent tooth (25) was not directly underneath it. Tooth 65 probably still has about 85% of its root structure left according to the radiograph.

Even though the tooth structure of this tooth (65) is still much shorter than tooth 26 they can often be surprisingly difficult to remove.

The root formation of tooth 26 here is quite conical — so not very splayed roots. As far as a tooth 26 normally goes to remove, it would have been relatively straightforward compared to the removal of many similar teeth.

In summary on the clinical 'feel' of extracting tooth 26 instead of tooth 65 they could have felt similar.

2. **In the circumstances described would you view the removal of tooth 26 as a departure from accepted standards? Please detail your reasons for your opinion.**

The removal of tooth 26 is a departure from expected and accepted standards.

The removal of any tooth requires care in the diagnosis, overall treatment plan and finally identification of the correct tooth. In this case the dentist had already been instructed which teeth were to be removed, so he just had to identify them correctly. He had the radiograph available to view with the correct teeth indicated on it and the oral presentation.

[Ms A's] tooth 26 is slightly smaller than the average first upper permanent molar. This would be in keeping with the relatively small size of her other teeth. However, it is in the correct position with tooth 27 behind it and tooth 65 (which was to be removed) in front.

Given that a panex radiograph[1] was available and all the teeth in a correct position it is straight forward, essential and basic dentistry to identify the correct tooth to be removed.

When removing a tooth usually the dentist will start with elevators first to encourage movement and then forceps to gain more movement and deliver the tooth. So there is more than one occasion to be sure you are proceeding with the correct tooth. It is important also to have the chairside assistant double check the correct tooth.

The removal of the incorrect tooth would be viewed by my peers as a medium to severe departure from accepted standard of care.

The severity is compounded by the fact that [Ms A] is so young and already has some congenitally missing teeth and a lifetime of very complicated dentistry to ensure good function and cosmetic result.

3. Was the decision to re-insert tooth 26 back into the socket a reasonable course of action?

The decision to reinsert tooth 26 back into the socket was a reasonable course of action and appropriate in the circumstance. This would give the tooth the best chance [of] long term survival. It would provide the orthodontist who would ultimately decide on the ongoing treatment plan the most options available.

Inserting the tooth back in immediately should have been relatively easy given the root formation.

When a tooth is avulsed (knocked out in an accident) the tooth has the best survival rate if 'reimplanted' within an hour. So it follows that reimplanting tooth 26 immediately would be the accepted standard of care in the circumstance.

4. Was [Dr B's] decision to carry out root canal surgery on the tooth appropriate given the circumstances?

[Dr B's] decision to carry out root canal surgery was appropriate in the circumstances.

Again, referring to the 'Trauma Guidelines' root canal treatment should be started on a reimplanted avulsed tooth in 7 to 10 days. Although there are no studies carried out on the wrongful extraction of a tooth, it makes sense that the same protocol would be followed.

This would give tooth 26 the best long term chance of remaining in a good position, not becoming mobile or developing any pathology.

Root canal therapy carried out by a specialist endodontist would ensure the best care possible and I note this has occurred.

[1] X-ray of entire mouth.

Conclusion

The incorrect removal of tooth 26 on [Ms A] was an accident. [Dr B] did not correctly identify the tooth to be removed. It was an error that could and should have easily been avoided if care and attention had been shown. The treatment did not follow [an] appropriate standard of care.

The removal of the incorrect tooth would be viewed as a medium to severe departure from [the] accepted standard of care.

[Dr B's] care and path of action after the extraction was acceptable in the circumstance."