Dentist, Dr C

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01136)

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation..2
Opinion: Dr C — breach...7
Changes made since events 12
Recommendations..12
Follow-up actions 12
Appendix A: Independent clinical advice to Commissioner.....................................13

Executive summary

1. This report concerns the dental care provided to a young woman by a dentist between 2011 and 2019.

2. In 2011, X-rays showed that there was early mineral loss between the woman's teeth, including the middle surface of tooth 25. She saw the dentist again in 2012, but the dentist did not take X-rays again until about a year later. By that time, the lesion on tooth 25 was of a significant size and required restoration.

3. The dentist initially restored tooth 25 in January 2014, but the restorative treatment had to be replaced on a number of occasions.

4. Also, the woman discovered that she had deep caries in tooth 46 only when she visited another dentist four months after she had seen the first dentist.

5. The dentist did not provide the woman with information about the state of her dental health, and also did not discuss treatment options with her when her wisdom teeth began to erupt. His clinical records were also inadequate.

Findings

6. The Deputy Commissioner found that the dentist did not provide services with reasonable care and skill, in breach of Right 4(1) of the Code. The Deputy Commissioner considered that the dentist's failure to take X-rays in 2012, his failure to manage and treat tooth 25 adequately, and his failure to diagnose advanced caries in tooth 46, indicated an overall sub-standard level of care.

7. The Deputy Commissioner also found the dentist in breach of Right 6(1) of the Code. The Deputy Commissioner considered that the dentist failed to provide information that a reasonable consumer in her circumstances would expect to receive. He failed to provide her with information about her dental health condition, and an explanation of the available treatment options for her wisdom teeth.

8. Further, the Deputy Commissioner found the dentist in breach of Right 4(2). The Deputy Commissioner considered that the dentist's clinical documentation failed to meet the Dental Council of New Zealand's required practice standards.

Recommendations

9. The Deputy Commissioner recommended that the dentist reflect on the woman's impact statement. The dentist has provided a written apology to the woman for the failings identified in this report.

10. Noting that the dentist has since retired from dental practice, the Deputy Commissioner recommended that he undertake a competence review, with the assistance of the Dental Council of New Zealand, should he return to dental practice.

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Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the dental care provided to her daughter, Ms A, by Dr C. The following issues were identified for investigation:

- *Whether Dr C provided Ms A with an appropriate standard of care between December 2011 and February 2019 (inclusive).*
- *Whether Dr C provided Ms A with adequate information about her condition, treatment and options between December 2013 and February 2019 (inclusive).*

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

13. The parties directly involved in the investigation were:

Ms A	Consumer
Ms B	Complainant
Dr C	Provider/dentist

14. Further information was received from the Accident Compensation Corporation (ACC).

15. Independent expert advice was obtained from a dentist, Dr Susan Gorrie (Appendix A).

Information gathered during investigation

Background

16. This report discusses the dental care provided to Ms A by Dr C from October 2011 to February 2019.

17. Ms A (aged in her teens at the time) first met with Dr C at his practice on 6 October 2011.[1] During the first visit, bitewing X-rays[2] of Ms A's teeth were taken, and Dr C documented in the clinical records that Ms A's teeth were "very well cared for".

18. The bitewing X-ray showed evidence of early mineral loss between Ms A's teeth, including the middle surface of tooth 25.

19. Ms A said that Dr C did not advise her of the "dental issues", and she did not receive any oral hygiene instruction from Dr C during this visit. There are no notes in the clinical records

[1] Dr C told HDC that he had been a member of the New Zealand Dental Association (NZDA) since his graduation. Over the years, he was also a member of the New Zealand Society for Sedation in Dentistry and the New Zealand Society of Endodontics.

[2] X-rays are used to generate images of tissues and structures inside the body. Bitewing X-rays show teeth above the gum line and the height of the bone between teeth.

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to show that Ms A was told about the mineral loss. There are also no notes in the clinical records to show whether any oral hygiene instruction, or other preventative advice, were provided to Ms A at this time.

20. Following her initial consultation, Ms A continued to visit Dr C on a regular basis during 2012 and 2016.

Visits between 2012 and 2016

21. At Ms A's next visit with Dr C on 17 December 2012, Dr C documented that there were no issues with Ms A's teeth and that she had very good oral hygiene. Dr C performed a scale and polish of Ms A's teeth, but no X-rays were taken during this visit.

22. Approximately one year later, on 18 December 2013, Ms A visited Dr C again. During this visit, Dr C took bitewing X-rays of Ms A's teeth and noticed a lesion[3] on tooth 25. A note was also made in the clinical records to "watch" a spot on tooth 24. There is no reference in the clinical notes to any oral hygiene advice being provided to Ms A, or to any information provided to Ms A, or discussion taking place, in relation to the spots noticed by Dr C.

23. Ms A visited Dr C again on 23 January 2014, approximately one year after her previous visit in 2013. Dr C completed restorative treatment[4] on tooth 25, being the tooth on which a lesion was noticed during Ms A's visit on 18 December 2013. Dr C also noted in the clinical records that he removed caries[5] on Ms A's teeth, but did not identify which teeth.

24. Ms A said that she first raised concerns with Dr C in relation to a "dark spot" on one of her teeth on 13 January 2015. In the clinical records on this date, Dr C recorded that a "black shadow" was noted on tooth 15. A note was also made to review tooth 25, which had been restored at Ms A's visit on 23 January 2014.

25. On 21 January 2015, Dr C completed restorative treatment on two of Ms A's teeth, being tooth 24 and tooth 15. He also replaced the restorative treatment on tooth 25, which was initially completed on 23 January 2014. Dr C recorded in the clinical records: "[C]aries removal replaced 25M just did not trust it."

26. Ms A visited Dr C again approximately seven months later on 31 August 2015. During this visit, Dr C recorded that Ms A had no issues, and that she had good teeth and oral hygiene. Dr C performed a scale and polish, and fluoride treatment[6] was provided. There are no notes in the clinical records as to whether any oral hygiene instruction, or other preventative advice, were provided to Ms A at this time.

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[3] An abnormal change in structure owing to injury or disease.

[4] Any dental process that focuses on repairing or restoring damaged oral structures. This can include procedures such as fillings, bridges, and implants, among many other services.

[5] Tooth decay.

[6] Fluoride treatments are professional treatments containing a high concentration of fluoride, which a dentist or hygienist will apply to a person's teeth to improve health and reduce the risk of caries.

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27. At Ms A's next visit on 30 June 2016, Dr C again recorded that Ms A had no issues, and that she had very good oral hygiene and teeth. Dr C performed another scale and polish. Again, there are no notes in the clinical records as to whether any oral hygiene instruction, or other preventative advice, were provided to Ms A.

Visits during 2019

28. After her visit in June 2016, Ms A moved overseas and did not visit Dr C again until 13 February 2019, when she returned to New Zealand. Bitewing X-rays were taken during this visit. Dr C noted in the clinical records "to remove check and replace" the restoration on tooth 25, which was initially completed on 23 January 2014 and replaced on 21 January 2015. Dr C also noted a "black spot" on tooth 26, as well as several other "spots".

29. Dr C said that he noticed "the issue with 25 tooth and a lesion on 26 tooth", but was reluctant to restore these teeth as he had not seen Ms A for about three years. He therefore suggested an X-ray review in six to nine months' time for matters to be reviewed and for further assessment.

30. Dr C also said that at the completion of treatment, he mentioned that there were several "suspect spots", but with Ms A's good hygiene, he felt that re-taking the X-rays and having another dental examination in six months' time was appropriate.

31. Ms A said that during her visit on 13 February 2019, she told Dr C that she had painful wisdom teeth, and he advised her that "they were fine". Dr C stated:

> "As we do very limited orthodontics in our practice, we do not routinely remove asymptomatic wisdom teeth following orthodontic treatment unless advised by the treating orthodontist."

32. Dr C said that in his view, asymptomatic wisdom teeth with minimal indication of becoming of clinical concern can be safely left in place. Dr C stated that at the time of Ms A's examination, her wisdom teeth were not causing her any concerns and, as such, he did not feel that they needed removal.

33. There is no record in the clinical notes of any examination or discussion in relation to Ms A's wisdom teeth.

34. On 19 February 2019, Dr C completed restorative treatment on tooth 26, and again replaced the restoration on tooth 25. This was the second time that the restorative treatment on tooth 25 was replaced by Dr C. Dr C recalls that there was "some marginal breakdown"[7] with the restoration.

[7] Marginal breakdown means the gradual fracture of the perimeter or margin of a dental amalgam filling, which leads to the formation of gaps between the amalgam and the tooth.

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35. The clinical records note that Dr C also provided Ms A with instructions on how to use an interproximal brush,[8] particularly in the area of the orthodontic wire,[9] and advised that she could also use the brush elsewhere, if she wanted to. This is the first time in the clinical records that any reference is made to oral hygiene instruction or preventative advice being provided to Ms A.

36. Ms A said that the advice she received from Dr C in relation to her oral care was limited only to his recommendation on 19 February 2019 that she use the interproximal brush to clean between her front two teeth, which is the area of the orthodontic wire. Ms A said that no other advice on cleaning was ever provided to her by Dr C.

Diagnosis and further treatment

37. As per Dr C's recommendation that matters be reviewed within six to nine months, on 18 June 2019, Ms A visited a dentist overseas, where she was based at the time, for a re-examination and review. The clinical records note that Ms A was "worried some stuff may have been missed".

38. Bitewing X-rays were taken on 19 June 2019 to assess Ms A's periodontal[10] condition and to detect any caries not visible during routine examination. Multiple carious lesions were identified in several of Ms A's teeth (teeth 25, 27, 36, 35, 45, 46, and 47), with the caries in tooth 46 being described as "very deep".

39. Ms A was required to undergo further restorative treatment (for teeth 25, 27, 45, 46, and 47).

40. The dentist also referred Ms A to an oral surgeon for an assessment of her wisdom teeth. The oral surgeon advised that Ms A's wisdom teeth had carious lesions,[11] which also required treatment. Following consultation with the oral surgeon, Ms A elected to undergo surgery to remove all four of her wisdom teeth.

Subsequent events

41. In June 2020, Ms A returned to New Zealand, and on 24 June 2020 visited another dentist. Ms A said that the dentist identified an issue with the restorative treatment provided by Dr C on tooth 25, and recommended that it be replaced again.

42. Ms A said that since her last appointment with Dr C, she had had approximately 20 further dental appointments. She said that it came "as a complete shock" to her when her dentist overseas discovered that she had seven cavities that required treatment, one of which was so large and deep that she was warned that she might lose the tooth.

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[8] A brush used to clean the space in between teeth.
[9] A wire conforming to the alveolar or dental arch that can be used with dental braces as a source of force in correcting irregularities in the position of the teeth.
[10] Periodontal relates to the tissue and structures surrounding or encasing a tooth.
[11] Where there is a visible breakdown in the tooth surface and the area may have softened walls or floor.

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43. Ms A stated: "[T]he cavities which were left [untreated for] far too long have left [her] with a crown which has needed to be replaced." She said that it was very painful at times, and she was required to take time off work to attend her dental appointments. It also affected her financially, and she experienced stress before, during, and after each dental appointment.

44. Ms A said that it was "another shock" when she learned that she had four "badly impacted wisdom teeth, some with small cavities developing", as Dr C had advised her in February 2019 that "they were fine". Ms A said that a short time later, her four impacted wisdom teeth were extracted by an oral surgeon under sedation, because of the risk of decay starting in the adjacent molars.

45. Ms A said that Dr C never advised her of her dental issues as they arose.

46. Dr C acknowledged that he made a clinical error by not reacting to the discolouration he saw on tooth 46 during the dental examination on 13 February 2019. He said that he fully accepts that the lesion on tooth 46 should not have been missed during his examination. Dr C apologised to Ms A for the distress his actions and errors may have caused her and her parents.

Further information — ACC

47. ACC obtained external clinical advice from a dentist on Ms A's treatment injury claim in relation to tooth 46.

48. The ACC dentist advised that based on the information provided, including the admission from the provider (Dr C), it is clear that there was a significant delay in the diagnosis of caries on tooth 46.

49. The ACC dentist stated:

> "[T]he radiograph … clearly shows a radiolucency consistent with significant caries on the occlusal surface of the tooth in addition to cavitation …, which is indicative of advanced, long standing decay. Caries is a slowly progressing process and it is highly likely that the decay on this tooth was present as far back as 2015, when the client first pointed out the 'dark spot' on the tooth."

50. The ACC dentist also stated that tooth 46 had sustained a physical injury, as it had lost a greater amount of tooth structure than it would have if the caries had been diagnosed earlier. The ACC dentist stated that tooth 46 "may be at a greater risk of endodontic[12] pathology in the future due to the progression of the decay toward the pulp[13] of the tooth during the delay in diagnosis".

[12] Endodontics is the branch of dentistry concerned with diseases of the dental pulp, which is the innermost part of the tooth.

[13] The pulp of the tooth is the innermost part of the tooth.

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Responses to provisional opinion

51. Dr C was given an opportunity to respond to the provisional opinion. He provided Ms A with a written apology for the failings identified, and for the stress caused to Ms A and her family.

52. Ms A was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. She reiterated her concerns that Dr C failed to diagnose caries on tooth 46, and that he failed to restore tooth 25 adequately. Ms A also reiterated her concerns that there is no record in the clinical notes to suggest that Dr C had a discussion with her about her wisdom teeth.

Opinion: Dr C — breach

Dental services provided to Ms A

53. First, I acknowledge the distress felt by Ms A and her family as a result of the dental services provided by Dr C. Ms A was a young patient who had regular dental visits with Dr C over the years, only to discover that she had numerous dental-related issues that had been undiagnosed and left untreated.

Tooth 46

54. Ms A visited Dr C in February 2019, but discovered that she had "very deep" caries in tooth 46 only when she visited her dentist overseas in June 2019.

55. I sought external clinical advice on this issue from a dentist, Dr Susan Gorrie. Dr Gorrie reviewed the X-rays and said that caries were "visibly present" on tooth 46, and that Dr C failed to diagnose the decay in tooth 46 at the dental examination on 13 February 2019.

56. The dentist who provided external clinical advice to ACC also reviewed the X-rays and advised that tooth 46 clearly showed a radiolucency consistent with significant caries, which is indicative of advanced, long-standing decay. The ACC dentist concluded that it was clear that there was a significant delay in the diagnosis of caries in tooth 46.

57. Dr C accepted that he failed to diagnose advanced caries in tooth 46 at the dental examination on 13 February 2019, and that the lesion on this tooth should not have been missed. Dr C apologised for this error.

Tooth 25

58. In addition to Dr C's failure to diagnose caries in tooth 46, Dr C also did not manage tooth 25 appropriately on 6 October 2011. Dr Gorrie advised that she could see evidence of early mineral loss between Ms A's teeth, including the middle surface of tooth 25, on the X-rays that were taken in 2011, when Ms A first saw Dr C.

59. Ms A saw Dr C again on 17 December 2012, but X-rays were not taken again until 18 December 2013. By that time, the lesion on tooth 25 was of a significant size and required

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restoration. In Dr Gorrie's view, Dr C's failure to take X-rays in 2012 was a departure from the accepted standard of care. I accept Dr Gorrie's advice.

60. I also find it concerning that the restorative treatment provided by Dr C on tooth 25 had to be replaced on a number of occasions. Dr Gorrie advised:

> "This is an unacceptable number of times in a short space of time for a filling to need replacing. Following the first filling there may have been some decay still present or breakdown of the filling material. However I am unable to comment on the quality of restoration based on the radiographic and not the clinical picture."

61. Dr C recalls that there was "some marginal breakdown" with the restoration, but it is not clear from the clinical records why the restoration needed to be replaced.

62. I am satisfied that it is more likely than not that because of the number of times tooth 25's restoration needed to be replaced, and Dr Gorrie's advice that this was unacceptable, the restoration was not completed to an adequate standard.

Conclusion

63. Dr C had a responsibility to provide Ms A services with reasonable care and skill. Having considered Dr Gorrie's advice, and for the reasons I have discussed above, I consider that Dr C:

- Failed to diagnose advanced caries in tooth 46; and
- Did not take X-rays in 2012, and did not manage and treat tooth 25 adequately.

64. The failures discussed above indicate an overall sub-standard level of care provided by Dr C to Ms A and, accordingly, I find that Dr C breached Right 4(1)[14] of the Code of Health and Disability Services Consumers' Rights (the Code).

Provision of information

Dental health information

65. Ms A said that Dr C did not explain or advise her properly about her dental issues as they arose.

66. Dr Gorrie advised that "if a patient had good oral hygiene and was getting decay a flag of concern should be raised". She considers that Dr C should have had a discussion with Ms A about the decay and the reasons for it.

67. In light of the absence of documentation, I accept that Dr C failed to provide Ms A with information about her condition when he first noticed the lesion on tooth 25 on 18 December 2013, and when he made a note to "watch" a spot on tooth 24. Dr C also failed to provide Ms A with information about her condition each time he noticed that something

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

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was wrong. In the circumstances, information about the lesions and her overall dental health condition was information that Ms A reasonably would have expected to receive.

Information on treatment options in relation to wisdom teeth

68. In addition to failing to provide Ms A with information about the lesions and the state of her dental health, Dr C did not discuss treatment options with Ms A when her wisdom teeth began to erupt.[15]

69. Dr C and Ms A presented different accounts of what was discussed about Ms A's wisdom teeth. Dr C said that at the time of Ms A's dental examination, her wisdom teeth were not causing her any concern and, as such, he did not feel that they needed removal. On the other hand, Ms A said that in February 2019 she told Dr C that she had some pain in her wisdom teeth, but he advised her that her wisdom teeth were "fine".

70. There is no record in the clinical notes to suggest that Dr C had a discussion with Ms A about her wisdom teeth. In light of the absence of documentation, I accept that Dr C failed to provide Ms A with treatment options in relation to her wisdom teeth.

71. Dr Gorrie stated that Ms A's wisdom teeth, and the progression of eruption, can be seen on the first X-rays that were taken in 2011. Dr Gorrie advised:

> "Not all dentists advocate for the extraction of wisdom teeth, however, it is a discussion that needs to be had at some stage with young adults so that the patient can make an informed decision on whether to have them extracted or not."

72. While I accept that not all dentists advocate for the extraction of wisdom teeth, I accept Dr Gorrie's advice that options for their care should be discussed with patients. In Ms A's case, her wisdom teeth had carious lesions that required treatment, and information on the treatment options should have been provided to her by Dr C.

73. Dr C should have had a discussion with Ms A about the condition of her wisdom teeth, and he should have provided her with information on the benefits and risks of having them extracted.

74. I wish to highlight the importance of providing information to patients, particularly young adults such as Ms A, so that they receive the necessary information about their available treatment options. Young patients can be vulnerable and less knowledgeable than adults, and may be more reliant on trusted professionals for information.

[15] Erupted wisdom teeth means that the teeth have emerged from the gum.

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Conclusion

75. I consider that Dr C failed to provide Ms A with information that a reasonable consumer in her circumstances would expect to receive. As such, I find that Dr C breached Right 6(1)[16] of the Code for the following reasons:

- He failed to provide Ms A with information about her dental health condition; and
- He failed to provide Ms A with an explanation in relation to the condition of her wisdom teeth, and did not provide her with an explanation of the available treatment options.

Clinical documentation

76. The Dental Council of New Zealand's "Patient Information and Records Practice Standard" dated December 2006 states:

> "1.1 The patient's treatment record is legally regarded as 'health information' and is an integral part of the provision of dental care. A record of each encounter with a patient will improve diagnosis and treatment planning and will also assist with efficient, safe and complete delivery of care considering the often chronic nature of dental disease. The treatment record will also assist another clinician in assuming that patient's care.
>
> …
>
> 2.6 The patient's treatment record must contain a record of **any and all treatment or service** provided within an oral health practice, whether it has been provided by an oral health professional or any other health practitioner or employee of the practice."

77. It states further:

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

and that:

> "2.8 The record **should**, in the interests of best practice, also include:
>
> (i) A description of any procedure, including any materials used, variation from any standard or usual technique, and any general comments on the procedure undertaken. The detail of the description should reflect the complexity of the treatment or the seriousness of the potential outcomes;

[16] 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."

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(ii) Advice given to the patient on any pre- and post-operative instructions and any likely treatment outcomes and/or complications …"

78. Further, the Dental Council of New Zealand's "Patient records and privacy of health information practice standard" dated 1 February 2018 provides:

"The patient record includes (but is not limited to):

- Clinical notes documenting: assessments, diagnosis, recommendations for prevention of disease and promotion of oral health, and treatment offered and provided, or declined."

79. It provides that the following information must be recorded in the patient record:

"• Relevant history, clinical observations and findings, and diagnosis;

- Treatment options given, information given to the patient on associated benefits, likely outcomes of care, and potential risks, and final care plan for which consent is obtained; and
- A record of any proposed care that is declined by the patient, along with the patient's related comments or concerns."

80. Another relevant standard that applied at the time of events was the Dental Council of New Zealand's *Working as an Oral Health Practitioner in New Zealand Handbook for the New Zealand Conditions of Practice*, which was updated on 8 August 2011. It states:

"You [oral health practitioners] must always obtain a medical history from a patient before commencing treatment, and you must check their history for any changes at subsequent visits. Changes must be recorded on the patient's notes. You must keep full, up-to-date and legible records for all dental treatment you provide …"

81. Dr C noted in the clinical records on 19 February 2019 that he provided Ms A with instructions on how to use an interproximal brush, particularly in the area of the orthodontic wire. I acknowledge Ms A's concerns that Dr C did not provide her with any oral hygiene advice, and there is no detailed record in the clinical notes to indicate what oral hygiene advice was provided to Ms A by Dr C prior to 19 February 2019.

82. Dr Gorrie advised that Dr C's notes did not reflect "the picture in the mouth". She stated that over the years, the X-rays showed that Ms A had visible areas of decay occurring between the surfaces of her teeth, but good oral hygiene was noted in the clinical records, and fluoride treatment was provided. Dr Gorrie concluded that the quality of Dr C's clinical records is poor, as they do not contain sufficient detail.

83. I accept Dr Gorrie's advice and agree that Dr C's documentation was inadequate. Dr C also acknowledged that his clinical records were "deficient".

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84. A full and accurate clinical record is vitally important, and in previous reports HDC has made numerous comments stressing the importance of good record-keeping and the accuracy of clinical records.[17]

85. In my view, Dr C's clinical documentation did not meet the Dental Council of New Zealand's required practice standards. Accordingly, I find that Dr C breached Right 4(2) of the Code for failing to comply with his professional responsibility to keep adequate records.[18]

Changes made since events

86. Dr C is no longer practising as a dentist.

Recommendations

87. As recommended in the provisional decision, Dr C provided a written apology to Ms A. I recommend that Dr C:

a) Reflect on the impact statement written by Ms A. Dr C is to provide HDC with evidence of having done so within three weeks from the date of this report.

b) Undertake a competence review, with the assistance of the Dental Council of New Zealand, should he return to dental practice.

Follow-up actions

88. 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 it will be advised of Dr C's name in covering correspondence.

89. 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 and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[17] For example: 19HDC01547, 12HDC00437, and 11HDC01103.

[18] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Dr Susan Gorrie, a dentist:

"I have read and agree to follow the Commissioner's guidelines for independent advisors.

My name is Susan Gorrie. I am a general dentist in private practice in Christchurch. I have been in practice for 39 years. I completed my BDS at Otago in 1981 and a postgraduate diploma in restorative dentistry in 1991. I am a fellow of the International College of Dentists. I have an interest in restorative dentistry.

I have been asked to review the documents and provide an opinion on the following issues:

1. The standard of care provided for tooth 25
2. The standard of care provided for tooth 46
3. The standard of care provided for [Ms A's] wisdom teeth
4. The quality of clinical documentation
5. Any other matters I feel warrant comment

I have been provided with the following documents:-

1. Letter of complaint dated 12 June 2019 and 28 June 2020
2. [Dr C's] response dated 19 August 2020
3. Clinical records from 6 October 2011 covering the period until 21 February 2019, including copies of imaging
4. Letter from [Ms B] dated 16 September 2020

[Ms B] raises concerns about the dental care provided to her daughter, [Ms A], by [Dr C]. [Ms A] began seeing [Dr C] on 6 October 2011 following the removal of her braces. She was a regular attender from 2011 to 2016.

At her exam on 13 February 2019 [Dr C] noted two teeth needed restorations and several areas warranted a review and suggested that she present for further X-rays in 6–9 months. Treatment was undertaken on 19 February 2019 for teeth 25 and 26 and a fluoride treatment given.

In June 2019 [Ms A] attended a dentist [overseas] and was told she had deep decay in tooth 46, the restoration in tooth 25 needed replacing and her wisdom teeth required extraction.

Dental caries (decay) is a complex disease process involving interactions between the tooth structure, bacteria, dietary carbohydrate, and salivary and genetic influences. It

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needs to be managed accordingly. Caries risk assessment is an essential component in determining the appropriate level of care. The type and extent of interventions required depends on the patient's individual risk profile. If the disease is controlled the number of initial carious lesions may remain unchanged or reversed. Clinical diagnosis of the activity of the carious lesion should take into account the location of the lesion, the surface appearance and careful tactile assessment as well as gingival health. In my opinion care should be provided based on a caries risk assessment. The treatment may be operative or preventative.

1. The standard of care for tooth 25

In 2011, when [Ms A] first attended [Dr C], X-rays were taken. On review of the radiographs provided I can see evidence of early mineral loss between her teeth, including the mesial surface of tooth 25. Well cared for teeth were noted and a fluoride application was provided. There was no mention of oral hygiene instruction or other preventive measures and although [Ms A] attended for a check up in 2012, X-rays were not taken again until 2013. By now the lesion on 25 mesial was of a significant size and required a restoration. I can see evidence of the progression of other sites and new areas of demineralisation. A note was made to watch the spot on tooth 24. There is no mention in the notes of further discussion. I believe this to be an omission of care. In my opinion it would be met with mild to moderate disapproval by peers.

The restoration in tooth 25 was first placed in 2013, replaced again in 2015 and then again in 2019. A short time later it was replaced again by the treating dentist in Australia. If I read correctly it needed replacing again in 2020. This is an unacceptable number of times in a short space of time for a filling to need replacing. Following the first filling there may have been some decay still present or breakdown of the filling material. However I am unable to comment on the quality of restoration based on the radiographic and not the clinical picture.

2. The standard of care for tooth 46

There was a failure to diagnose decay. Radiographs are shades of grey and subject to misinterpretation. Caries can also progress slowly or rapidly. It is possible to miss diagnosing caries when present and most dentists would be guilty of this at some time. However [Ms A] had active caries elsewhere and a shadow had been noted by the patient on tooth 46 in 2015. This was diagnosed at the time as a stained fissure and did not require treatment. The radiograph cannot have been reviewed closely enough in 2019 as caries is visibly present. [Dr C] has admitted this and apologised.

In my opinion this would be a mild departure from the accepted standard of care. Reflective practice should ensure a process is in place to review X-rays, maybe at the end of the day.

3. The standard of care provided for [Ms A's] wisdom teeth

There is no mention in the notes of the painful wisdom teeth that [Ms B] alleges [Ms A] complained of. In itself, having orthodontic treatment does not necessitate the

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extraction of wisdom teeth. If obviously impacted (stuck) a discussion should be held into the benefits/risks of extraction and the options for care explained to the patient — possible referral to an oral surgeon etc.

The regular X-rays taken are not diagnostic for wisdom teeth problems. However the wisdom teeth here can just be seen at the corners and over the time from the first X-rays in 2011 until 2019 the progression of eruption can be seen. The eruption of the wisdom teeth can be uncomfortable and does not mean the teeth need to come out. I cannot interpret the clinical picture from X-rays. Not all dentists advocate for the extraction of wisdom teeth, however it is a discussion that needs to be had at some stage with young adults so the patient can make an informed decision on whether to have them extracted or not. The NZDA has a very useful leaflet to give to patients.

I believe the standard of care to have been acceptable here.

4. The quality of clinical documentation.

The notes do not reflect the picture in the mouth. [Ms A] had visible areas of interproximal caries (decay occurring on the in-between surfaces of the teeth) on progressive X-rays over the years. Good oral hygiene was noted and a fluoride treatment carried out. I would expect, if you were giving a fluoride treatment, you would say why/discuss decay and the reasons for, leading to a discussion on cleaning in-between the teeth and other risk factors. If a patient had good oral hygiene and was getting decay a flag of concern should be raised.

On 13/01/15 the wrong tooth number is charted, however the correct tooth is treated.

The fillings are composite (tooth coloured) yet amalgam is charted — this is just a coding issue with the programme used and the dental benefit coding scheme.

In my opinion the quality of notes is poor, there is not enough detail. This is a departure from the accepted standard of practice and would be met by mild disapproval from peers.

> 'The public has a right to expect and receive care from competent dental practitioners. The individual practitioner is responsible for maintaining his or her competence to practice. This requires the practitioner to be reflective in practice. Reflective practice requires the practitioner to actively and critically reflect on all aspects of their clinical practice to identify their competency limitations and undertake appropriate activities to reach the required competence' (ref NZDA Code of Practice Continuing Professional Development).

Susan Gorrie"

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