Dentist, Dr B

A Report by the

Health and Disability Commissioner

(Case 05HDC06970)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider/Dentist
A Dental Centre	Employing Authority
Dr C	Locum general practitioner
Dr D	House surgeon
Dr E	Oral surgeon

Complaint

On 16 May 2005, the Commissioner received a complaint from Ms A about the dental services provided by Dr B. The issues identified for investigation were:

- *Whether the dental treatment and follow-up care Dr B provided to Ms A in February 2005 were adequate and appropriate. In particular:*

  — *when Ms A presented with a painful tooth on 2 February 2005.*

- *Whether the dental treatment and follow-up care Dr B provided to Ms A in March 2005 were adequate and appropriate. In particular:*

  — *when Ms A presented with another painful tooth on 1 March 2005.*

- *Whether Dr B provided adequate and appropriate information to Ms A in February–March 2005. In particular:*

  — *when Ms A's tooth broke in the course of extraction on 2 February 2005;*
  — *when Ms A's tooth broke in the course of extraction on 1 March 2005.*

An investigation was commenced on 27 June 2005.

Information reviewed

Information from:

- Ms A
- Dr B
- Dr C
- Dr E
- A District Health Board — Ms A's clinical records of 3 and 4 March 2005.

Ms A's:

- Dental radiographs taken on 2 February and 1 March 2005
- Dental panoramic radiograph taken on 9 March 2005
- Fractured dental roots from teeth 26 and 46.

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

Information gathered during investigation

Background
Ms A, a woman in her mid-50s, was a patient of a dental centre. Dr B was one of two dentists operating independent practices from the dental centre. On 9 January 2004, Ms A presented with severe toothache from tooth 48. As it was "badly decayed", Dr B extracted the tooth. On 3 November 2004, Ms A presented again with toothache from teeth 15 and 34, both of which Dr B extracted.

Dental extraction in February 2005
On 2 February 2005, Ms A consulted Dr B as she was experiencing toothache from tooth 26. On examination, Dr B reported that it was "very tender and had a very deep filling with secondary decay, which [was] clear on the X-ray". She told Ms A that the tooth could either be preserved through root canal treatment or extracted. Although the extraction was likely to be difficult owing to extensive decay, Ms A chose an extraction as she maintained she had been informed by Dr B that tooth 26 could not be preserved.

During the course of the extraction, tooth 26 crumbled, leaving the roots in situ. To remove the remainder of the tooth, its roots had to be surgically separated. Dr B decided to leave the palatal root in Ms A's gums as she was concerned about the risk of damaging Ms A's sinus. According to Ms A, Dr B did not advise her of such a risk. Instead, "Dr B just kept drilling and drilling to get the tooth out." Ms A said the drilling took a long time and she "became extremely stressed" while Dr B "appeared

agitated and unsure of herself". Dr B advised that the residual root "would either be dormant or could in years to come, come to the surface and be easily removed". She explained this to Ms A and told her "not to worry". Dr B advised Ms A to return for her gums to be checked and cleaned if the area subsequently became sore or infected. Dr B prescribed metronidazole 200mg (oral antibiotics used to prevent acute dental infections) and advised Ms A to take paracetamol or Nurofen for any post-extraction pain.

Several days after the extraction, Ms A's gums and surrounding tissue became infected. She also experienced ongoing pain from the extraction for four weeks. Instead of returning to Dr B, Ms A took oral antibiotics and analgesics to alleviate her symptoms.

Dental extraction in March 2005

On 1 March, Ms A presented with severe toothache from tooth 46. She was accompanied by her husband. He remained in the surgery during her treatment, as he was concerned about the outcome of her February extraction. Ms A complained of pain from that extraction, saying that it "didn't feel right". From the examination and X-rays, tooth 46 was noted to be heavily filled, with deep secondary decay. Dr B recommended either an extraction or root canal treatment. Despite Dr B's view that the extraction would be difficult owing to the tooth's long roots and extensive decay, Ms A opted to have her tooth extracted.

During extraction, the crown of tooth 46 broke, and Dr B advised Ms A that its roots would have to be surgically separated. In doing so, Dr B observed that the dental bone was dense. Ms A recalled that similar to the earlier extraction, Dr B "kept drilling and drilling" and appeared "unsure of herself". Dr B succeeded in removing approximately half the roots, and left the rest in Ms A's gums. According to Dr B, Ms A's husband became "very agitated [and] vocal". As a result, Dr B felt intimidated and discontinued the extraction. She dressed Ms A's tooth socket with Alvogyl gel and provided her with a clean swab. Ms A was advised to keep her gums clean and to rinse with saline solution. Dr B also advised her to return (without needing to make another appointment) in the event of any post-extraction pain. She explained that if there was no subsequent pain or infection, Ms A's gums would shrink, and the remaining root could surface, which would ease a future extraction. Dr B told Ms A that there was "no need to worry", and gave her another prescription for metronidazole 200mg and Synflex 275mg (oral anti-inflammatory analgesic).

Post-extraction care

Shortly after the second extraction, Ms A experienced acute pain around the socket of tooth 46, and residual pain in the socket of tooth 26. In her diary notes, Ms A recorded that she returned to Dr B on 2 March. However, Dr B's treatment notes state that on 3 and 4 March, Ms A consulted her for localised osteitis (dry socket). Noting that there was no infection, Dr B cleaned Ms A's gums and applied Alvogyl to alleviate the post-extraction pain and tenderness. The consultation on 3 March included a discussion about the retained roots of teeth 26 and 46, and the ongoing

dental care required. Ms A agreed to Dr B's suggestion of a referral to an oral surgeon. As she felt responsible for Ms A's overall dental care, Dr B offered to cover the oral surgeon's treatment costs. After contacting several oral surgeons, Dr B managed to make an appointment for Ms A to see Dr E in a nearby town.

On the evening of 3 March, Ms A experienced hot flushes and swelling in her face. By 9pm that night, she felt "beside [herself] with pain" and asked her husband to drive her to a public hospital. Ms A was admitted to the Emergency Department and given several analgesics, including tramadol and intravenous morphine, to alleviate her pain. After reviewing Ms A several hours later, Dr D advised her to return to Dr B and to consult her general practitioner. Dr D discharged Ms A at approximately 4.30am on 4 March.

Later that day, Ms A consulted Dr C, a locum general practitioner at a medical centre. He observed that the sockets around teeth 26 and 46 and surrounding gum area were "dark" in colour, and prescribed Ms A several antibiotics and analgesics.

Ms A returned to Dr B that evening. Ms A received the same post-extraction care as on 3 March and was given a referral to Dr E.

Oral surgery

On 9 March, Ms A presented to Dr E with an inflamed and painful oral wound from tooth 46. She sought his advice about the remaining roots from the extractions on 2 February and 1 March. Dr E examined her mouth and took a radiograph. As the mesial and distal roots of tooth 46 and the residual roots of teeth 25 and 26 were retained in Ms A's gums, Dr E recommended oral surgery. According to Ms A, he said that Dr B was "out of her depth" in providing the dental care she did. Dr E gave Ms A written information and prescribed oral analgesics for the period prior to the procedure.

On 14 March, Dr E removed the remaining roots of teeth 25, 26 and 46 under local anaesthetic by elevating and releasing their envelope flap (mucous membrane and fibrous tissue retracted from a horizontal incision along the fibrous connective tissue surrounding the tooth and its crown). He recorded his findings as "bulbous roots". Gelfoam was applied into the respective tooth sockets, which were closed using dissolvable gut sutures. In his report to Dr B, Dr E noted that there had been no operative complications, and requested her to review Ms A a week later. He gave Ms A a further prescription of oral analgesics and referred her back to Dr B for ongoing dental care. In contrast, Ms A does not recall being referred back to Dr B. She clarified that she was advised to return to Dr E for any future extractions she may need.

Since the events in question, Ms A has been receiving care from another dentist.

Independent advice to Commissioner

On 30 September 2005, the following expert advice was obtained from Dr Mark Goodhew, a general dental practitioner in Timaru:

> "I have been asked by the Health and Disability Commissioner to provide advice for this complaint. I have been a general dental practitioner for nineteen years, following one year as a dental house surgeon in Dunedin Public Hospital. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
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> The Commissioner has asked for my opinion on the dental care provided to [Ms A] in February to March 2005 by [Dr B]. In particular, he has requested comment on:
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> 1 The pre-extraction and post-extraction care provided in relation to:
>
> (a) Tooth 26
>
> (b) Tooth 46.
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> 2 The adequacy and appropriateness of the advice/explanation [Dr B] provided to [Ms A] in relation to the:
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> (a) Remaining palatal root of tooth 26
>
> (b) Remaining roots of tooth 46.
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> 3 [Dr B's] decision to refer [Ms A] to an oral surgeon. Should the referral have been made on 1 March 2005 when [Ms A] presented with a second toothache?
>
> 4 Was [Dr B's] documentation of an adequate standard?
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> In formulating my advice I have considered the following material:
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> - Copy of [Ms A's] complaint letter of 14 April 2005,
> - Copy of notes of telephone discussion between [Ms A] and investigator on 27 May 2005,
> - Copy of [Ms A's] diary notes recording the dental care she received,
> - Copy of HDC's notification letter of 27 June 2005 to [Dr B],
> - Copy of written response dated 5 August 2005 from [Dr B] with enclosed copies of dental treatment notes,
> - Letter to the New Zealand Dental Association and training courses attended,
> - Copy of HDC's letter of 27 June 2005 to [the public hospital] requesting for [Ms A's] medical notes,

- Copy of [Ms A's] medical notes dated 3-4 March 2005 from [the public hospital],
- Copy of HDC's letter of 27 June 2005 to [the medical centre] requesting [Ms A's] clinical notes on 4 March 2005,
- Copy of letter of response from [the medical centre] dated 30 June 2005 with attached clinical notes dated 4 March 2005,
- Copy of letter of 27 June 2005 requesting information from [Dr E], oral surgeon,
- Copy of letter of response dated 15 August 2005 from [Dr E], with attached copy of treatment notes,
- Dental radiographs (6 in total) 3 dated 02/02/05, 3 dated 01/03/05,
- Dental panoramic radiograph dated 09/03/05,
- [Ms A's] teeth 26 and 46 (3 fractured roots), removed surgically by [Dr E].

1 (a) The pre- and post-extraction care provided in relation to tooth 26

[Ms A] attended [Dr B] for an urgent extraction of tooth 26 on 2 February 2005. This tooth had become painful some hours earlier. [Dr B] examined [Ms A's] mouth, noted that this tooth was heavily filled and tender, took one left posterior bite wing radiograph and one peri-apical radiograph of tooth 26, and discussed treatment options of root canal therapy or extraction. Her notes also record her informing [Ms A] that an extraction may be difficult. I am satisfied that [Dr B's] pre-extraction care was appropriate and adequate.

Following a difficult extraction, a large part of the palatal root of tooth 26 was left in place. In such circumstances, the decision to leave a portion of root can occasionally be the most appropriate and prudent course of action although I stress that where possible it is preferable to remove them. Further attempts to retrieve palatal roots can sometimes dislodge a root into the maxillary sinus or create a surgical breach of the floor of the sinus, and increases the degree of surgical trauma. Retained roots can often be retrieved with comparatively little trouble some months or even years later, or indeed may never require further treatment. I note in passing that tooth 25 had evidently fractured at an earlier date, as the retained root can be clearly identified on various radiographs, and was symptomless. It was later removed by [Dr E], at the time of his intervention.

In this particular case, the amount of root remaining was large, and in my experience this quantity of root can sometimes require removal in the short term. However, [Dr B] made the judgement at the time that the risks of further attempts at removal were greater than the potential risks of leaving the palatal root in place.

[Ms A] was informed of the presence of the tooth root, given a prescription of metronidazole (a type of antibiotic) advised to take Panadol or Neurofen for pain, and advised to return if in pain or discomfort. [Dr B] also took a post-

operative radiograph of the 26 socket, to confirm the position and presence of the palatal root.

I regard this as an adequate and appropriate level of post-extraction care. Perhaps [Dr B] could have additionally considered prescribing anti-inflammatory medication, such as diclofenac (voltaren), but this is a relatively minor point. She may also have recommended a follow up appointment to check the progress of the healing socket. Alternatively, [Dr B] could possibly have followed up with a telephone call a day or two after the extraction to check with [Ms A] on her recovery. These suggestions would have provided a better level of care, but I regard the level of care she did provide as adequate.

[Ms A] did not again contact [Dr B] until 1 March when she presented with toothache in tooth 46.

1 (b) The pre- and post-extraction care of tooth 46

On 1 March, [Ms A] told [Dr B] that tooth 46 was now causing pain, and that the socket from the previous extraction was still causing some trouble. [Dr B] took further radiographs of tooth 46 and of the 26 socket. As with the earlier appointment, [Dr B] discussed with [Ms A] two options available to her (namely root canal treatment or extraction), and the fact that any extraction was once again likely to be difficult. I have reservations about her not considering a referral for the extraction of tooth 46, which I will discuss in a later answer. However, in my opinion, and with this reservation, this is an adequate and appropriate level of care.

As anticipated, this extraction proved to be difficult, and this time both mesial and distal root fragments were left in place, after attempts to remove them failed. [Dr B] informed [Ms A] of the presence of the remaining roots, a post-extraction radiograph was taken, and [Dr B] prescribed a further course of metronidazole and Synflex (an anti-inflammatory medication).

Because of the continuing trouble that [Ms A] had experienced with the 26 socket, and the difficulties experienced with the 46 attempted extraction, in my opinion it would have been advisable to arrange a follow-up appointment within the next 2 or 3 days. That [Dr B] did not consider this is a minor departure from an acceptable standard of care.

[Ms A] states that her husband (who was present for this extraction) thought that swabs that had been used during the extraction might not have been changed, but [Dr B] states that sterile swabs were used throughout. In my opinion it is very unlikely that not changing swabs would have any bearing on any post-operative problems.

Unfortunately, the socket around 46 became very painful, and [Ms A] returned to [Dr B] on either 2 March or 3 March (there is some discrepancy between

[Ms A's] diary and [Dr B's] notes). [Dr B] diagnosed a localized osteitis (or "dry socket"), a painful and well-recognized complication of difficult dental extractions. [Dr B] dressed the socket with Alvogyl (a standard dry socket dressing material). She also notes discussing further care for the retained roots.

[Ms A] then had to attend the emergency department of [a public hospital] on the evening of 3 March, complaining of fever, pain and a swollen face. After overnight IV antibiotic and analgesic treatment, she sought the advice of her medical GP, and attended [Dr B] again, who irrigated the socket, redressed it, and arranged a referral to an oral surgeon.

In my opinion, [Dr B] has provided post-extraction care of an adequate standard, with the exception of arranging a post-extraction check appointment. While this is of little consolation to [Ms A], and I sympathize fully with her experience, it is nevertheless the case that dental extractions are not always straight-forward and uncomplicated.

[Dr B] could possibly have carried out a full surgical removal of the tooth roots at the 1 March appointment, which would have involved a procedure that was later carried out by [Dr E], but if she felt her skills in this area of oral surgery were not sufficient, then it was a prudent course of action not to proceed further.

I will discuss the timing of the referral to an oral surgeon in a later answer.

2 The adequacy and appropriateness of the advice/explanation [Dr B] provided to [Ms A] in relation to the

(a) Remaining palatal root of tooth 26

(b) Remaining roots of tooth 46.

When deciding whether to abandon attempts at removing fractured roots, a dentist needs to consider the risks of leaving retained roots in place against the risks of further surgery, and balance this against the benefits of either removal or retention.

I have briefly outlined the risks and benefits for removal of the palatal root of tooth 26 in an earlier answer. The situation for tooth 46 is similar, in that further attempts at removal (without a full surgical extraction) at that appointment, in my opinion, would have been likely to result in further trauma. Additionally, I believe that without a full surgical procedure it was most unlikely that the remaining roots would have been successfully removed. However, there was no apparent active infection at the time of the extraction, so there was no imperative to remove the roots of this tooth at that time.

If this second appointment is considered in isolation then the decision to leave the fractured roots of tooth 46 in place is in my opinion justifiable. I am also satisfied that [Dr B] adequately advised [Ms A] of the presence of the roots of these teeth, and that they may need further treatment.

However, the second appointment of 1 March (tooth 46) has to be considered in context with the earlier appointment of 2 February (tooth 26). I will discuss this in answering the next question.

3 Referral to an oral surgeon. Should the referral have been made on 1 March 2005 when [Ms A] presented with a second toothache?

It is clear from the radiograph taken on 1 March that tooth 46 was likely to be a very difficult extraction. It had long roots, was heavily filled and the distal root in particular appears to be rather bulbous. This was later confirmed by [Dr E]. [Ms A] also has a history of difficult extractions. Bearing in mind [Dr B's] earlier experience with tooth 26, and with the benefit of hindsight, it would have been appropriate to consider the option of a referral to an oral surgeon at the outset of that appointment. This would also have facilitated further treatment for the retained root of tooth 26 that was still troubling [Ms A].

In this respect, I am of the opinion that the care offered by [Dr B] (in not considering referring the extraction of 46 to an oral surgeon on 1 March) is a moderate departure from an acceptable standard of care.

However, my opinion is qualified, as I am mindful of the difficulties that dentists may experience in provincial areas of New Zealand in accessing specialist care for their patients. This can involve a delay in treatment, and the necessity of travel. These factors can act as disincentives to referral, for both dentists and patients, particularly in urgent care circumstances.

4 Was [Dr B's] documentation of an adequate standard?

[Dr B's] notes and records of treatment are of an acceptable standard in my opinion. There is a slight discrepancy as noted in an earlier answer between the dates noted in [Ms A's] diary and [Dr B's] record for the first follow up visit after tooth 46 was extracted, but this is not materially important.

Further Comment

[Dr B] may need to review her referral thresholds for minor oral surgery. General dentists do need to have a good understanding of their own clinical strengths and weaknesses, and to have in place sound referral procedures when referral is indicated."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is 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.

Opinion: Breach — Dr B

An assessment of the standard of care Dr B provided to Ms A involves looking at both the extraction of tooth 26 on 2 February 2005, and of tooth 46 on 1 March 2005.

Care in February 2005
The standard of dental care Dr B provided on 2 February 2005 was satisfactory. Ms A presented with toothache from tooth 26, which Dr B examined and radiographed. She observed that it was tender, decayed and heavily filled, and documented in her treatment notes that extraction could be difficult. Ms A disputes that she was told about the difficulty. While it is not possible to determine what information Dr B provided Ms A, I am satisfied that it did not compromise her pre-extraction care, which I consider adequate.

Following a difficult extraction, a large part of the palatal root of tooth 26 was left in Ms A's gums. In such circumstances, leaving a portion of the root may be the most appropriate and prudent course of action. However, my advisor favoured removal where possible since subsequent attempts to retrieve palatal roots can sometimes dislodge a root into the maxillary sinus or create a surgical opening on the floor of the sinus, increasing the degree of surgical trauma for the patient.

If the amount of root remaining is large (as in Ms A's case), it is sometimes advisable to remove it sooner rather than later. However, Dr B decided that the risks of further attempts at removal outweighed the potential risks of leaving the palatal root in place. As there was no sign of active infection, total removal was not imperative. I accept my expert's advice that Dr B's decision was appropriate in the circumstances.

Dr B took a postoperative radiograph of tooth 26 socket to confirm the position and presence of the palatal root. She also informed Ms A of the presence of the remaining root, advised her to take analgesics and to return if the pain or discomfort persisted. My advisor commented that Dr B could have provided a better level of care by prescribing anti-inflammatory medication such as diclofenac, and recommending a follow-up appointment to check the progress of the healing socket around tooth 26. It

would have been good practice to make a follow-up telephone call a day or two after the extraction to check with Ms A on the progress of her recovery. I accept my advisor's view that these omissions were relatively minor, and did not compromise the standard of care that Dr B provided on 2 February.

In summary, Dr B provided adequate information about the tooth root, and her postextraction care was satisfactory. In addition, her documentation was of an acceptable standard.

Overall, my view is that Ms A received satisfactory care from Dr B on 2 February 2005.

Care in March 2005
On 1 March, Ms A returned to Dr B as she had toothache from tooth 46 and residual pain from the socket around tooth 26. Dr B took radiographs of tooth 46 and of the socket around tooth 26, and advised Ms A on the option of extraction or root canal treatment. After opting for the former, Dr B advised that as with tooth 26, extracting tooth 46 was likely to be difficult owing to its structure and condition. My advisor considered that Ms A should have been given the option of referral to an oral surgeon at this point (see below), but that Dr B's pre-extraction care was otherwise adequate.

In the course of extracting tooth 46, Dr B experienced difficulties and left both mesial and distal root fragments in place after attempts at removing them failed. She took a post-extraction radiograph and informed Ms A of the presence of the remaining roots. She also prescribed Ms A metronidazole and Synflex to alleviate her post-extraction pain. According to my advisor, Dr B's decision to leave the root fragments in place was justifiable if the second extraction is viewed in isolation. As with tooth 26, tooth 46 had no signs of active infection. However, given Ms A's pain from the socket around tooth 26, which lasted for a month, and the difficulties encountered in extracting tooth 46, Dr B should have arranged a follow-up appointment to check Ms A's dental sockets two to three days after the second extraction. Patients rely on their dentist to be available and attentive to review them and respond to any pain or problems after major dental work, such as an extraction or root canal. I accept Dr Goodhew's advice that Dr B's omission constituted a minor departure from an acceptable standard of care. In this respect, Dr B's post-extraction care breached Right 4(1) of the Code.

As Ms A experienced acute pain from the socket around tooth 46, she returned to Dr B on either 2 or 3 March. (While there is some discrepancy between Ms A's diary and Dr B's records, the dates do not materially affect my decision.) Dr B diagnosed a localised osteitis ("dry socket"), which was appropriately dressed with Alvogyl. She advised Ms A on further care for the retained roots. A day later, Ms A consulted Dr B again after seeking medical assistance from a public hospital and her general practitioner. The dental treatment on 4 March included irrigating the socket around tooth 46, redressing it and arranging a referral to an oral surgeon. I consider that Dr B

provided Ms A with adequate information about the remaining dental roots, and that her documentation was of an acceptable standard.

I accept my advisor's view that Dr B provided adequate post-extraction care in March 2005 with the exception of failing to arrange a follow-up appointment.

Referral to oral surgeon
On 1 March 2005, Dr B correctly envisaged the likely difficulties of extracting tooth 46. Ms A had a history of difficult extractions, including her experience the previous month. In my view, it was imprudent for Dr B to proceed with extracting tooth 46 on 1 March without discussing with Ms A the option of referral to an oral surgeon. My advisor pointed out that a specialist could also have facilitated further treatment for the retained root of tooth 26, which continued to trouble Ms A.

In mitigation, my advisor noted the difficulties that some dentists in provincial areas experience when accessing specialist care. This can be a disincentive to refer, for both the dentist and patient. While Dr B eventually referred Ms A to an oral surgeon, she should have offered to do so at the time of the 1 March consultation. Her treatment notes on that date give no indication that she considered a specialist referral. It was only when Ms A returned on 3 March, two days after the second extraction, that Dr B suggested and arranged a referral to an oral surgeon.

In failing to offer a timely specialist referral, Dr B failed to provide Ms A with dental care of an appropriate standard, and breached Right 4(1) of the Code.

Opinion: No Breach — The Dental Centre

In addition to any direct liability for a breach of the Code, an employing authority may be vicariously liable under section 72(3) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an agent of the employing authority. Section 72(5) affords a defence for an employing authority if it took such steps as reasonably practicable to prevent the act or omission in question. Dr B clarified that she is self-employed, operates independently, and does not receive a salary from the dental centre (the Centre). She leases a surgery room and is responsible for all the dental care provided to her patients.

The exact legal relationship between Dr B and the Centre is not entirely clear. It is possible that Dr B could be an agent of the Centre, and that the Centre could be vicariously liable for Dr B's acts and omissions. In this case, I am satisfied that Dr B's failure to offer a timely specialist referral was an independent clinical decision, and not one that an employing authority could have prevented. Accordingly, the Centre is not vicariously liable for Dr B's breaches of the Code.

Actions taken

In response to the provisional opinion, Dr B accepted that she breached Right 4(1) of the Code in relation to the care she provided Ms A on 1 March 2005, and provided a written apology. Dr B commented:

> "I have carefully noted the recommendations regarding follow-up appointments after treatment, and also the need to more carefully consider and offer referral to a patient when treatment appears difficult in relation to my own GP [general practice[1]] expertise.
>
> This has been a salutary lesson for me."

Follow-up actions

- A copy of my final report will be sent to the Dental Council of New Zealand.
- A copy of my final 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.

[1] A term used for non-oral specialists