# Dr B, Dental Practitioner

## A Report by the

## Health and Disability Commissioner

## (Case 03HDC15639)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Parties involved

| | |
|---|---|
| Dr A | Consumer |
| Dr B | Provider/Dental Practitioner |

## Complaint

On 16 October 2003 the Commissioner received a complaint from Dr A about the dental services provided to him by Dr B. The following issues were identified for investigation:

- *Whether Dr B provided Dr A with services of an appropriate standard on 4 October 2003. In particular:*
  - *whether Dr B had conducted appropriate investigations of Dr A's condition prior to performing an extraction;*
  - *whether the extraction performed was appropriate in the circumstances; and*
  - *whether Dr A was provided with appropriate postoperative care.*

- *Whether Dr B provided Dr A with the information he could reasonably expect. In particular:*
  - *whether Dr B provided Dr A with a reasonable explanation about his condition and the options available for treating that condition; and*
  - *whether Dr B provided Dr A with accurate information about his qualifications.*

An investigation was commenced on 16 December 2003.

## Information reviewed

Information from:

- Dr A
- Dr B, including:
  - correspondence
  - dental records
- Dr A's regular dentist, including
  - correspondence



*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

  - dental records
  - X-ray films
- Dental Council of New Zealand

Independent expert advice was obtained from Dr Roger Gain, dentist.

## Information gathered during investigation

On Saturday, 4 October 2003, a filling fell out of Dr A's upper left molar (tooth 26). The remainder of the tooth had sharp edges which lacerated Dr A's cheek and tongue, causing him discomfort. Dr A contacted his regular dentist to arrange an appointment. An answerphone at Dr A's regular dentist's surgery directed Dr A to contact a locum, and a further message on the locum's answerphone directed him to contact Dr B. Dr A was given an emergency appointment for 5.30pm that day with Dr B.

On arrival at Dr B's rooms, Dr A filled out a health questionnaire with details of his current medication regime. He had undergone repeated abdominal surgery and had a Hartmann's colostomy, adhesions, incisional hernias, and late-onset diabetes (LOD) following abdominal sepsis, complicated by liver and kidney damage sustained before the LOD was diagnosed. He could not remember the name of one of the anti-hypertensives he was taking, but Dr A said that Dr B told him it was irrelevant. The patient questionnaire completed by Dr A records that he had undergone abdominal surgery and suffered from high blood pressure, diabetes and chest problems/bronchitis. It also lists Dr A's medications as follows: "Pentasa, Loperamide, Naplin, Gliclazide, Metformin, Zo-tab [Zopiclone], Atacan[d], Lipex." Dr A said he informed Dr B during their conversation that he was taking cefaclor (an antibiotic), although Dr A did not include this medication amongst those contained on the patient questionnaire. The questionnaire also reads: "Dressing for 1st upper ⊗ molar please."

Dr B recalled Dr A coming to the dental surgery and completing the patient information sheet, including his past medical history and medications. He said Dr A told him he was taking antihypertensive medication, but that his blood pressure was under control and within the normal limits. He noted that Dr A had diabetes and liver/kidney damage.

Dr B examined Dr A, observing that Dr A had no extra-oral swelling and his lymph nodes were not enlarged. Dr B recorded:

> "[tooth] 27 [26] oblique crown fracture. 1–2 mm distal crown present. Other part below the gingiva and alveolar bone."

According to Dr B, the fracture of Dr A's tooth was partly due to gross secondary caries (decay) and the coronal aspect of the tooth was brown and soft when probed. Dr B explained that he informed Dr A about the tooth structure and fracture, and that the tooth was "totally rotten". Dr A confirms that he was told that the tooth was rotten, but disagrees that Dr B told him the tooth was fractured or examined him for extra-oral swelling or enlarged lymph nodes. Dr A said that Dr B then insisted on an extraction. Dr A stated:

> "I told [Dr B] again that I wanted only a temporary dressing and he flatly refused, saying that it was impossible to dress, that it was in urgent need of extraction, that there was nothing else he could do and if I did not wish it extracted I could go home."

Dr B said that the options he put to Dr A were as follows:

> "I told the patient that the treatment options available [were] … extraction of the root or if he likes the restorative option to go home and see his regular dentist during the weekdays … as I knew he was a restorative dentist."

Dr B gave two reasons why he did not provide Dr A with a temporary dressing. The first was that he believed that restoration of the tooth would involve complex procedures, best done by only one dentist. The second was that he was hesitant to drill into the root of Dr A's tooth because it was soft. In response to my provisional opinion, Dr B further explained:

> "… the temporary dressing was out of the question for me as the tooth was soft and [the] tooth was fractured below the gum and I did not see there could be any possible retention available [on which] to put the filling and also the risk of not getting a proper retention [meant] the filling could dislodge. As [Dr A] is medically compromised with multiple abdominal surgeries, diverticular disease, the dislodgement of the filling can end up … in three places, 1. outside the mouth, 2. [it could be] aspirate[d] into the lungs, 3. [swallowed and end up] in the GI tract. This is why I told him I could not put [on] a temporary dressing in [his] situation."

Dr B also said that he did not consider that a temporary filling was a good option as there was no irritation, trauma to the tongue or adjacent tissues, or systemic involvement. He felt that Dr A could wait to see his own dentist if he chose the restorative option.

Dr A claims that, despite expressing an interest in having the tooth capped, he was told by Dr B that this was impossible. He said he was advised by Dr B that an implant might be possible if he did not want a plate. Dr A said he has since been advised by his regular dentist that having a root canal and capping was a viable option, but that an implant was not a viable option because of inadequate bone height and the thin floor of the maxillary sinus. Dr B believes that as Dr A's regular dentist did not see the condition of Dr A's tooth, such a statement cannot be made in retrospect. Dr B confirmed that he may have

mentioned that capping Dr A's tooth could lead to "a poor outcome". However, he explained:

> "Implant treatment planning is another consultation, and cannot be incorporated during the emergency visit. If there is inadequate bone height in that region there are many options, including a sinus lift."

Subsequent to this discussion with Dr B, Dr A consented to having his tooth extracted. Dr B did not take a periapical X-ray of the tooth before attempting to extract it. He advised that he did not think he needed to take an X-ray, as the presenting problem was obvious. He added that Dr A was an emergency patient, presenting on the weekend.

In response to my provisional opinion, Dr B stated that an X-ray provides useful information in a situation where a diagnosis cannot be made. He submitted that in Dr A's case a diagnosis could be made on the basis of information obtained by taking a history of the presenting complaint by taking medical, dental, family and social histories, as well as undertaking "a review of systems" and completing an examination. Dr B stated that the treatment options for Dr A (in his view, restoration or extraction only) would not have changed had an X-ray been taken, "nor [would an X-ray] tip the equation toward one side in [Dr A's] situation".

While Dr B acknowledged that an X-ray may have helped him identify the shape of the roots for the surgical extraction, he submitted that his dental experience was such that he was comfortable to perform the extraction without a periapical X-ray.

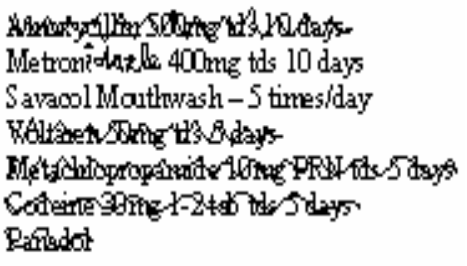
Initially, Dr B attempted to extract the tooth by sectioning it, but this was unsuccessful, and he extracted it by removing buccal bone.

Dr B prescribed Dr A postoperative antibiotics using a rubber stamp designed for the purpose. The impression reads:

Amoxycillin 500mg tds 10 days
Metronidazole 400mg tds 10 days
Savacol Mouthwash – 5 times/day
Voltaren 50mg tds 5 days
Metachlopramide 10mg PRN tds 5 days
Codeine 30mg 1-2 tab tds 5 days
Panadol

According to Dr A, Dr B wanted to prescribe ten days of metronidazole and amoxycillin, and Voltaren postoperatively, and stamped the prescription as above. Because of his diabetes and liver and kidney damage, Dr A was concerned about being prescribed amoxycillin and Voltaren and refused these. He was concerned about their potential effects on his existing medical conditions and decided to delete them from the stamped list and to limit the metronidazole to five days.

The prescription Dr A presented to a pharmacist, dated 4 October 2003, reads:


Metronidazole 400mg tds 10 days
Savacol Mouthwash – 5 times/day

Dr B disputes Dr A's recollection of events. Dr B said that he used his rubber stamp and, after discussion with Dr A, deleted some of the drugs from the stamp prescription himself, leaving only metronidazole and Savacol mouthwash. He explained that he did so having also consulted a *New Ethicals Catalogue (New Ethicals)* to check for potential side effects, drug interactions and toxicity.

Dr A does not accept Dr B's assertion that he consulted *New Ethicals* before prescribing amoxycillin and Voltaren, stating "He was never out of my sight following the extraction and, had he done so, he should certainly not have considered prescribing Voltaren to someone in my state."

Dr B advised Dr A to rest for 24 hours and to take the tablets prescribed as instructed, but to take the analgesics (Panadol and codeine) directly. He told Dr A to bite on gauze if he experienced bleeding and to consult him if bleeding persisted. Dr B further advised Dr A to use mouthwash the following day, to eat on the right-hand side of his mouth and not to ingest anything too hot or cold for a day. In response to my provisional opinion, Dr B advised that in addition to the verbal instructions he gave, Dr A should have received an envelope containing gauze and a written postoperative instruction sheet from the attending nurse. Dr B was not aware whether Dr A had received these items.

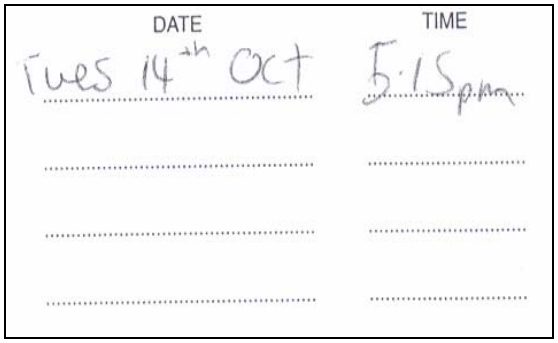
Dr A does not recall whether or not he received any written postoperative instructions but said he had not received any gauze. Dr A disputes that he was told to rest for 24 hours, as he had discussed with Dr B that he wanted to attend an event and to go out to dinner the following day and this was one reason why he had not wanted to have an extraction. Dr A recalled that Dr B reassured him that, with the use of analgesics and by chewing carefully on the right side of his mouth during dinner, he would still be able to meet his prearranged plans.

Dr B said he advised Dr A to consult him, or his regular dentist, seven to ten days after the extraction in order to have the sutures removed. Dr B recalled that Dr A said that he would decide about this at a later date, which Dr B found "totally acceptable" due to patients often being stressed following surgical extractions.

In relation to the length of time sutures were to remain in place, Dr A stated:

> "He [Dr B] told me he was leaving the stitches in for 14 days *'to be on the safe side'*. I thought he meant 4 days but he was quite definite that he wanted them in for 14 *'because we don't want an abscess'*. This is the very opposite from being on the safe side in the mouth, which is loaded with bacteria [and] heals faster than anywhere else in the body, and would be a virtual guarantee of stitch abscesses."

Dr A provided me with a copy of Dr B's business card at the time he made his complaint. The reverse side of the card reads:




Dr A acknowledges that Tuesday, 14 October, was ten days after the date his tooth was extracted by Dr B. Dr A "guessed" that these details could have represented an appointment to have the stitches removed by Dr B, although given the time that has passed since the events in question he finds this difficult to recall.

Three days following the extraction, Dr A saw his regular dentist. Notes of Dr A's consultation with his regular dentist read:

> "07/10/03, exam and 3 films, PA [periapical X-ray] of tooth 26 socket given to patient who is very upset. He saw the after hours dentist for a dressing on 26 because it was sharp to tongue and cheek. Emergency dentist refused a dressing and said either xl [extraction] or nothing! Pt [patient] now regrets having the tooth removed, gap is bigger than expected, would have preferred a root filling and a crown, all options not considered on the day. Agreed to write a report to Health and Disability [Commissioner] if asked."

On examination, Dr A's regular dentist found untrimmed tissue around the extraction site of tooth 26. Dr A's regular dentist was concerned that Dr B did not contact him to advise about the care he had provided to Dr A, or provide him with an X-ray of tooth 26.

Dr B stated that if a patient was not referred to him by their regular dentist, he was not obliged to provide a report to that dentist. In response to my provisional opinion, Dr B added:

> "When [a] dentist treat[s] a patient during a[n] emergency visit in Australia [they] do not give any letter to the regular dentist and I was used to this and [the] only instance we send a report is if the patient has been referred by the dentist."

Dr B stated that he was unable to provide any information to Dr A's regular dentist, because Dr A had not made a decision about whom he would see to have his sutures removed. Dr B believed that Dr A's regular dentist would have been able to contact him if necessary, and recalled that he *had* spoken to Dr A's regular dentist, who had asked Dr B why he had removed the buccal bone to extract the roots.

Dr A's regular dentist recalled receiving a telephone call from Dr B, but could not remember exactly when this occurred. Dr A's regular dentist said that it was most likely that their discussion related to a complaint having been made, and not to Dr A's treatment or follow-up.

## Independent advice to Commissioner

The following expert advice was obtained from Dr Roger Gain, dentist:

> "**Report to the Health and Disability Commissioner from Roger Gain BDS (Otago)**
>
> I have been requested to provide expert dental advice on case 03/15639.
>
> I graduated in 1962 and have been in general dental practice since then. I am a Fellow of the New Zealand Dental Association, and a Fellow of the International College of Dentists. These fellowships are honorary.
>
> I have read the Guidelines for Independent Advisors and agree to follow them.
>
> I have also read the supporting information provided, as detailed below.
>
> **Supporting Information**
>
> Letter of complaint, dated 16 October 2003. (p 1–5)
> Letter of notification, dated 16 December 2003. (p 6–8)
> Information from [Dr A]. (p 9–19)
> Information from [Dr B]. (p 20–44)
> Information from [Dr A's regular dentist]. (p 45–51)
> Information from the Dental Council of New Zealand (DCNZ). (p 52–59)

**Expert Advice Required**

*Did [Dr B] provide services of an appropriate standard to [Dr A] on 4 October 2003? In particular:*

*1. Was [Dr B's] assessment of [Dr A's] condition adequate?*
[Dr B] obtained consent from [Dr A] to extract tooth 26 but in my opinion this was not **informed** consent.[1] [Dr B] did not explain the options for treatment of the situation — he merely informed the patient that he could have the tooth extracted or go away. This constitutes a failure of duty of care (or dereliction of duty).

[Dr A] was not in pain, he had a sharp edge which was irritating his tongue and cheek. It should have been a simple matter to either smooth the sharp portion of the tooth, or cover the root face with a material such as glass ionomer cement and refer him back to his own practitioner.

[Dr B] states (p.22, para 3) 'The restorative option (...) This was one of my reasons (for not doing) any temporary dressing.'

In my opinion, this is very poor reasoning, and unconvincing. Placing a temporary dressing would not have made any difference to any future treatment of the tooth, whether or not it was a complex procedure.

He further states (p.26, last para) 'Implant treatment planning (…) cannot be incorporated during the emergency visit.' Implant treatment would have been one of the post surgical options for [Dr A]. As [Dr B] had failed to take an X-ray, he had no way of knowing whether or not this was a viable option. He therefore should have placed a simple dressing and referred the patient back to his own dentist.

*2. Should [Dr B] have imaged tooth 26 with a periapical X-ray prior to extracting it?*
[Dr B] should have X-rayed the tooth before extracting it. Without an X-ray, it would have been impossible to provide the patient with the possible options for the tooth as it stood, or for the restoration of the space had the tooth been extracted. That is, without an X-ray, informed consent was not possible.

[Dr B] states (p.24, para 1) 'I did not anticipate any complications such as maxillary sinus communication.' He could not possibly know that for certain without an X-ray, nor could he know the extent of the caries (decay), or the morphology of the roots.

[1] Informed Consent: "The patient has the right to know the details of examination procedures, the state of their oral health, any disease diagnosed, the probable cause, available options for treatment, and likely costs, benefits and risks. NZDA Code of Ethics p. D2 [Dr Gain's emphasis.]

He goes on to infer that, as there were no complications to the extraction, it didn't matter that an X-ray was not taken. In my opinion this is irrelevant, as without a radiograph, informed consent is impossible.

*3. Did [Dr B] perform an appropriate extraction of tooth 26?*
I believe that [Dr B] did perform an appropriate extraction of tooth 26, given that informed consent had not been obtained and that an X-ray was not taken.

Ideally, if an implant is contemplated to replace an extracted tooth, the preservation of as much bone as possible is paramount. [Dr B] apparently removed the buccal (outside) plate of bone to access the roots. It is true to say however, that such bone removal may have been necessary in any case.

*4. Was the postoperative care [Dr B] provided to [Dr A] appropriate?*
Following extractions, patients are often in some degree of shock, and so it is important that any verbal postoperative instructions are reinforced with written ones. [Dr B] provided [Dr A] with instructions on the care of the extraction site and with a prescription for an antimicrobial agent (metronidazole) and a mouthwash.

There is an apparent difference of opinion over which drugs were crossed out on the stamped imprint on the prescription form, and by whom. I am unable to comment, except to say that the deletions on the pharmacy copy supplied appear to have been done by the same hand.

It would have been appropriate however for [Dr B] to have made a firm arrangement with [Dr A] regarding the removal of the sutures. There is some dispute over the time the sutures were to remain in place, and the 10 days which is the outer limit of [what] **[**Dr B] says he recommended, does seem a rather long time. 5–7 days would have been more 'normal'.

Instead of the open ended arrangement [Dr B] made for suture removal, he should have scheduled an appointment for [Dr A] to return to see him, or told him (Dr A) to see his own dentist, and followed that up with a phone call or note to [Dr A's regular dentist].

*5. Was [Dr B] appropriately qualified to provide [Dr A's] treatment?*
[Dr B] has only supplied a copy of his RACDS diploma but he states (p.29, last para), that he graduated BDS from [a] dental school [overseas] and that he has [a certificate from another country] to practise (ADC). This was confirmed to [Dr A] (p.3, para 4) by […] the Dental Council of New Zealand.

I have no reason to doubt that [Dr B's] FRACDS qualification is not genuine.

In my opinion, [Dr B] was appropriately qualified to provide dental treatment to [Dr A].

*6. Whether [Dr B] prescribed [Dr A] Augmentin (amoxycillin) and Voltaren is disputed. However, please comment on the likely effect of these medications on [Dr A's] condition.*
Augmentin tablets are composed of amoxycillin trihydrate and potassium clavulanate. It is possible that the undesirable effects of Augmentin[2] on the gastrointestinal and liver systems could have further compromised [Dr A's] condition. He was already taking medications for intestinal problems (Pentasa and Loperamide) and for his late onset diabetes (Gliclazide and metformin).

Voltaren (generically known as diclofenac sodium) needs to be used with caution[3] in patients with symptoms indicative of gastrointestinal disorders and in patients with impaired liver function. It is quite likely that Voltaren would cause [Dr A's] symptoms to get worse.

I need to state that I have only a basic knowledge of pharmacology and most of my information has been obtained from the referenced publication. While I believe that my statements above regarding Augmentin and Voltaren are correct, if more in depth information is needed, a pharmacologist should be consulted.

*7. On the information available, did [Dr B] provide [Dr A] with all the information he could reasonably expect to receive about the condition and treatment of tooth 26?*
As stated in 1 above, [Dr B] failed to provide [Dr A] with all the treatment options for tooth 26, so [Dr A] was unable to make an informed judgement on whether he should agree to have his tooth extracted.

[Dr B] was unable to assess the options for treatment as he failed to take an X-ray of the tooth. (He attempts to excuse this failure because it was an emergency situation and after hours, but this is not acceptable.)

In my opinion, [Dr A] did not receive the information he should have reasonably expected, nor did he receive the treatment the situation warranted.

*8. Are there any issues that you consider warrant further investigation?*
No.

[2] *New Ethicals Compendium* 7th edition p.183. Published by Adis International Ltd.

[3] *New Ethicals Compendium* 7th edition p.2016. Published by Adis International Ltd.

*9. Additional comment*
[Dr B] was offering an emergency service and a patient attending should reasonably expect to have his symptoms alleviated. [Dr A] requested that the sharp portion of tooth (or root) that was irritating his cheek be smoothed.

[Dr B] in effect refused to do this — (p.22 para 1) '(…) treatment options available are extraction of the root or (…) the restorative option to go home and see his regular dentist …'. [Dr B] says he provided [Dr A] with the treatment options — it seems to me [Dr A] had 'Hobson's choice' if he wanted the sharpness removed.

What [Dr B] had offered were **his** options, and they paid no heed to [Dr A's] request or predicament.

I find it hard to escape the feeling that [Dr B] was attempting to maximise financially from [Dr A's] situation."

## Response to Provisional Opinion

Dr B responded to my provisional opinion and challenged a number of Dr Gain's conclusions.

*Assessment and treatment options*
In response to Dr Gain's comment regarding Dr A's request that the sharp edges of his tooth be smoothed, Dr B stated:

"I did not want to smooth the grossly carious (rotten) 26 as it [had] not been damaging or causing an obvious trauma or ulcer of the tongue or soft tissues and [Dr A] would have been put under tremendous stress of giving buccal infiltration and a greater palatine block to do this procedure. Also as I have mentioned until [the] whole fractured surface is covered with restoration [a] patient may put the tongue to the ULM region and still may feel irritation even after drilling and [smoothing]."

Dr B said that he read Dr Gain's advice as implying that an X-ray was all that was required for treatment planning, and that detailed history-taking and examination were not essential. He stated:

"… Dr Gain argues that proper history taking and proper examination are not an essential part in the diagnosis and treatment plans and treatment options and only an X-ray is essential to obtaining informed consent …"

Dr B commented on Dr Gain's statement that he was trying to maximise financially from Dr A's situation:

> "I do not understand why Dr Gain feels like that. I told [Dr A] that he could have the restorative option by going home and seeing his regular dentist the next day, which would not have provided me with extra income."

*Post-extraction instructions regarding suture removal*
Dr B is not aware of any regulations stating that dentists should give written postoperative instructions to patients. He said that, at the surgery where he worked, written instructions following tooth extraction were given as a matter of course. Dr B believes that it would only have been problematic for Dr A not to have received written instructions had he developed a complication of surgery preventable by written advice.

In relation to the length of time the sutures were to remain in place, Dr B cited the following publication: "Steward, G R, Harris, M, McGowan, DA, Killey, HC, and Kay. LW, *An Outline of Oral Surgery*: Parts 1 and 2 (Butterworth-Heinemann Medical, 1998), which states:

> "Sutures are normally left for 5–7 days where closure is completely without tension. Where tissues have been displaced and some degree of tension created, as in the rotation or advancement of a flap to close an oro-antral fistula, it is better to leave them for 10–14 days. Preferably sutures should be left until local tissue oedema has subsided at which time the loop will probably lie loosely over the wound and can be removed easily and without causing the patient discomfort." (p 42)

Dr B stated:

> "I advise the patients that after mandibular and anterior maxillary teeth extraction, sutures will be removed 5–7 days later and from the maxillary posterior teeth, 7–10 days. [The reason] I advise the patients 7–10 days for upper posterior teeth surgical extraction is that especially with the upper molars, extraction carries the risk of [oro-] antral communication. So I feel if the sutures can stay there longer, there is less chance of [oro-] antral communication …"

*Informed consent*
Dr B stated that he has always tried to explain to his patients all of the available treatment options, and that stating the options but not explaining them to the patient would "likely be problematic". In relation to Dr A, Dr B says "He decided for himself and consented to the extraction verbally after he had been well informed."

Dr B disagreed with Dr Gain's view that an X-ray would have aided him in presenting all possible options for the tooth and/or the restoration space. Dr B stated that he does not understand Dr Gain's advice that an X-ray is essential to gaining informed consent:

> "In this situation it was not a diagnostic X-ray. Treatment options do not change if an X-ray is taken or not. The patient was well informed of the condition of the tooth, as [Dr A] accepted [the] treatment options, the expected complications of [the] surgical removal of [tooth] 26 (including pain, infection, OAC [oroantral communication], fracture or damage to adjacent teeth) all of which was explained. Benefits and cost of surgery were discussed prior to the treatment …"

## Further expert advice

Dr Gain was asked to comment on aspects of Dr B's response to my provisional opinion, and provided the following further advice by telephone:

*Assessment and treatment options*
Buccal infiltration and a greater palatine block are used to anaesthetise the surface area and tooth. Dr B would have had to use both to extract the tooth. Therefore these processes and the stress they may cause the patient were "irrelevant" to Dr B's decision not to smooth the rough edges of the tooth.

Based on the information provided, using glass ionomer cement as a short-term dressing for an exposed root would have been satisfactory. The possibility that a temporary dressing could be swallowed, aspirated or fall out was "not relevant at all" in terms of whether this was an appropriate treatment option for Dr A. Even if a temporary dressing had dislodged, it would have been unlikely to cause problems in this patient. Furthermore, there was no reason why a temporary dressing could be problematic given Dr A's existing medical conditions.

*Oroantral fistula and suture removal*
An oroantral fistula is an abnormal connection/channel between the mouth and the maxillary sinus (antrum). Roots which extend close to the maxillary sinus may become pushed into the sinus during extraction, causing a fistula, which is susceptible to infections and may require surgical closing.

If Dr B suspected an oroantral fistula in Dr A's case, then leaving sutures in for 7–10 days would be usual. However, because no X-ray was taken, it is impossible to know how close the roots extended towards the antrum and therefore whether oroantral fistula was a realistic possibility.

## 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.*

…

*5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

*RIGHT 5*
*Right to Effective Communication*

…

*2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*

*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 —*

…

*(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option;*

*RIGHT 7*
*Right to Make an Informed Choice and Give Informed Consent*

*1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*

## Opinion: Breach — Dr B

*Assessment*

Dr A attended Dr B for an emergency weekend appointment for a broken tooth. My expert advisor, Dr Gain, was critical that Dr B did not appropriately assess Dr A's tooth before doing an extraction; specifically, that he did not take an X-ray. Dr Gain advised that Dr B should have done so for several reasons. In particular, without an X-ray Dr B could not know the extent of the caries or the morphology of the roots, whether there was any likely risk of oroantral communication, nor could he advise Dr A of all of the possible treatment options. In Dr Gain's view, an X-ray was vital to determine what the treatment options for the tooth were, and whether there were any complicating factors that would make one treatment option more viable than another.

Dr B agrees with my expert that an X-ray would have provided information on the morphology of the roots, but qualifies that he was comfortable in performing an extraction without one. Notwithstanding, Dr B is adamant that all possible treatment options were considered in the course of his assessment of Dr A. I am not satisfied that this was the case.

Dr Gain's advice is that, in the absence of a proper assessment, Dr B should have placed a simple dressing on the tooth and referred Dr A back to his own dentist. By doing so, he would have preserved all treatment options for Dr A. I am concerned by the extent to which Dr B challenges Dr Gain's advice on this issue, and Dr B's apparent confusion as to why Dr Gain considered an X-ray was warranted.

In my opinion, Dr B did not undertake an assessment of Dr A's broken tooth with reasonable care and skill before proceeding to extract the tooth and therefore breached Right 4(1) of the Code.

*Informed consent*

Dr A attended an appointment with Dr B and requested that his broken tooth be dressed, as it had jagged edges which were causing discomfort. Essentially, Dr B refused to do this. He advised Dr A that there were two treatment options – to have his tooth extracted or to go home and wait and see his usual dentist on a weekday. He told Dr A that dressing the tooth was not an option. In the course of my investigation, Dr B said that one of his reasons for not doing a temporary dressing was in case Dr A wanted his tooth restored. Dr B also submitted that placing a temporary dressing would have been inappropriate because there was not enough retention available to secure a temporary filling, and without adequate retention the filling could dislodge, posing danger. Dr B said that he was concerned about the possible consequences for Dr A, given his medical conditions, of the filling dislodging and being swallowed (and remaining in the gastro-intestinal tract) or being aspirated into the lungs.

Dr Gain has advised that Dr B's rationale is poor, unconvincing and not relevant to the future treatment of the tooth. He states that it would have been appropriate to use glass ionomer as a temporary dressing, since this would have been consistent with Dr A's

request for treatment, and he could have seen his own dentist after the weekend as anticipated. I accept Dr Gain's advice.

An additional option was to smooth the sharp edge of the broken tooth. Dr B said he did not explore this possibility because anaesthetising the area and the tooth would have put Dr A under considerable stress. I agree with Dr Gain that this explanation is again unconvincing, as in any event anaesthetic injections would have been required when Dr B extracted the remaining part of Dr A's tooth.

As Dr B did not undertake an adequate assessment before proceeding to discuss treatment options with Dr A, he therefore could not, and did not, provide Dr A with the range of possible options for the tooth as it stood, or for restoration of the space if the tooth was extracted. My advisor did not accept Dr B's explanation that discussing an implant was not an appropriate part of an emergency visit. Rather, he stated that "Implant treatment would have been one of the post surgical options for [Dr A]. As [Dr B] failed to take an X-ray, he had no way of knowing whether or not this was a viable option. He should therefore have placed a simple dressing and referred the patient back to his dentist."

I agree with Dr Gain's assessment. There is no doubt that Dr A gave his verbal consent for the extraction of the remaining portion of tooth 26. However, the key issue is whether that consent was properly informed. Right 7(1) of the Code provides that services may be provided to a consumer only if the consumer makes an informed choice and gives informed consent. I consider that Dr B did not adequately inform Dr A of all of his treatment options — or provide an assessment of the expected risks, side effects, benefits and costs of each option — before extracting his tooth. This is information that Dr A would want to know and would expect to receive — and to which he was entitled under Right 6(1)(b) of the Code. Instead, Dr B presented *his* options for the treatment of Dr A's tooth and essentially refused to do what was requested of him.

In my opinion, by failing to inform Dr A of the range of options available before extracting the tooth, Dr B breached Rights 6(1)(b) and 7(1) of the Code, as Dr A did not have sufficient information about treatment options to make an informed decision about his treatment options and so give informed consent.

## No further action

*Post-extraction instructions*
Dr A and Dr B have differing accounts about how many days Dr B told Dr A he should wait to have his sutures removed. In my view it is probable that Dr B anticipated the sutures would be left in situ for seven to ten days before removal by himself or Dr A's regular dentist. Dr Gain advised that, while this length of time is at the upper limit of what is usual, it would be appropriate in circumstances where oroantral fistula was a possibility.

Otherwise, five to seven days would be "normal". Because no X-ray was taken, further clarification of the likelihood of oroantral communication affecting the time frame for suture removal is not possible.

Irrespective, the key issue is whether Dr B gave Dr A reasonable post-extraction instructions, which, in the circumstances, were clear and easily understood. My expert advisor considered that Dr B's verbal postoperative instructions for suture removal were not specific enough. He advised that Dr B should have made clear written arrangements with Dr A about suture removal and given him the option of having the sutures removed by him or his regular dentist. If the former option were taken, Dr Gain considered Dr A should have been given an appointment; if the latter, Dr B should have contacted Dr A's dentist by telephone or letter.

Dr B advised that he did give Dr A these two options. He recalls that Dr A said he would decide which option to take at a later date. Dr A does not recall whether an appointment was arranged with Dr B for the removal of his sutures, although the appointment card for Tuesday, 14 October, (ten days subsequent) would appear to confirm that this was the case. Dr B maintains that it was unnecessary for him to communicate with Dr A's regular dentist. It is apparent that discussion between them did occur at some point after 4 October 2003, but on the information available I cannot be certain when, why, or what was discussed.

The question remains whether adequate written instructions were given to Dr A by Dr B, to reinforce any verbal advice offered. Dr Gain pointed out that patients are often in some degree of shock following a dental extraction and accordingly verbal postoperative instructions should be reinforced in writing. In response to my provisional opinion, Dr B advised that it is his standard practice to have his attending nurse provide written postoperative instructions (usually in an envelope with some gauze). Dr B was not certain whether these had been given to Dr A, who also does not recall whether he received any written instructions, but denies receiving any gauze.

In light of the differing accounts about follow-up arrangements for the removal of the sutures, uncertainty as to written information received, and when communication between Dr A's regular dentist and Dr B may have occurred, I am not able to form a view on whether Dr B breached the Code in respect of these issues. I do not believe that further investigation of these issues will be helpful, given the time that has elapsed since the events in question.

Nevertheless, I take this opportunity to remind Dr B that he has a professional and ethical obligation to communicate effectively with all the patients he sees, whether they are his own patients, or individuals who come to him, instead of their regular dentists, in an "emergency" or locum capacity. Dr B is also required to co-operate with other dentists to ensure quality and continuity of services. Dr A was referred to Dr B by a message left on Dr A's regular dentist's answerphone (and not by Dr A's regular dentist directly), but Dr B

was well aware who Dr A considered to be his regular dentist. In these circumstances, written or verbal communication from Dr B to Dr A's regular dentist regarding his assessment and treatment of Dr A was necessary. It is not acceptable for Dr B to have placed the onus on Dr A to recall details of the treatment given when he next saw his regular dentist.

*Prescription*
Dr B assured me that he had consulted the *New Ethicals* catalogue for drug interactions and deleted a number of drugs from the stamped prescription himself. However, Dr A states that *he* deleted the drugs from the prescription. I am unable to determine who ultimately was responsible for the amendments to the prescription that Dr B gave Dr A, and which Dr A presented to a pharmacist, and therefore am unable to take further action on this aspect of Dr A's complaint.

*Qualifications*
Dr A queried Dr B's qualifications to practise dentistry. The Dental Council of New Zealand confirmed that Dr B was on the New Zealand dental register when he treated Dr A. He qualified with a BDS overseas in 1992, and obtained FRACDS status from another country in 1998. This was subsequently recognised in New Zealand in accordance with a mutual recognition agreement. As Dr B was qualified to practise dentistry in New Zealand at the time he provided dental services to Dr A, I do not intend to pursue this aspect of the investigation any further.

## Recommendations

I recommend that Dr B take the following action:

- Review his practice in light of this report.

## Follow-up actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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

- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, on completion of the Director of Proceedings' processes.

## Addendum

The Director of Proceedings issued proceedings before the Health Practitioners Disciplinary Tribunal. At a hearing on 23 May 2006, the Tribunal concluded that the Director of Proceedings had failed to prove that Dr B had failed to accurately advise Dr A of other options prior to extraction, and whilst the failure to X-ray tooth 26 was undesirable, it was not an omission that satisfied the test of professional misconduct. Accordingly, the charge was dismissed.



*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*