Dental Surgeon, Dr C

A Report by the

Health and Disability Commissioner

(Case 02HDC12290)

Parties involved

Mr A	Consumer / Complainant
Ms B	Complainant
Dr C	Provider / Dental Surgeon
Dr D	Dental Surgeon
Dr E	Dental Surgeon
Mr F	Dental Technician
Mr G	NZDA Representative
Ms H	Agency Nurse
Ms I	Team Leader, Department of Corrections

Complaint

On 3 September 2002 the Commissioner received a complaint from Ms B about the services provided by Dr C to Mr A. The complaint was summarised as follows:

Dr C failed to provide services of a reasonable standard to Mr A. In particular Dr C:

- *took a total of seven impressions of Mr A's teeth, all of which were unusable;*
- *inserted two temporary teeth to 'push up the gums' and, when removing them, 'snapped' the stumps;*
- *did not remedy this situation for several weeks;*
- *did not keep several appointments;*
- *caused undue stress during treatment.*

An investigation was commenced on 23 September 2002.

Information reviewed

- Letter of complaint from Ms B, dated 2 September 2002

- Further information provided by Ms B and Mr A, including
  - File note of a conversation between Ms B and Investigation Officer, dated 5 September 2002
  - File note of a conversation between Mr A and Investigation Officer, dated 19 November 2002
  - Letter from Mr A and Ms B, dated 14 November 2002

- Mr A's medical/dental records obtained from a prison, including:
  - ACC forms and correspondence
  - Clinical Record, from 20 October 2001 until 19 August 2002
  - Dental Record, from 17 December 2001 until 19 August 2002
  - Dental X-rays

- Response from Dr C, received 9 October 2002

- Further information provided by Dr C, including:
  - Letter from Dr C, dated 20 December 2002
  - Transcript of an interview between Dr C and Investigations staff, dated 11 April 2003
  - Correspondence between Dr C and the prison

- Information received from the New Zealand Dental Association (NZDA), dated 8 November 2002, including correspondence between:
  - NZDA and Dr D
  - NZDA and Dr C
  - NZDA and Ms B

- Information received from Dr D, including:
  - Letter from Dr E, dated 18 November 2002
  - Five dental X-rays, dated 27 August and 11 September 2002
  - Patient notes from 11 September 2002 until 24 October 2002

- Information received from ACC, including:
  - Injury Claim Form, entered 20 March 2002
  - Amended Injury Claim Form
  - Letter from Mr A to ACC, dated 4 April 2002
  - ACC activity logs, dated 21 March, 26 March (x2) and 9 April 2002
  - Letter from ACC to Mr A, dated 26 March 2002

- Letter from Mr F, dated 3 November 2003

Independent expert advice was obtained from Dr Mark Goodhew, dentist.

Information gathered during investigation

In 1989 Mr A had bridging work done on his front teeth, owing to a missing tooth.

In 2001, Mr A had root canal work done, which weakened the bridge. The bridge subsequently broke and required replacing. Mr A was, at the time, an inmate at a prison. The prison had a contract with Dr C, a dental surgeon, to work four hours a week at the prison

undertaking essential dental work for inmates, who were also able to have more advanced dental work done at their own cost. Mr A discussed the necessary work with Dr C, who quoted a cost of around $3,000. Mr A arranged for ACC to share the cost.

The records of the treatment actually undertaken by Dr C are incomplete. However, it appears that treatment began on 4 March 2002, when the notes record "talked about the work needed", and concluded on 19 August 2002, when Mr A refused to accept further treatment from Dr C.

Treatment provided

Mr A states that his original bridge was put in 12 years ago, under ACC cover. It fell out early in 2002. Mr A discussed a replacement with ACC and Dr C. On 17 April 2002 ACC wrote to Mr A, approving payment of $2,144.90 for the "treatment plan proposed by [Dr C]". The "treatment plan" comprised a "Dental Treatment and Tax Invoice Form". It included the following relevant information (Dr C's comments in are in italic):

ORAL TISSUE			TREATMENT		
Contusions	*NIL*		Exam & Report	*x1*	*31.60*
Lacerations	*NIL*		Radiographs	*x2*	*15.30*
			Post and Core *x2*	*51x2*	*74.60*
TEETH				*52x2*	*110.90*
Fractured	*11/13*		Bridges *3 or 5*	*54x5*	*1912.50*
JAWS					
Maxilla	*NAD*				
Mandible	*NAD*				
T.M.J.	*NAD*				
PROSTHESES					
Bridges *PFM 11/12/13*					
Restorations in damaged teeth prior to accident? *Do not know*					
[Illegible] in damaged teeth prior to accident? *Do not know*					
Periodontal disease about the damaged teeth					
Gingivitis	*NIL*		NET FEE PAYABLE		*2144.9*
Periodontitis with bone loss	*NIL*				

Mr A's summary

Mr A states that he first saw Dr C at the prison dental clinic for an assessment. He then saw Dr C for the second time, on 1 May 2002, at Dr C's surgery in a suburb. At this visit, which lasted two and a half hours, Dr C "shaved down" his teeth ready for the new bridge. Dr C also took an impression and told him that the bridge would be ready in a week's time. Following

this visit Mr A was left with sensitive, painful, and sharp uncovered tooth stumps[1] in his mouth.

Mr A states that the third appointment, which took place six weeks later, was also at Dr C's surgery in the suburb and lasted approximately two hours. At this appointment Dr C shaved his teeth down further. Mr A states that these visits were arranged by Dr C, as the prison clinic did not have the appropriate facilities.

Mr A's dental records from the prison indicate that, between 12 June and 19 August, Mr A saw Dr C twice more, although (as discussed below) it is not possible to confirm this.

Mr A reported that at the last visit, on 19 August, Dr C used a sharp chisel-like instrument to carve his gums into shape for the bridge. While doing this Dr C slipped and stabbed him in the roof of the mouth. During the course of this visit, Mr A had seven anaesthetic injections, which left him feeling unwell for the remainder of the day.

Mr A states that, over the course of the treatment, Dr C took seven impressions. When Mr A questioned him about this, Dr C said that it was because the technician was unable to get the bridge made properly.

Mr A states that he had two "razor sharp stumps" and "broken stumps and numerous gaps", and that his teeth were left in this state for four months, until the work was completed (by Dr E) in September 2002. This delay led to one tooth needing a root canal and another a new post and core.

Dr C's response

Dr C states that when he first saw Mr A they discussed the treatment needed to fit a new bridge. He told Mr A that he would have to prepare the teeth on each side of the bridge, take impressions to allow the technician to build the new bridge, put temporary teeth in to protect the tooth stumps in the meantime and, when the bridge was ready, take out the temporary teeth and put in the bridge. Dr C said that this process would normally take two to three weeks.

Dr C said that unfortunately, "everything that could go wrong, did go wrong". He did take an initial impression, which was used to make the temporary bridge and as a plan for the permanent bridge. Once the temporary bridge was made and fitted, which took about a week, the permanent bridge was begun. However, Mr F, the dental technician who was making the bridge, suggested that the span was too big for one bridge. They decided that it would be better to do the permanent bridge in three different sections. Dr C then had to take three new impressions. These were taken over successive appointments, so that each section of the

[1] There has been some confusion in this case about the difference between "stumps", "crowns" and "temporaries / temporary teeth". In this report, I refer to the actual remains of Mr A's teeth as "stumps" and the prosthetic teeth that were used to cover the stumps as "crowns". In this context, crowns, temporaries and temporary teeth all refer to the same thing.

bridge could be built and inserted before the next was done. Mr F needed one of the impressions to be redone. Dr C states that he took five impressions in total.

In response to my provisional opinion, Dr C stated that there was only one visit to his surgery in the suburb. This was to do a "crown prep". The prison confirms that it has records for only one visit to Dr C's surgery, on 7 August 2002.

Dr C states that, during the period where the various impressions were being made, Mr A broke one of the temporary "crown preps" attached to the temporary bridge. When he examined the temporary crown he noted that there was a sliver of tooth stump still attached to it. This left a sharp stump in Mr A's mouth. He said that he took out the sliver of tooth and recemented the crown in place. Dr C thinks that the crown had been out for some time, as that particular tooth required remedial work at a later date.

In response to my provisional opinion, Mr A denied that this event occurred. He stated that, regarding "snapped" or "broken" "crown preps" Dr C did break one of the posts on which a crown had been attached. This occurred about a week after the initial posts and temporary crowns had been put in. Dr C attempted to remove one of the crowns in order to put on the permanent crown. However, he was using a lot of force and snapped off the post. He replaced it at the time, but the new post subsequently had to be replaced by Dr E because it was too long.

There is no record of either incident in Dr C's notes.

Dr C cannot recall what prompted the difficulties at the final consultation on 19 August 2002. He states that Mr A was very abusive and upset because he had told him that "there was one more thing we needed to do before he got his completed work … in place". Dr C could not recall what the remaining problem was or what he meant when he said, as recorded in the note, that "the work had not been done".

Ms H, the nurse assisting Dr C at the time, recorded in Mr A's dental record that on 19 August:

> "Dentist had to explain to inmate that not only had the work he needed done not been done the dentist was going to need to start again due to an unfortunate break-down between the Dentist and the technician involved. Inmate was understandably upset and angry; claiming dentist was a liar, – was seen by dentist, discussion and explanations were made on both sides."

Ms H also recorded the incident in Mr A's clinical record:

> "Inmate justifiably upset at breakdown in process between dentist and technician concerned. Inmate discussed situation with nurse and Dentist, – decided – to continue with procedure even though the procedure would have to be started again from scratch. He took his place in the chair, was given local anaesthetic, procedure began, after approx 5 minutes, Inmate motioned for process to be discontinued, got up from chair, said that the

> dentist didn't know what he was doing and was pricking him … Time was spent trying to explain breakdown to inmate, – inmate was given profuse apologies and assurances but remained angry, claims the dentist is a liar."

There is clearly a difference between Dr C's statement that he told Mr A that there was "one more thing … to do" and Ms H's contemporaneous note that "not only has the work … not been done [but] the dentist was going to need to start again" "from scratch". I consider that the notes made by Ms H at the time are more likely to be an accurate reflection of events.

Access difficulties and delays

Dr C states that there were significant problems arranging appointments with Mr A and that a number of appointments were arranged, but missed, owing to prison staff not bringing Mr A up for treatment at the prison dental clinic. A two-month gap between 18 March and 16 May was one such occasion. However, there were no delays in preparing the bridge and impressions.

Dr C states that he made around 15 to 18 requests to see Mr A at the prison, which were not actioned. Dr C claimed to have written records of about six or seven of occasions. During the course of the investigation he agreed to provide me with correspondence that would illustrate the difficulties. However, he has provided me with only two relevant faxes. One was sent to the prison at 9.21pm on 15 August 2002, enquiring whether he could "do a bit of work" for Mr A the next day; the second, sent on 26 August, asked to be informed about Mr A's "position". Dr C states that he did not receive a reply to these faxes or "about 20 others concerning other issues and inmates". I note that the consultation of 19 August took place four days after Dr C's first fax, but that by the time Dr C sent his second fax on 26 August, treatment had already been terminated.

Dr C states that as he was not an employee of the prison, he did not have automatic access to the prisoners, and visits had to be arranged with the security staff. He also states that there was a short period where staff were on strike and no visits could be made. In response to my provisional opinion, Dr C stated that he accepted that he had stretched himself too far to accomplish some good when he was not in control of many aspects of the treatment, particularly access to Mr A.

Mr A states that he was not aware of any logistical problems with the prison, but that Dr C postponed approximately four or five visits, because the prosthetic was not "satisfactory". Further, in response to my provisional opinion, Mr A stated that there was no prison strike while he was an inmate.

Ms I, the Team Leader, Department of Corrections, has confirmed that there were two strikes during the relevant time at the prison. One in July lasted for two days, and a second in August lasted three days. Ms I advised that the strikes would have caused only "minimal disruption" to the provision of dental services at the prison.

Ms I also advised that on occasion there could be difficulties with prisoners being "brought up" for dental treatment at the request of the dentist – for example, if there were insufficient

prison staff available or if the prisoner was out working at the time. However, there would not be "repeated problems" and any such difficulties should be recorded in the prisoner's dental records. There are no such notes in Mr A's records.

Subsequent treatment
Following the relationship breakdown with Dr C on 19 August 2002, Mr A arranged further treatment, through the prison authorities, from another dentist, Dr E. This was carried out at Dr E's surgery in a city over the course of five visits in September and October 2002.

Dr E notes that, during his examination, he observed that the margins of Mr A's teeth (14, 13, 11 and 21) had been prepared for a bridge but that they required further adjustments and shaping. He also observed that there were post and core restorations on two teeth (11 and 13) and that the restoration on tooth 13 was not adequate. One of the prepared teeth (21) was causing discomfort, and two other teeth (22 and 23) had carious lesions.

Dr E excavated and restored the carious lesion on teeth 22 and 23, did a root canal and restoration on tooth 21, replaced the inadequate post and core restoration on tooth 13 and redid the preparation on teeth 14, 13, 12, and 21. He then placed a permanent crown on tooth 14 and a permanent bridge on teeth 13, 11 and 21.

Dr E provided me with his notes and X-rays from Mr A's treatment. However, he was not able to provide his study models as they had been discarded.

Dental records
The dental record obtained from the prison notes 11 interactions between 17 December 2001 and 15 August 2002. For the most part they are noted briefly and can be quoted in full below. The entries made by Dr C are in italics:

"*17/12/01* *c/o swelling 'abscess' + O/E Heavily [illegible] 46/47 ++ decayed 45. P A X Ray taken to [illegible] and Tx as [illegible]*

30/12/01 *PA X Ray shows old RC 46 and 45. [Illegible] 46. Filled 45 G/C.*

7/01/02 *[Illegible] filling 46 [illegible] Will wait and [illegible] at next appt. To be brought up urgently if in pain.*

14/01/02 *[Illegible] 11 of PJL #ed Re [illegible] and [illegible] longevity*

4.03.02 Talked about work needed

18.3.2 Filled out ACC forms

16.5.2 Checked impressions

17.6.02 Temp crowns & bridge put in place, review 2 wks

1/7/02 to see in 1 wk if not earlier. Gums receded satisfactory

11/7/02 ~~Temp bridge removed, impression taken.~~ Requires 2 hr app at surgery

19/08/02 Called to Dental. Dentist had to explain to inmate that not only had the work he needed done not been done the dentist was going to need to start again due to an unfortunate break-down between the Dentist and the technician involved. Inmate was understandably upset and angry; claiming dentist was a liar, – was seen by dentist, discussion and explanations were made on both sides. Inmate decided he would continue with the [illegible] – dentist anaesthetised inmate – Locally, began procedure, – after 5 minutes approx, – inmate demanded to have procedure discontinued, – said the dentist was 'pricking' him, – and didn't know what he was doing – got up – walked out – Stated I'm taking this to court. Ms H
Agency Nurse"

Ms H also recorded the incident on 19 August 2002 in Mr A's clinical record:

"19/08/02 Inmate justifiably upset at breakdown in process between dentist and technician concerned. Inmate discussed situation with nurse and Dentist, – decided – to continue with procedure even though the procedure would have to be started again from scratch. He took his place in the chair, was given local anaesthetic, procedure began, after approx 5 minutes, Inmate motioned for process to be discontinued, got up from chair, said that the dentist didn't know what he was doing and was pricking him and, that he was taking 'it' to court. Time was spent trying to explain breakdown to inmate, – inmate was given profuse apologies and assurances but remained angry, claims the dentist is a liar.
Ms H
Agency Nurse"

Dr C states that the records provided by the prison are not complete and that there was a period of about a month to six weeks, possibly between 16 May and 17 June and/or between 1 July and 11 July 2002, when Mr A's records were misplaced and visits were recorded on a "temporary record". Dr C thought that this "temporary record" consisted of at least one, and possibly two, sheets of paper, which "recalls quite a lot of the work which we have done".

During my investigation, I requested a copy of Mr A's dental records from the prison, which it provided. Following Dr C's statement that he had used "temporary records" I again wrote to the prison requesting that it search for and, if possible, provide me with any such "temporary" records. The prison subsequently provided me with a full copy of Mr A's dental record (as detailed above) and clinical record. These records did not contain anything that resemble the "temporary records" described by Dr C.

Given that the "temporary records" cannot be located, that they are not referred to elsewhere in Mr A's records, and that Dr C has been unable to state when exactly they may have been used, I consider it probable that they have never existed.

Dr C explained that his records are brief because of the immense time pressure he was under while seeing many patients at the prison. He also noted that, because of this pressure, it was normal for him not to fill out the dental chart as part of the dental notes. In response to my provisional opinion, Dr C stated that, in future, he would endeavour to "make copious notes of just about anything that transpires" for his own protection.

Impressions, study models and occlusal records
Dr C has told me that any physical models or impressions he took at the prison would have been retained by the prison. In response to my provisional opinion he confirmed that he does not "have in [his] possession any material in the form of models etc".

Mr A confirmed that numerous impressions were taken throughout the treatment. I have made enquiries with both the prison and Mr F, the dental technician who Dr C contracted to do the work for Mr A, about these impressions. The prison informed me that it "never kept dental impressions or models in our Dental Clinic". Mr F informed me that at the time of Mr A's treatment he did not keep records of the work he had done. However, to the best of his recollection he "poured some models for Dr C, provided temporary crowns and returned the models and temporaries to Dr C at the prison".

I have been unable to locate any of the impressions that Dr C made during the course of Mr A's treatment, although I accept that they were taken as part of the process of making the crowns.

I have also enquired whether Dr C prepared any study models or occlusal records as part of the treatment planning process. Dr C cannot remember whether he made any models; if he had he would have made a note of it. I note that neither Mr A's dental record nor the dental treatment and tax invoice form refers to study models or occlusal records. On the basis of the available information, I consider it probable that Dr C never made any study models or occlusal records prior to beginning Mr A's treatment.

Independent advice to Commissioner

The following expert advice was obtained from Dr Mark Goodhew, dentist:

> "*Did [Dr C] use reasonable care and skill in treating [Mr A]?*
> This has been a time-consuming and at times confusing case to understand because of the limited quantity and quality of the records available. I have spent considerable time trying to establish a sequence of events. It appears that [Dr C] and [Mr A] first discussed the construction of a 5-unit bridge for teeth 14, 13, 12, 11 and 21 (with tooth 12 being the pontic, or missing tooth) on March 4, 2002. This was required to replace a broken twelve-year-old 3-unit bridge that had covered teeth 13, 12 and 11. Following ACC approval, treatment began on or about May 1. Treatment had not been completed by August 19,

2002, when [Mr A] terminated an appointment after being informed by [Dr C] that he would have to 'start again'.

My advice and comments are related to this period of treatment. Where the available records and information does not allow me to form an objective opinion, I have indicated so. Because the quality of the records is such a central feature of this case, I have begun by answering the question related to this first.

Are [Dr C's] records and x-rays of a reasonable standard?
I have a number of serious concerns regarding the dental records I have seen. Firstly, there are a number of entries in different handwriting, and none, except the last (which is also by far the fullest entry) is signed or initialled. In an institution-based clinical environment such as this, where a number of different operators are likely, it is vital for later users to be able to identify who wrote what.

Secondly, the entries we are concerned with (again, except for the last) contain no detail at all of presenting complaints, history, diagnostic steps, treatment planning, teeth involved, techniques and materials used, or advice given; in short, nothing whatsoever that would enable a proper record of treatment to be established.

Thirdly, I am convinced that at least one treatment appointment entry for May 1 has been omitted. I suspect this was undertaken at [Dr C's] private surgery, on the basis of notes made by [the Investigation Officer] of a telephone conversation with [Mr A], November 19, 2002.

Fourthly, there is a complete absence of a dental chart or medical history. It is sometimes accepted that emergency or casual-care situations may not need a full charting to be carried out, but the construction of a 5-unit bridge is not in that category.

Lastly, there is no record of broken or cancelled appointments (referred to by both [Dr C] and [Mr A]). This may seem a minor point, but it would help establish an understanding of a possible delay in treatment.

The New Zealand Dental Association Patient Information and Records Code of Practice outlines a set of mandatory minimum standards in this area of dental practice. Because of the deficiencies listed, these dental records fail to meet the requirements of the Code of Practice.

The NZDA Code of Ethics requires dentists to 'maintain full, accurate and legible' records of patient treatment, and clearly [Dr C] has failed to meet that obligation in this case.

Further, in my opinion, these dental records are severely substandard.

It is very likely that only one of the five x-rays supplied with the dental records was taken by [Dr C], but this x-ray is undated and concerns two lower back teeth. It is of reasonable quality. However, I was surprised to find that no x-rays had been taken of the teeth

involved in the proposed bridge. While it could be argued that teeth 14 and 13 are visible in an earlier film, I would consider it an absolute necessity to have appropriate, up-to-date and accurate x-rays of all of the teeth involved in a 5-unit bridge, and adjacent teeth, as part of a full treatment planning process.

There are also no study models or occlusal (bite) records available. These also form part of the planning process, and the patient records. If in fact none were ever made, I would have to conclude that standards of care, with respect to adequate diagnosis and treatment planning, fall well below an acceptable minimum standard.

Was it reasonable for [Dr C] to need up to seven attempts to obtain a useful mould?
The construction of a 5-unit bridge is a complex procedure, and may require a number of different impressions to enable a technician to make the bridge, and to make temporary crowns or bridges. [Dr C] also states that he had to retake two impressions ('moulds') because of 'blurred margins'. I would regard this as prudent, as a faulty impression will result in a faulty bridge. So while seven impressions may seem a high number, it could be reasonable in this case.

It is not clear from the records what materials or impression techniques were used, and how many appointments were involved with impression taking, so I cannot form an opinion as to whether [Dr C] used reasonable skill in this aspect of treatment.

Was it reasonable for [Dr C] to have broken two temporary teeth while removing them?
Before attempting to answer this, I should point out that the original letter of complaint from [Ms B], on behalf of [Mr A], to [Mr G], dated September 2, 2002, states that 'stumps' were 'snapped', rather than temporary teeth. This is an important distinction.

It is very common for temporary teeth (which are used to cover prepared teeth between appointments) to break on removal, and this is of no consequence.

If 'stumps' are broken on removing temporary teeth, it is an undesirable complication. It certainly makes the completion of treatment more difficult, and is unusual, but not unknown. The degree to which it complicates treatment in this case depends upon how badly the 'stumps' were broken, and which teeth were involved. It may also indicate that the 'stumps' were weak, but there is no way of confirming this.

There are no notes to indicate at which point this event took place, or which teeth were involved, or how badly they were broken, but it probably was a factor in delaying the completion of treatment. Again, I cannot form an opinion as to whether reasonable skill and care have been used in this case, because I do not have all the information I require. In general, however, I am of the opinion that breaking 'stumps' on removing temporary teeth is undesirable, but not unreasonable.

Did [Dr C] adequately prepare [Mr A] for the new bridge?
There are two aspects to this question that need to be discussed. The first aspect is whether the actual tooth preparations were adequate. Clearly, I cannot make a judgement on this because I have not examined [Mr A] before the treatment by [Dr E] began, and there are no study models of the prepared teeth. I note that [Dr E] has stated in his letter of 18 September, 2002, to [Dr G], that he felt the tooth preparations needed 'some improvement'. [Dr E] confirms this in a later letter to [the Investigation Officer], and states that the post and core restoration on tooth 13 'was inadequate'.

The second aspect that I think needs to be explored further is whether a thorough diagnostic and treatment planning sequence was carried out. There is no documentary or physical evidence that it was. As I have stated in an earlier answer, if this is the case then standards of care and skill have fallen well below an acceptable minimum standard.

Did [Dr C] leave [Mr A] untreated or partially treated for an unreasonable length of time?
I have assumed that treatment by [Dr C] began on May 1, 2002, (on the basis of a note in the letter from [Ms B] to [Dr G] dated September 2, 2002, and [the Investigation Officer's] telephone notes of November 19) but this needs to be verified. [Dr C] has stated that he estimated to [Mr A] that treatment would take 'fourteen days' (letter to [Dr G], October 17, 2002). If treatment still was not completed by August 19, 2002, then this seems to be an unusually drawn-out period of time.

If good temporary crowns or bridges are in place, extended periods of treatment are possible, and it may be that [Dr C] was attempting to allow the gums to reposition themselves. This is a recognised technique. However, [Dr E] states that [Mr A] told him at his first visit that the temporary bridge 'had broken a few weeks before'. It is not clear what period this covers, or how long individual teeth were left without temporary cover. [Dr E] has also said that one of the teeth (21) required root canal treatment 'due to being left exposed for a few months'.

It is a fact that by their nature, temporary crowns or bridges can break or be dislodged. This is not at all an unusual event. It is also possible that contact between [Mr A] and [Dr C] was difficult, and access limited. As I have noted earlier, breaking the 'stumps' of two teeth would also have complicated proceedings. There were also a number of cancelled or broken appointments that would have further delayed completion. With these considerations in mind, I am concerned that [Mr A] may have experienced an unnecessarily prolonged period of treatment. That there was seemingly no progress at all over the course of treatment may indicate a degree of mismanagement. However, because of the lack of information I have, I am unable to give an opinion as to whether this was an unreasonable length of time.

Are there any aspects of the care provided by [Dr C] which you consider warrants either:
- *Further exploration by the investigation officer?*

I am aware that [Dr C] was asked by the Health and Disability Commissioner to provide copies of all medical records, x-rays, moulds, dental matter, notes and any other correspondence relevant. It would be helpful to confirm that there is no other material held at [Dr C's] private surgery.

It may also be useful to ask [Dr E] if he obtained any photographs or study models of [Mr A's] teeth before he began treatment.

- *Additional comment?*

It is generally acknowledged that the delivery of dental care to people in an institutional environment, and particularly to prison inmates, is often a demanding task, for a variety of reasons. The highest standards of dental care may not be achievable, and in some circumstances compromises have to be accepted. However, I want to emphasise that the lack of an adequate standard of record keeping, and the apparent lack of any treatment planning, has, in my opinion, seriously compromised [Dr C's] capacity to complete a complex procedure."

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.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

3 Provider Compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

2) The onus is on the provider to prove that it took reasonable actions.

3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Relevant standards

The "Code of Practice – Patient Information and Records 1996" (the Code of Practice), which has been adopted by both the New Zealand Dental Association (NZDA) and the Dental Council of New Zealand (DCNZ), states:

"Reason for records

Information on patients is kept for a number of reasons.

1. A record of each encounter with a patient will improve diagnosis, treatment planning and assist with efficient, safe and complete delivery of care given the chronic nature of dental disease or in the event of another clinician assuming that patient's care.

2. Patient records may be used in patient identification or other aspects of forensic dentistry.

3. Patient records form the basis for self-protection in the event of a dispute arising.

4. Patient records form for some types of self-monitoring or audit systems used in quality review systems.

…

Definition of Patient Records

…

Records include:

– notes made by clinicians
– completed medical history questionnaires
– consent documents
– copies of correspondence about the patient
– radiographs, tracings, measurements
– models
– special test reports eg histology, MRI, blood tests, X-ray reports

…

Standards for Record Keeping

…

Records should include:

1. the date of every visit and appointment made which the patient failed to attend

2. a description of the presenting complaint, relevant history, clinical findings, diagnosis, treatment options and treatment plan agreed to

3. advice given to the patient on
   – treatment options
   – pre and postoperative instructions
   – likely outcomes

4. any treatment undertaken

   Notes should include detail about the procedure including materials used, variation from your usual technique and comments on the procedure. The detail should reflect the complexity or seriousness of potential sequelae.

5. any treatment advised that the patient was unwilling to accept

6. drugs prescribed (quantity, dose and instructions)

7. consents obtained for treatment

8. unusual sequelae to treatment reported by the patient

9. estimates or quotes for fees

10. relevant comments by patients on concerns over offered treatments

Entries into the records are the responsibility of the clinician and should be initialled or be identifiable for a clinician if more that one clinician is involved in the practice or providing for that patient's care. All entries made on patient records should be signed or initialled by those who made the entry and entries must be made in ink.

Records must be legible and abbreviations should be standard. They must be readily understood by any third parties who access the file. The information held about individual patients must be accurate, up to date, complete, relevant, and not misleading. Thus information which is subject to change over time should be checked for accuracy and updated at reasonable intervals. It is considered reasonable for dentists to keep a list of standard abbreviations and the meaning for patients."

Opinion: Breach

Treatment planning
In my opinion, Dr C's diagnosis and treatment planning were of an unacceptable standard. I note my expert advice that it was absolutely necessary to have appropriate, up-to-date and accurate X-rays of all of the teeth involved as part of the treatment planning process and that Dr C should have made study models and occlusal records prior to beginning treatment. The X-rays provided by Dr C are severely substandard.

Dr C cannot remember whether he prepared any study models or occlusal records as part of the treatment planning process, but states that if he had, he would have made a note of this. As there are no references to any study models or occlusal records in Mr A's records, I consider it probable that Dr C never made any study models or occlusal records prior to beginning Mr A's treatment.

In my opinion, by failing to carry out a full treatment planning process, including the use of appropriate X-rays, study models and occlusal records, Dr C did not provide services with reasonable care and skill and thus breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Record-keeping
There are several serious deficiencies in Dr C's record-keeping. In several respects, the record of Mr A's treatment does not meet the standard set by the Code of Practice of the New Zealand Dental Association and the Dental Council of New Zealand.

First, none of Dr C's records are signed in any way, except for the last on 19 August 2002, which was signed by Ms H. I note that, under the Code of Practice, entries in the records are the clinician's responsibility and that he or she should ensure that all entries are signed or otherwise attributable to a provider. I note my expert's comments that, in an institutional environment like a prison, this is especially vital for continuity of care.

Dr C's last identifiable note is on 14 January 2002, even though treatment continued until August 2002. It is fortuitous that Dr C's handwriting is very distinctive. This has enabled me to identify which notes he wrote himself. It appears that the other notes have been made by several different people, possibly Dr C's assistants, although they are also unsigned.

I do not consider that it is sufficient for Dr C to have relied on his assistants, or any other person, to keep records of the treatment he provided to Mr A. This failing is compounded by the fact that the records entered by unidentified others are even shorter than those of Dr C and are almost useless for constructing a complete record of Mr A's treatment.

Further, while Dr C's writing is distinctive, it is also, at times, illegible and cannot be readily understood by a third party. This does not meet the required standard for legible notes.

Dr C's records do not contain:

- The date of every visit or appointment made where the patient failed to attend. In particular, there is no record of the one established consultation at Dr C's surgery, on 7 August 2002. I note that this appointment does not fall within a period when temporary records were alleged to have been used.

  There is also no record of the broken or cancelled appointments, referred to by both Dr C and Mr A. I note that if missed appointments were such a problem and concern to Dr C it is surprising that he did not record this in the notes. I agree with my expert that, while this may seem a minor point, it would help explain the delay in treatment. If this was a significant problem, as Dr C claims, he should have noted these matters as part of a "complete" and "not misleading" record.

- Any significant details about Mr A's presenting complaints, relevant history, diagnosis, treatment options or the treatment plan agreed to. The records do not contain any completed dental chart or medical history. Mr A's dental record form has a dental chart on it, but it has not been filled out. Similarly the area for medical information, such as allergies and medications, has been left blank. I accept my expert advice that, in some emergency or casual-care situations, full charting may not be required; however, in this case, where treatment was intended to be done over several weeks, such omissions are clearly inadequate.

  Dr C states that his "treatment plan" was submitted to ACC. I do not consider that the dental treatment and tax invoice form to which Dr C refers amounts to an adequate "treatment plan" under the Code of Practice.

- The advice given to Mr A. I note that the only record of any consultation, prior to the final visit on 19 August 2002, is on 4 March 2002 – "talked about work needed".

- The techniques and materials used, any variation from Dr C's usual technique or any comments on the procedures undertaken. There is no mention of the apparently significant problems Dr C encountered in producing usable impressions or the remedial work needed when Mr A broke one of the crowns.

- Any consent given by Mr A to treatment. I acknowledge that, in the circumstances, written consent may not have been required. However, at the least, Dr C should have noted when Mr A's consent was obtained, how this was done (verbally) and what treatment he had consented to (with reference to a treatment plan).

- The sequelae to the treatment. There is no record of the final condition in which Mr A's teeth were left. In particular, there is no reference to the carious lesion on teeth 22 and 23, the tenderness in tooth 21, the inadequate post and core restoration on tooth 13, and the fact that the permanent bridge had not been fitted. I note that all of these relevant facts were discovered by Dr E on 9 September when he first saw Mr A, only three weeks after Dr C's last consultation.

Having considered all these matters, I am satisfied that Dr C's record-keeping failed to meet at least six of the ten required elements for good records under the Code of Practice. I also accept my expert advice that the records do not contain sufficient information to establish a proper record of treatment.

In addition to the poor written record, Dr C has not made or retained adequate X-rays or study models. Such material, as well as being an integral part of the treatment planning process, also forms part of the treatment record.

Dr C says the records are brief because of the immense time pressure inherent in seeing many patients at the prison. He states that Mr A's notes are not unusual in this respect.

Clause 3 of the Code provides a defence for a provider to show that he or she took reasonable actions in the circumstance to comply with the Code. I have carefully considered Dr C's explanation. While I accept that he was working under less than ideal circumstances, in my view keeping adequate records is an essential part of good clinical practice. I note the Code of Practice statement that patient information is kept to "improve diagnosis, treatment planning and [to] assist with efficient, safe and complete delivery of care". In this case, while the time pressure on Dr C is a relevant consideration, it cannot excuse the total inadequacy of the record.

I further note that Dr C does not appear to have made any attempt to remedy the situation. If Dr C had to provide services in an environment that he thought unacceptable, because of time pressure or any other matter, he should have raised his concerns with the prison authorities.

This is not the first time that I have had reason to consider Dr C's standard of record-keeping. In a recent opinion (02HDC01805), concerning treatment Dr C provided at his private surgery, I found that Dr C's records were "inaccurate", "incomplete" and "clearly misleading". In my view, this tends to indicate that Dr C's poor record-keeping in this case was not simply the result of poor working conditions at the prison.

In summary, Dr C's records are clearly inadequate and do not meet the standard required under the Code of Practice. Accordingly, Dr C breached Right 4(2) of the Code.

I note my expert advice that Dr C's failure to keep adequate records, including treatment planning, seriously compromised his ability to complete a complex procedure and fell well below an acceptable minimum standard of care. I consider that this is a significantly aggravating feature of Dr C's breach of Right 4(2) of the Code.

Delays in treatment

Mr A complained that Dr C missed several appointments during his treatment and that he was left with his mouth in a "state of deterioration" for several months.

Under Right 4(4) of the Code, consumers have the right to have services provided in a manner that minimises the potential harm to them. This can, in some circumstances, include the right to have services provided in a timely manner.

Dr C states that any delays in treatment were the result of the prison not bringing Mr A up for treatment at the clinic. Mr A states that, as far as he was aware, the only delays were because of Dr C cancelling appointments. There is nothing in Mr A's records to explain the reasons for these delays.

Dr C claims that he sent numerous emails and faxes to the prison asking about Mr A. However, despite his assurances that he would do so, Dr C has provided little evidence to substantiate his claims. He has provided me with only two relevant faxes – one sent to the prison at 9.21pm on 15 August 2002, enquiring whether he could "do a bit of work" for Mr A the next day, and another, sent after the treatment was terminated, asking to be informed about Mr A's "position".

Ms I has advised me that while, on occasion, there could be difficulties with prisoners being "brought up" for dental treatment, there would not be "repeated problems" and that any such difficulties should have been recorded in Mr A's dental record. As observed above, there are no such problems noted in Mr A's records.

I consider that the delays in Mr A's treatment were unacceptable. Between March and August 2002, a period of six months, Dr C did not complete the treatment, which he had initially anticipated would take two to three weeks.

I note that the delays in completing Mr A's treatment left his teeth needing substantial remedial work, which had to be done by Dr E. This included excavating and restoring carious lesions, a root canal and restoration, replacing an inadequate post and core, redoing the preparation on four teeth and fitting a permanent crown and bridge. Dr E completed this treatment over five visits, in six weeks, at his surgery.

Under the Code, Dr C had an obligation to provide services in a manner that minimised potential harm to Mr A. While I accept that the delays in treatment may not have been solely the fault of Dr C, I have seen no evidence to suggest that he made any real attempt to remedy the deteriorating situation caused by the delays in treatment over a period of six months. In the circumstances, I consider that Dr C did not take reasonable steps to minimise the potential harm to Mr A caused by the delays, and accordingly breached Right 4(4) of the Code.

Undue stress during treatment

Mr A complained that, by leaving him untreated for so long and by accidentally stabbing him in the roof of his mouth while "carving" the teeth, Dr C caused him unnecessary pain and discomfort.

Right 4(4) of the Code entitles consumers to services provided with a minimum of stress and discomfort. While many health and disability services will inevitably involve some degree of pain, stress or discomfort, providers must take reasonable steps to minimise such harm.

In this case, in itself, the "stabbing" incident on 19 August was almost certainly an unfortunate accident, and does not amount to a breach of the Code. However, in the context of Mr A's treatment overall, it is clear that he was placed under a considerable amount of stress as a

result of his dental treatment. A number of factors contributed to this, including: a number of missed appointments; a lack of progress with the treatment; Mr A being left to suffer from painful uncovered stumps for several months; and the ongoing problems being beyond Mr A's control.

Viewed in its context, it is not surprising that, having just been told that Dr C was going to have to start the procedure again from scratch, the "stabbing" incident prompted an angry response from Mr A. His reaction clearly illustrates the stress and frustration he had been experiencing with Dr C and his treatment overall.

In light of the problems with Mr A's treatment, Dr C should have been particularly aware of the need to minimise the resulting stress. There were a number of steps that Dr C could have reasonably taken, including keeping Mr A informed of the progress of the treatment, dealing with any access difficulties in order to expedite treatment, and ensuring that the treatment caused a minimum of pain and discomfort. I am satisfied that Dr C did not take sufficient steps to acknowledge or address any of these matters. I note that neither Dr C nor Mr A refers to any discussions about the lack of progress (prior to 19 August), access difficulties or how they would deal with Mr A's "deteriorating" condition.

In my opinion, Dr C did not take reasonable steps to ensure that Mr A's treatment was conducted in a manner that minimised the stress and pain he was experiencing. In these circumstances, Dr C breached Right 4(4) of the Code.

No further action

As noted above, I have attempted without success to locate the "temporary notes" and impressions referred to by Dr C. Given the deficiencies in the records available and the conflict in the evidence provided by Dr C and Mr A, I have been unable to form an opinion on several of Mr A's complaints (as set out below). Accordingly, I have decided to take no further action on these matters.

Number of impressions taken
Mr A complained that, over the course of the treatment, Dr C had to take seven impressions for his bridge. When he asked about this, Dr C told him that it was because the technician was unable to get the bridge made properly.

Dr C states that he took an initial impression to make the temporary bridge. He also took four impressions for the permanent bridge (one for each of the three sections of the bridge, and one replacement done at Mr F's request). Dr C states that he took five impressions in total.

I note my expert advice that it may have been reasonable for Dr C to require seven different impressions to be taken, as the construction of a 5-unit bridge is a complex procedure, and

that it would have been prudent for Dr C to retake impressions if the originals had "blurred margins".

However, as there is no information available about what materials or impression techniques Dr C used to take impressions, and how many appointments were involved, my advisor was unable to determine whether Dr C used reasonable skill in this aspect of treatment.

Extraction of crowns
Mr A complained that Dr C broke one of the posts on which a crown had been attached. This occurred when Dr C attempted to remove one of the crowns in order to put on a permanent crown. Mr A states that Dr C used a lot of force and snapped off the post. Dr C replaced the post, but it had to be replaced by Dr E as it was too long.

Dr C states that the only recollection he has of any "snapped stumps" was when Mr A came to him with a broken temporary crown. When he examined the temporary crown he found a sliver of tooth stump still attached to it. This left a sharp stump in Mr A's mouth. He took out the sliver of tooth and recemented the crown in place.

There is no record of either of these incidents in Mr A's dental or clinical record.

Because of the lack of information, my advisor was unable to determine whether Dr C used reasonable care and skill when removing the crowns. Dr C and Mr A have provided irreconcilable statements about the problems encountered with the removal of the crowns, and there is no documented evidence to corroborate either version of events. In the circumstances, I am unable to determine whether Dr C used reasonable care and skill when removing the crowns.

Previous investigation
I note that a previous investigation of Dr C's clinical practice resulted in a breach finding that was referred to the Director of Proceedings (Case 02HDC01805, 19 September 2003).

Further actions

Referral to Director of Proceedings
I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken in relation to Dr C.

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

Education
A copy of this 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, upon completion of the Director of Proceedings' processes.

Addendum

Pursuant to section 34 of the Health Practitioners Competence Assurance Act 2003 the Director of Proceedings decided to refer the matter to the Dental Council of New Zealand for competency review. No proceedings were issued.