Oral and Maxillofacial Surgeon, Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC13700)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider / Oral and Maxillofacial Surgeon
Dr C	Oral Surgeon
Dr D	Anaesthetist
Ms E	Dental Assistant
Mr F	Consumer's partner

Complaint

On 23 November 2001 the Commissioner received a complaint from the consumer, Ms A, about services provided by Dr B, an oral and maxillofacial surgeon. The complaint is that:

On 19 October 2001, oral surgeon Dr B extracted Ms A's wisdom teeth. Dr B did not provide services to Ms A of an appropriate standard as follows:

- *damaged one of Ms A's teeth during the extraction*
- *did not adequately manage Ms A's pain after her wisdom teeth extraction*
- *did not diagnose or treat the cause of Ms A's post-operative pain*
- *did not fully inform her of the side effects and complications of the surgery prior to having her wisdom teeth extracted.*

An investigation was commenced on 14 February 2002.

Information reviewed

- Dental records from Dr B and Dr C, another oral surgeon
- A copy of Ms A's ACC file

Independent expert advice was obtained from Dr Rohana Kumara De Silva, consultant oral and maxillofacial surgeon.

Information gathered during investigation

First consultation – 13 September 2001
Ms A, aged 35 years, was referred to Dr B, oral surgeon, by her dentist for assessment of her impacted wisdom teeth. Ms A visited Dr B on 13 September 2001 and brought with her x-rays taken by her dentist. Dr B examined the x-rays and her mouth. Dr B recalled:

> "She had some slight discomfort in the lower jaw a few weeks earlier which was probably due to chronic infection around the lower impacted teeth. I took periapical x-rays which showed medium depth mesio-angular impaction of both lower wisdom teeth and unerupted upper wisdom teeth. I advised her that it was quite likely she would have acute infection flaring up around one of these teeth in [the] future and it was better to remove them before she reached the age of 40 when complications of surgery would be more likely."

Dr B told Ms A that her impacted wisdom teeth would need to be removed under general anaesthetic. Ms A agreed to surgery.

Pre-operative advice
Ms A complained that Dr B did not warn her about any of the complications that could occur with wisdom teeth removal or give her any written information outlining risks and complications prior to the surgery.

She assumed the extraction would be a simple procedure, as her partner had had his wisdom teeth removed under local anaesthetic only a couple of weeks earlier without any problems. She advised me:

> "I told [Dr B] I would prefer a Friday [for the extraction] as I could just take the Friday off work and be fine to go back to work on the Monday as I only had one sick day left with my job. He said I may not be able to talk that well on the phone on the Monday so I assured him it would be OK because there are others at work to answer the phone. He then looked in his diary and made an appointment date for Friday 19 October 2001 which turned out to be Labour weekend which I thought was good as I had the extra day to recover. Had I been informed on what could go wrong and how painful it could be I would not have had my teeth removed until after February when I am issued with more sick leave."

Dr B acknowledged that he did not give Ms A any written instructions about post-operative complications. However, he did discuss possible complications with her. He stated that he routinely advises wisdom teeth patients about bleeding, swelling, pain and tiredness, which generally resolves within a week. He advises patients not to undergo wisdom teeth surgery for three to four weeks before important events.

Dr B recalled telling Ms A that in similar cases some patients were able to go back to work three or four days after surgery but five to seven days was more usual. However, should she be able to work during this time, that would not affect the healing process.

Dr B stated that he also advised Ms A as follows:

> "The main complication I warned her of was damage to one or the other of the interior dental nerve. At her age and with the proximity of the roots to the interior dental canal there was a one in 50 chance there could be involvement and often this could result in some permanent loss of sensation in her lip. I advised her that she would be better to have the surgery now rather than 10 years' time when there would be an increased risk of damage to the nerves."

Dr B stated that he did not warn Ms A of the possibility of damage to the lingual nerves because he routinely protects them with a retractor, and any loss of function experienced by the patient is temporary and usually resolves over a few weeks.

At the conclusion of the consultation, Dr B gave Ms A an information sheet entitled "Instructions to patients before a general anaesthetic" and a prescription for antibiotics and Panadeine. The information sheet advises patients not to eat or drink four hours prior to anaesthetic, not to drive for 24 hours following the anaesthetic, to advise the dentist of any medications being taken or drug allergies and to wear appropriate clothing in case blood gets on their clothes.

Surgery – 19 October 2001
Ms A returned to Dr B's surgery on Friday 19 October for her wisdom teeth extraction. Immediately prior to the extraction, Dr B told her that the x-rays he had taken showed that she had only three wisdom teeth, not four as he had thought. Ms A advised that "another man came in and put a needle in my arm and asked me if I had ever had a general anaesthetic before, so I gathered he was the anaesthetist". The anaesthetist, Dr D, administered a general anaesthetic to Ms A and Dr B performed the procedure with the assistance of his nurse, Ms E. Dr B advised that the procedure was "uneventful" and that he took particular care to protect the lingual nerve with a retractor.

Tooth damage
Ms A complained that during the extraction her upper left second molar was fractured. Dr B denied this and stated that when extracting the upper left wisdom tooth he was not aware of breaking either a tooth or a filling. He stated:

> "I am sure I and the nurse and probably the anaesthetist would have noticed if a fragment had fallen on the tongue because we are constantly vigilant that no particles get to a position that they could enter the airway …"

Neither Ms E nor Dr D can recall any damage occurring during the procedure, and stated that they would have remembered if it had. Ms E further commented that part of her role, as chairside assistant, is to be vigilant in looking for particles that could block the patient's airway.

Pain management
Ms A advised that when she woke from the anaesthetic she was "in extreme agony with a mouthful of blood and a splitting headache". She stated that a woman told her that her

headache was probably due to coffee withdrawal. When Dr B entered the room Ms A complained that she was in agony, and that her tongue was completely numb. However, he assured her that "that happens". He instructed her to take Panadeine when she got home, as he had none at the surgery. He told her that the only other option was to give her an injection, which would send her to sleep, and he did not think that was advisable. When Ms A left the surgery, she was given an information sheet entitled "Instructions to patients after oral surgery", which describes the care that needs to be taken of the healing sockets, such as mouth rinses, ice packs, and taking prescribed pain relief. The only complication referred to is bleeding.

Ms A took two Panadeine when she got home, another two an hour later and then two every four hours, but the pain did not subside. The next day, 20 October, Ms A was still in severe pain. Her partner, Mr F, went to the chemist, who suggested combining Nurofen with Panadeine. Ms A tried this combination but was still in severe pain.

On Labour Day, 22 October, Mr F telephoned Dr B at his home and expressed concern about the amount of pain Ms A was in. Dr B suggested that she combined the Panadeine with aspirin and have hot salt-water washes. He told Mr F that sometimes pain "took a while to settle". Ms A followed Dr B's instructions, but there was no improvement in her pain. The next day, Tuesday 23 October, Ms A drove to work and "nearly flaked out and had to stop". Because of the pain she was in, she left work early and returned home. Ms A said Mr F telephoned Dr B again about her pain and spoke to a woman, who said that Ms A should just keep taking what Dr B had prescribed and rest.

Mr F could not recall his telephone calls in any detail. He thought he made two telephone calls several days apart, because of "the huge amount of pain [Ms A] was in". Mr F did not remember whether he spoke to Dr B directly, but recalled talking to Dr B's nurse at some point. The woman he spoke to suggested "Panadol and rest". Mr F stated that "their advice was of no help".

Because of the pain she was in, Ms A telephoned Dr B's surgery on Wednesday 24 October. She told the woman who answered the phone that she was "still in agony" and wanted to bring her appointment (set for the next afternoon) forward. However, Ms A was told that Dr B could not see her until the following morning. A further prescription for Panadeine was offered; however, Ms A declined this "as they didn't work anyway".

Dr B recalled only one telephone conversation in relation to Ms A's post-operative pain, which was with Ms A's partner, two days after the extraction. He did not record this conversation in Ms A's notes.

Follow-up consultation – 25 October

During her follow-up consultation with Dr B on 25 October Ms A complained that she was still in pain. She advised that Dr B told her that there did not seem to be any reason why she should be in so much pain, but he "could see exposed bone on my top gum where a stitch had come out".

Dr B advised me that when he reviewed Ms A he considered her sockets were progressing satisfactorily. He was concerned that she still had pain but "was satisfied that there was no infection or dry socket [where the blood clot sealing the socket is lost, exposing bone and causing severe pain]". He reassured her that by removing the sutures her sockets would be more comfortable. Dr B removed her remaining sutures and gave her a further prescription for Panadeine and aspirin. In view of her continuing pain and tongue numbness (mentioned at the end of the consultation), he made an appointment to review her again in a week.

Ms A continued to be in significant pain despite the removal of the sutures. She rang her general practitioner's practice. She explained about her recent surgery, and that she needed something stronger than Panadeine. Her general practitioner prescribed the painkillers Codeine and Mersyndol. Ms A advised that the Codeine provided some short-term relief and the Mersyndol, which has a sedative in it, allowed her to sleep.

Consultation with Dr C
The following morning, 26 October, Ms A "had had enough". She made an appointment with oral surgeon Dr C that same day. Dr C advised:

> "When seen on the 26th October she exhibited full lingual anaesthesia bilaterally, the 27 tooth appeared to be fractured but there was dental caries [cavities] present and this may well have been present preoperatively. In addition to this she exhibited bilateral inflammation surrounding the sockets and a provisional diagnosis of dry socket was made. The sockets were lavaged, dressed and she was prescribed a course of antibiotic therapy together with Tramadol for pain relief …"

Dr C gave Ms A a pamphlet that he gives to all of his patients prior to wisdom teeth extraction. Ms A advised me that she was "extremely surprised" by the level of detail in the pamphlet, which outlined all the common complications, including pain.

Dr C advised ACC of the following about his first consultation with Ms A:

> "I did note that preoperatively she had received no written information on her surgery and according to her she has received no oral communication with regards to this. When I saw her initially her lack of understanding of the risks and subsequent problems would indicate that she had not received adequate preoperative instructions or advice."

Ms A found Dr C's treatment effective, with an immediate reduction of her pain. When she returned to his surgery three days later Dr C noted that her pain was reduced. He confirmed his provisional diagnosis of dry socket, as exposed bone was now apparent, and dressed Ms A's sockets. Ms A told him that her tongue was still numb. Dr C reviewed her again on 31 October. Ms A's pain had settled and she had returned to work. However, she was still troubled by her numb tongue.

Dr C saw Ms A again on 7 November. At this appointment he noted that her sockets were settling but that her tongue was still numb. She was also experiencing some discomfort in her left temporomandibular joint (where the upper and lower jaws meet). On further

assessment on 4 December Ms A was pain free; however, her tongue was still concerning her.

ACC
Ms A continued to experience problems in relation to her numb tongue for some months, tripping over her words and lacking taste sensation. She lodged a medical misadventure claim with ACC in relation to the pain and numbness she experienced following her wisdom teeth extraction.

The advisor to ACC, Dr G, concluded that Ms A had suffered an injury to her lingual nerve, causing her numb tongue. He advised that while it was common practice, it was not mandatory to warn patients pre-operatively of the possibility of sustaining lingual nerve damage, since it occurred in less than 1% of cases. Dr G did not consider Dr B was negligent in not warning Ms A of this possibility. Accordingly, no "medical error" had occurred.

As the effects of Ms A's lingual nerve injury were not long term, and did not meet ACC's criteria for severity, her claim also did not meet the threshold of "medical mishap". In relation to Ms A's broken tooth, Dr G commented that it was "possible" that the tooth could have been damaged during the extraction. However, he could not determine if this was when the tooth was fractured. Even if the tooth was damaged at this time, the incident would not meet the criteria for medical misadventure.

Independent advice to Commissioner

The following expert advice was obtained from Dr Rohana Kumara De Silva, consultant oral and maxillofacial surgeon:

> "In preparation for this medical report I read all letters sent to the Health and Disability Commissioner and I examined the radiographs (x-rays) taken before and after surgical removal of this patient's wisdom teeth.
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> Introduction:
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> Surgical removal of wisdom teeth can be associated with various complications. Pain, swelling of the face and difficulty in opening the mouth invariably occur in almost all people who undergo surgical removal of lower wisdom teeth. Pain can be controlled with painkillers and other medications but patients still feel some discomfort for some time. These symptoms usually improve within one week's time. Dry socket formation is one of the main complications which give rise to increasing pain after approximately two days' time but may take longer time to develop.
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> There are various reasons for dry socket formation, but no absolute reason has yet been found. It is commonly seen after extraction of lower wisdom teeth and other lower

molar teeth. It is more commonly seen in smokers and women who are on the contraceptive pill. Prescription antibiotics can reduce the incidence of this problem. Diagnosis depends on clinical observation; sudden increase of pain approximately two days after extraction and loss of blood clot from the socket with exposed bone and full of food debris. Treatment includes cleaning of the tooth socket, packing with a sedative dressing and prescription of more potent painkillers. Antibiotics are usually not required to treat this condition.

There are two nerves in the mouth closely associated with the wisdom teeth. One travels through the jaw bone and supplies all teeth and the lip sensation. In a good radiograph (x-ray picture) this nerve can be identified in relation to the roots of the wisdom tooth. The other nerve (lingual nerve) runs just under the skin of the mouth at the tongue side gum of the wisdom teeth. This nerve provides taste sensation and normal sensation to the front two thirds of the tongue.

The nerve which goes through the lower jaw can be damaged during surgery. Incidence of this problem is greater in elderly patients, where the nerve is very closely associated with the tooth and surgical extractions are very difficult. The tongue nerve is usually protected during surgical operations, but sometimes at the time of protection it can be damaged as well. Usually damage to the lingual nerve is due to stretching or direct damage from the instruments (drills or chisels) which have gone beyond the surgical field. In extremely rare situations nerves can be damaged as a result of the injection given to numb the lower jaw teeth. In the majority of patients these damaged nerves recover within about a three month period. If there is no recovery in six months special treatment may be required to correct the nerves.

When taking into consideration, letters sent by [Ms A], the information provided by [Dr B] and [Dr C] to ACC and HDC, it is reasonable to believe that [Dr B] had not provided [Ms A] with written information about wisdom teeth and possible complications that may occur after surgical removal of the wisdom teeth. Certainly [Dr B] has not informed her verbally about possible damage to the lingual nerve which he indirectly accepted in his letter to ACC and HDC. However he had warned her about the possible damage to the nerve to her lower lip and given her written information on pre-general anaesthesia and post-operative instructions. There is evidence in [Ms A's] and [Dr B's] letters that there had been discussion on post-operative complications and when [Ms A] could go back to work. Therefore it is reasonable to believe that [Dr B] had verbally provided [Ms A] with some information regarding post-operative complications. On comparing the radiograph (x-ray) taken by [Dr C], with the radiograph (x-ray) taken by [Dr B], it is reasonable to suggest that [Dr B] had taken care and exercised skill during the surgery. No unwanted bone had been removed from the lower wisdom teeth sites. Further in his letter to ACC and HDC he mentioned the use of a medium mouth prop to open the mouth and support it and the use of a periosteal elevator to protect the lingual nerve during surgery, as is good clinical practice of wisdom teeth surgery. He has provided her with prophylactic antibiotics with intention to avoid any infection to the site. [Ms A] was discharged home with painkiller (analgesic) Panadeine. If taken

properly Panadeine usually controls the pain after surgical removal of wisdom teeth in most patients.

The amount of pain experienced by [Ms A] was unusual immediately after the surgery. In her letter she complained that she had a splitting headache and numb tongue. There was no mention of pain in her mouth. Headache after general anaesthesia was very common and the anaesthetist usually takes care of those symptoms. There is no mention of bleeding from the mouth when [Ms A] was discharged. She mentioned in her letter that bleeding continued for two to three days but it was not mentioned to [Dr B] when he was telephoned two days later. [Ms A] continued to experience severe pain immediately following the surgery until she obtained a different painkiller from [Dr C]. When she telephoned two days later, she was prescribed a different painkiller but [Dr B] failed to follow up the results of his new medication and to review her sooner when she telephoned him for the second time.

If there were dry sockets in [Ms A's] jaw on 25 October 2001 when her sutures were removed, [Dr B] should have diagnosed them. The cause for her unusually severe pain was not diagnosed on that day. She was not provided with adequate pain relief to manage her pain symptomatically.

Letters from [Dr C] to ACC and HDC showed contradictory information. If the correct information was available in his letter to ACC dated 13 December 2001 and clinical notes, he has not treated the dry socket but provided her with additional (different) painkiller. In addition dry sockets usually cause sudden increase in pain level a few days after extractions. In [Ms A's] letter this was not indicated. She had continuous pain since the time of the operation. Therefore the dry socket may not be the cause of the severe pain suffered by [Ms A]. He had treated the sockets with irrigation and dressing three days later, then she was much more comfortable.

No mention of clinical signs of a dry socket were present in [Ms A's] letter or [Dr B's] letter to ACC and HDC, but it was mentioned in [Dr C's] letter that he suspected a dry socket and it was difficult to visualise the sockets. According to [Dr B's] letter, [Ms A] had mentioned her numb tongue just before her appointment was completed. [Dr B] had made a review appointment to look into this matter, but by that time the patient had changed specialists and cancelled appointments. She informed [Dr C] about her numb tongue on the second appointment with him.

[Dr B's] radiographs (x-rays) do not show significant evidence that there was a large decay under the filling of the fractured tooth, but some caries can be seen under the filling (recurrent caries). A large carious lesion is clearly shown in [Dr C's] radiograph though it is not a type of x-ray taken to detect caries. No evidence is available from [Dr B], his assistant or from the anaesthetist that this tooth was fractured during the surgery. It is usually obvious to all of them if the tooth was fractured at surgery. This tooth has decay under the filling and even if it was not fractured [Ms A] will need to have it attended to in the near future.

Summary:

There is no evidence that [Ms A] was provided with written information before surgical removal of her wisdom teeth by [Dr B]. It is reasonable to believe that [Dr B] failed to warn her about possible damage to her lingual nerve before the operation. She was provided with some verbal information on post-operative complications, written information on pre-anaesthetic care and post-operative instructions. [Dr B] had taken reasonable care and skill in the operation on 19 October 2001 and immediate post-operative period, but he had failed to provide her with enough pain relief or to review her sooner when she telephoned back to say she was still having pain.

There is no evidence that there was dry socket formation on 25 October 2001. It was only a suspicion of a dry socket and no proper treatment for dry socket was carried out on that day. [Dr B] had not diagnosed the cause of her pain on that day and had not provided her with alternate painkillers, however, he had diagnosed her numb tongue and taken proper action by making an appointment to see her at a later date. The radiograph (x-ray) taken by [Dr C] clearly shows a carious lesion under the filling of the fractured tooth, but the radiograph taken by [Dr B] shows a small carious lesion under the filling. As the tooth was already weakened, it may have been broken before, during or after the surgery. There is no evidence to confirm this. This tooth needs to have the filling replaced anyway due to the carious cavity under the filling."

Response to Provisional Opinion

The lawyer for Dr B, responded to my provisional opinion on his behalf as follows:

"1. Information about post-operative complications.

There are conflicting accounts between [Dr B] and [Ms A] about what information was given pre-operatively. You have referred to [Dr G's] report to ACC in finding that this was a breach saying *'I am comforted by [Dr G's] advice that it is "common practice" for oral surgeons to warn patients of this risk.'*

This is in direct conflict with [Dr G's] comment on page 2 *'His pre-operative information and post-operative care appear far from ideal, but would not appear to be negligent. His care would appear to broadly fit with a reasonable standard.'* As you know, a breach of the Code is falling below a reasonable standard of care. Clearly the expert retained by ACC did not think that was the case and indeed at page 3 again confirms this saying *'There are some issues relating to medical error but I do not feel that in the circumstances of this case that [Dr B's] care breaches the threshold for failure to observe a reasonable standard.'*

Your own expert does not comment directly on this point on whether or not the information reached a reasonable standard. Therefore the only expert opinion in relation

to this aspect is that of [Dr G], who found that [Dr B's] care did not breach reasonable standards of practice.

Post-Operative Pain

The diagnosis of alleged dry socket, comes from [Dr C's] correspondence with you. As your expert has rightly pointed out, there was a clear conflict between [Dr C's] initial letter to ACC, and his subsequent letter to you, as to whether there was dry socket or not. His notes clearly reveal that the original diagnosis was only provisional, and he did not treat the patient for that. Accordingly there is no evidence that there was a dry socket at the time that the patient attended [Dr C].

[Dr B] has instructed me that he was able to see the lower sockets very clearly when the sutures were removed and therefore observed there were no dry sockets. Dr De Silva has noted that the history of pain did not fit in with there being dry sockets or wound infection. [Ms A] advised [Dr C] there had been bleeding for two days post-operatively and this would make it even less likely that she would develop a dry socket. [Dr C] in any event did not treat her for this.

[Dr B] accepts with the benefit of hindsight that he may have underestimated [Ms A's] perception of her level of pain. He did however see and assess her when requested and at the usual follow-up time.

Your own clinical adviser states *'If taken properly Panadeine usually controls the pain after surgical removal* of *wisdom teeth in most patients'*. He also states *'The amount of pain experienced by [Ms A] was unusual immediately after the surgery. In her letter she complained that she had splitting headache and numb tongue. There was no mention of pain in her mouth. Headache after general anaesthesia was very common and the anaesthetist usually takes* care of *those symptoms.'*

With respect, your expert does not say that [Dr B] should have followed-up with [Ms A] to see if her pain had settled and offered her an earlier appointment (other than the next day) when she requested it. [Dr B] had already made a review appointment to look into the matter that [Ms A] mentioned, of her numb tongue, but by that time she had changed specialists and cancelled appointments. [Dr B's] view on 25 October was that the removal of the sutures should assist in abating her pain.

It is not true to say that [Dr B] offered another prescription for Panadeine; he added aspirin to that prescription, in the hope that would assist [Ms A's] pain management.

[Dr B] has instructed me that he has taken a number of steps to review his practice since this complaint.

- He now gives all his patients copies of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons Wisdom Teeth Guidelines. Appreciating that his verbal discussion with [Ms A], regarding the likely outcomes of wisdom teeth extraction were perceived differently by [Ms A] than what had been his intention.

- He has purchased a Panorex x-ray machine to better visualise the inferior dental nerve.
- He has introduced informed consent documents and patient information brochures for each type of operation.
- He has introduced a more comprehensive note-keeping and continuing clinical audit of complications and outcomes.
- He has continued to attend education meetings at a formal and informal level.
- He has reduced the delegation of post-operative arrangements and instructions to patients and their relatives."

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.

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 …

Opinion: No breach

Tooth fracture
Ms A alleges that Dr B fractured her upper left molar during the extraction of her wisdom teeth.

Dr B denies this, and states that had this occurred, it would have been obvious to him and the other parties present, his nurse, Ms E, and the anaesthetist, Dr D. Neither Dr D nor Ms E recalled a tooth or filling being fractured, and believe that they would have noticed had this occurred.

The advisor to ACC, Dr G, commented that Ms A's tooth was heavily restored and, at the time of her consultation with Dr C, extensive decay was present under the filling. He noted that this decay did not appear to be as extensive in Dr B's x-rays. While it was possible that Ms A's tooth was fractured during the extraction, Dr G could not conclusively determine that this was when the fracture occurred. My independent advisor informed me that as the tooth was already weakened (through restoration and decay) it was possible that it fractured before, during, or even after the extraction. He commented that when a tooth is fractured during an extraction, "it is usually obvious".

I note that Dr C, who actually saw the fractured tooth, also commented that the fracture could have been present pre-operatively. In my view, there is no conclusive evidence as to when Ms A's tooth was fractured. In particular, there is no evidence that Dr B fractured Ms A's tooth during the extraction. None of the three parties present during the extraction can recall damage occurring. The extraction procedure was described as "uneventful".

There is insufficient evidence to support Ms A's allegation that Dr B fractured her tooth. Accordingly, in my opinion Dr B did not breach Right 4(1) of the Code in relation to this aspect of Ms A's complaint.

Opinion: Breach

Information about post-operative complications
Ms A complained that Dr B did not adequately warn her of the possible complications of having her wisdom teeth extracted. In particular, he did not warn her about the degree of pain she would experience and the amount of time she would require off work. Ms A also assumed that the extraction would be a simple procedure as her partner had had his wisdom teeth extracted under local anaesthetic without any problems a few weeks earlier. Had she known her recovery was going to take up to a week she would have delayed the surgery until she was issued with more sick leave.

Dr B stated that he routinely warns patients to expect pain and swelling for up to five to seven days. He told her that although some patients were able to return to work in three or

four days after surgery, five to seven days was more usual. If she were able to work during this time it would not affect the healing process.

I clarified with my advisor what information about complications a patient such as Ms A would expect to receive. He stated that prospective patients should be warned about pain, difficulty opening the jaw, and swelling, which usually resolve over a week but can take up to ten days. Recovery depends on the personal circumstances of the patient. A student, for example, would be able to return to his or her usual activities within a few days, whereas a receptionist would not. Recovery also depends on the difficulty of the extraction. In his view, Ms A's extraction was quite difficult and the degree of pain she experienced post-operatively was proportional to the amount of surgery she had.

I am unable to resolve Dr B's and Ms A's conflicting accounts about information given pre-operatively. However, Right 6(1)(b) of the Code makes it clear that advice given to patients needs to be tailored to their specific circumstances, especially if their recovery will depend on their circumstances. In Ms A's case, her extraction was not straightforward. X-rays showed medium depth mesio-angular impaction of her lower wisdom teeth. Dr B should have known that this would result in more pain, and tailored his advice accordingly. This was especially important as he did not give her an information sheet.

In relation to the damage to Ms A's lingual nerve, my advisor commented that he considered that Dr B had exercised reasonable care and skill in terms of the extraction and took appropriate precautions to protect the nerve from damage. The incidence of permanent lingual nerve damage is rare (less than 1%). Dr G, the advisor to ACC, also commented that while it is common practice to warn patients of possible damage to the lingual nerve, he did not consider it mandatory. I clarified this point with my advisor. He stated that patients should be told why teeth need to be removed, the method of removal, the surgical procedure and any complications (pain, swelling, difficulty opening the mouth, damage to the nerve and tongue).

The adequacy of information disclosure to patients is a matter on which expert advice of accepted practice is relevant, but not determinative. It is ultimately for me, as Commissioner, to determine what a reasonable patient would expect to be told. In my opinion, any patient contemplating wisdom teeth extraction, and certainly a patient in full-time employment as a receptionist, would expect to be told of the possibility of a slow (up to 10 days) and painful recovery. I also consider that a patient should be told of the recognised risk of permanent damage to the lingual nerve. Although the risk is less than 1%, any loss of sensation in the tongue would naturally be of major concern to patients. Under the patient-centred standard of information disclosure set out in Right 6(1)(b) of the Code, patients are entitled to information about this level of risk.

In my opinion Dr B did not adequately inform Ms A about the possible complications and delayed recovery from her wisdom teeth extraction. Accordingly, Dr B breached Right 6(1)(b) of the Code.

Post-operative pain
Ms A complained of severe pain following the extraction of her wisdom teeth.

Ms A's partner, Mr F, made two telephone calls to Dr B about the amount of pain she was in on 22 and 23 October. Dr B suggested she combine Panadeine with aspirin. A woman at Dr B's surgery advised Ms A to "just keep taking what [Dr B] had prescribed and rest". When Ms A telephoned Dr B's surgery to request an early appointment she was told that she could not be seen until the next morning. Ms A also sought advice from a pharmacist (on 20 October) and treatment from her own general practitioner (on 25 October).

In responding to Ms A's complaint Dr B referred to only one telephone call, when he spoke to Ms A's partner two days after her extraction. However, I accept that Ms A and Mr F together made three telephone calls to Dr B's rooms.

My advisor stated that Panadeine (which Dr B prescribed for Ms A's post-operative pain) provides effective pain relief following wisdom teeth extraction in most patients, when used appropriately. However, Ms A's post-operative pain was severe and unusual and, in her case, Panadeine did not effectively manage her pain.

My advisor noted that some patients do experience significant pain following extractions. He considered Dr B's response on 22 October (suggesting that Ms A combine Panadeine and aspirin) was reasonable in the circumstances. Prescribing a painkiller such as Tramadol is not the preferred option so soon after oral surgery because of the side effects of nausea and vomiting. However, my advisor considered Dr B should have followed up with Ms A to see if her pain had settled, and offered her an earlier appointment (other than the next day) when she requested it.

At the follow-up consultation on 25 October Dr B failed to establish the cause of Ms A's pain or offer appropriate treatment, beyond another prescription for Panadeine and aspirin. Ms A's pain continued unabated until she obtained a second opinion from Dr C the next day. In view of her severe pain, Dr C made a provisional diagnosis of dry socket and also noted that she had a fractured filling. He prescribed the painkiller Tramadol, and an antibiotic, which resulted in a marked reduction in her pain. Three days later he confirmed the diagnosis and dressed and packed her sockets.

Dr B advised me that he was satisfied that there was no evidence of dry socket or infection, which could have been causing the pain, when he saw Ms A on 25 October. My advisor was not sure that Ms A's post-operative pain was caused by a dry socket, as she had experienced severe pain continuously from the time of the extraction (rather than an acute onset of pain). However, he stated in relation to the consultation on 25 October:

> "The cause for her unusually severe pain was not diagnosed that day. She was not provided with adequate pain relief to manage her pain symptomatically."

I further clarified this point with my advisor. He stated that Tramadol, or an injection to numb the area, would have been appropriate treatment options in the circumstances.

Although Dr B could not see any obvious reason for Ms A's pain, he was aware that she had been experiencing pain at such a level that he had been telephoned at home by her partner, and she had also requested an earlier appointment. Dr B failed to offer Ms A

alternative pain relief. Instead, he offered another prescription for Panadeine and aspirin, despite Ms A's lack of response to this treatment.

In my opinion, by not following up with Ms A regarding the effectiveness of the suggested pain management and not providing adequate pain relief on 25 October, Dr B failed to treat his patient with reasonable care and breached Right 4(1) of the Code.

Other comment

Documentation
It is standard dental practice to document clinical information about patients. None of Ms A's and Mr F's telephone calls to "a woman" at Dr B's practice were documented. Dr B did not document his telephone conversation with Mr F. These telephone calls provided important clinical information, which added to Ms A's clinical picture and may have altered her management, and should have been documented in her file.

Review of practice
I commend Dr B on the steps he has taken to review his practice in light of Ms A's complaint.

Recommendation

I recommend that Dr B apologise to Ms A for his breach of the Code. This apology is to be sent to my Office and will be forwarded to Ms A.

Follow-up actions

- 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 sent to the New Zealand Dental Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.