Dental Surgery / Dentist

Report on Opinion - Case 98HDC13803

Complaint

The Commissioner received a complaint from the consumer that in mid-January 1996 a dental surgeon failed to notify the consumer of the results of testing on a growth in her mouth. As this occurred before 1 July 1996 the Commissioner is unable to investigate this complaint.

Further to this, the consumer made the complaint that:

- *For the period December 1996 to March 1997 the dental surgery accidentally filed* [without reviewing] *the consumer's x-rays.*

- *In March 1997 the dental surgery failed to refer the correct x-ray to the consumer's oral surgeon.*

Investigation

The complaint was received in April 1998 from the consumer and an investigation was commenced in June 1998. Information was obtained from:

The Consumer
The Dentist
The Second Dentist

Information Gathered During Investigation

Jurisdiction

As the Commissioner is unable to investigate events that occurred prior to 1 July 1996, those incidents involving failure to diagnose the tumour in the consumer's jaw do not fall within the Commissioner's jurisdiction and have not been investigated. The Commissioner's jurisdiction applies to events that occurred after 1 July 1996. The consumer's complaints relating to her x-rays concern events that all occurred after 1 July 1996, beginning with the filing of her x-rays in December 1996. The Commissioner investigated those events.

Continued on next page

Dental Surgery / Dentist

Report on Opinion - Case 98HDC13803, continued

Information Gathered During Investigation, *continued*

Background

During January 1996 the consumer had a growth removed from her lower right jaw by an oral surgeon. The consumer requested that the growth be tested. The oral surgeon informed her that a sample would be forwarded to a university for testing and that she would be contacted with the relevant information. The consumer received no more than an itemised account stating "*removal of cyst*". She concluded that her fears that the growth was dangerous were unfounded.

On a date in mid-November 1996 the consumer visited the dentist at the the dental surgery for a regular check-up. The consumer mentioned that she was still feeling pain in the area where the growth had been removed.

In December 1996 the consumer again visited the dental surgery for the replacement of a filing, and again commented on the pain in her jaw. The dentist took a PA radiograph of the region that showed a multiocular radiolucency associated with the apices of tooth 46. The dentist discussed this with the second dentist and they agreed that a panoramic x-ray ("panex") was needed to determine the full extent of the lesion. The dentist referred the consumer for a panoramic x-ray.

In December 1996 the consumer travelled to a provincial city to have a panex taken. She returned that same day and delivered the panex to the dental surgery herself, handing it to a receptionist.

The panex was filed away by the receptionist. It remained in the filing system until February 1997 when the consumer phoned the dental surgery after a recurrence of pain in her jaw. In response to her call the receptionist at the dental surgery informed the consumer that the x-ray had arrived. The consumer replied that she was aware of this as she had bought the x-ray in personally two months previously. The receptionist informed her that someone would look at the x-ray and would phone her back either that same day, or the day following.

Two further weeks passed without contact from the dental surgery. A file note indicates that during this period the dentist reviewed the consumer's panex with the second dentist and that the dentist attempted, unsuccessfully, to contact the consumer by phone.

Continued on next page

Dental Surgery / Dentist

Report on Opinion - Case 98HDC13803, continued

Information Gathered During Investigation, *continued*

In early March 1997 the consumer took time off work and went to the dental surgery in person. At this visit the dentist reviewed the panex with the consumer, and immediately referred her to an oral surgeon.

Consequently, the consumer made an appointment with the oral surgeon. The dentist forwarded a panex to the oral surgeon, but accidentally sent a panex taken in 1995, rather than the panex taken in December 1996. When the consumer talked with the oral surgeon and discovered this error she returned to the dental surgery and picked up the correct panex herself.

Based on the correct panex the oral surgeon conducted a biopsy. The consumer subsequently underwent oral surgery.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...

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

...

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

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 –

...

f) The results of tests.

Continued on next page

Dental Surgery / Dentist

Report on Opinion - Case 98HDC13803, continued

Opinion: Breach The Dentist

Right 4(5)

In my opinion the dentist breached Right 4(5) of the Code. The consumer could have reasonably expected that the dentist would send the correct panex to the oral surgeon. This did not occur. The dentist's failure to do so placed additional stress on the consumer at a time when she was already under significant strain.

Opinion: Breach The Dental Surgery

Right 4(2)

In my opinion the dental surgery breached Right 4(2) of the Code in failing to have procedures in place to bring x-rays to the attention of the appropriate dentist.

Failure to have these procedures in place resulted in a breach of Right 4(2) of the Code.

Right 6(1)(f)

In my opinion the dental surgery breached Right 6(1)(f) of the Code in failing to review the consumer's panex results within a reasonable timeframe. In total over two months elapsed between the panex results being delivered at the dental surgery by the consumer and the time at which she was informed of the results.

Any reasonable consumer should expect to be informed of test results within a reasonable timeframe. Two months is not a reasonable timeframe. Where the consumer is in pain, and where these test results have significant implications for the health of the consumer, urgency in relaying these results to the consumer is even more important. By failing to inform the consumer of the test results the dental surgery placed unnecessary stress on the consumer.

The consumer could reasonably have expected that her panex results would be reviewed and discussed with her shortly after she delivered these to the dental surgery. This did not occur. Failure to inform the consumer of her panex results in a timely manner is therefore a breach of Right 6(1)(f) of the Code.

Continued on next page

Dental Surgery / Dentist

Report on Opinion – Case 98HDC13803, continued

Actions

The Dental Surgery
I recommend that the dental surgery actions the following:

- Implements procedures to ensure that consumers are informed of test results within a reasonable timeframe.
- Implements procedures to ensure x-rays are immediately brought to a dentists attention and not filed upon receipt.
- Apologises in writing for its breach of the Code to the consumer. This apology should be sent to the Commissioner who will forward it to the consumer.

The dentist
I recommend that the dentist apologises in writing to the consumer for his breach of the Code. This apology should be sent to the Commissioner who will forward it to the consumer.

Other Actions

A copy of this opinion will be forwarded to the Dental Council of New Zealand.