Functional Orthodontist, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC03104)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Complainant
Dr B	Functional Orthodontist / Provider

Complaint

On 28 February 2003 the Commissioner received a complaint from Dr A concerning the service provided to him by Dr B, functional orthodontist. The complaint was summarised as follows:

Dr B did not provide dental services to Dr A with reasonable care and skill between March 2001 and February 2002. In particular, Dr B:

- *incorrectly diagnosed the cause of Dr A's problems and pain;*
- *commenced a treatment plan that was inappropriate given Dr A's presentation;*
- *did not adequately supervise his employees during the implementation of the treatment plan, leading to the inappropriate instalment of an occlusional plate on two occasions;*
- *did not undertake sufficient tests prior to commencing the treatment, including an accurate bite registration, an orthodontically trimmed study model, a lateral cephalogram radiograph, or an orthodontic cephalometric analysis;*
- *at the first consultation, did not identify a pre-existing condition of an infected wisdom tooth;*
- *did not provide remedial treatment in a timely manner when the occlusional plate broke the first time.*

Dr B did not provide Dr A with sufficient information either prior to commencing the treatment, or when the problems with the treatment became apparent. In particular, Dr B did not provide sufficient information in relation to:

- *alternatives to the proposed treatment;*
- *shortcomings, risks and side-effects of the proposed treatment;*
- *options other than termination of the treatment, when Dr A indicated the problems he was experiencing.*

An investigation was commenced on 30 May 2003.

Information reviewed

- Complaint letter from Dr A's lawyer, dated 27 February 2003
- Letter from Dr A to the dental clinic, dated 7 February 2002
- Letter from Dr B to Dr A, dated 23 February 2002
- Statement recorded by Dr B and witnessed by Dr B's assistant on 23 January 2002
- Letter from Dr A to Dr B, dated 29 April 2002
- Letter from Dr B's lawyer to Dr A, dated 8 May 2002
- Professional opinion provided to Dr A's lawyer by an oral and maxillofacial surgeon, dated 11 October 2002
- X-rays taken of Dr A's jaw on 11 April 2001
- Response to complaint by Dr B, dated 13 August 2003
- Dental records relating to Dr A held at the dental clinic; copies of information sheets and questionnaires now in use at the dental clinic; information pack and informed consent form of the type used at the dental clinic at the time of Dr A's consultations

Independent expert advice was obtained from Mr David Lovrich, functional orthodontist.

Information gathered during investigation

On 28 March 2001 Dr A saw Dr B, dentist, at a dental clinic with a history of teeth-grinding and pain in the temporo-mandibular joints (the joints connecting the mandible of the jaw to the temporal bone of the skull) causing headaches. After this consultation, Dr A made a further appointment to see Dr B on 11 April 2001.

On 11 April, Dr B performed a clinical examination on Dr A, including a lateral cephalogram X-ray (head X-ray), a panoramic X-ray (an X-ray that shows the entire jaw on a single film) and a joint vibrational analysis. Dr B's assessment also included taking photos of Dr A's posture and feet. An information sheet included with his assessment report stated that good posture is an integral part of correcting teeth and jaw problems. Dr B diagnosed retroclination of the anterior teeth (an overbite) causing malocclusion (abnormal contact between the teeth of the upper and lower jaws), incorrect jaw posture and temporo-mandibular joint dysfunction. Dr B proposed treating this with appliances made of acrylic and fixed orthodontic wires. Dr B advised me that he told Dr A that the success of this treatment depends on the patient wearing the appliances at all times as instructed, that the patient is responsible for taking care of the appliances, and that they may cause discomfort.

Dr A advised me that he was not told about alternative treatments, or the risk and potential shortcomings of the proposed treatment, including an increased risk of tooth decay. He said that while he was told about the potential for discomfort and problems with speaking, he felt Dr B trivialised them. He believes that insufficient radiographs and testing occurred before

the treatment plan was implemented. Dr A later found that he had an impacted and infected lower right wisdom tooth, and believes that this should have been noticed at the time.

On 14 May 2001 Dr B completed a report to Dr A confirming the discussion they had about treatment on 11 April. This document included the following statements:

> "Your chief complaints were a mismatched bite and an overbite. You also stated that you have been experiencing severe headaches.
>
> …
>
> **Plan**
> Recommended treatment includes comprehensive orthodontic treatment to the adult dentition, fixed lower orthodontic appliances, fixed upper orthodontic appliances, a removable lower jaw repositioning appliance and a removable upper jaw repositioning appliance.
>
> **Why correct an Orthodontic Problem?**
> Orthodontic treatment is necessary to correct your bite. A correct bite gives correct function to the teeth and jaws, protects the teeth against incorrect wearing and stops aberrant muscle activity. This should help the incorrect muscle activity that I feel is causing your headaches. It also improves the appearance of the teeth and face, and often improves the patient's self image. Crowded teeth attract dental decay and gum disease; straight teeth are easier to clean. There is less chance of jaw joint problems when the teeth and jaws are in their correct position.
>
> **Difficulties with orthodontic treatment**
> You would have initial difficulty in speaking with your new appliances but most patients adjust in a few days. Also, a small amount of discomfort is normal during the first week or two.
>
> It is important that you be responsible with the care of your appliances. Replacement appliances are expensive, as are the repairs needed to fix damaged appliances.
>
> Also, you will have to take special care of your teeth while having orthodontic treatment. Teeth are susceptible to decay, especially with fixed appliances, so you must be careful with your cleaning and flossing.
>
> It is important that during the orthodontic treatment we check your teeth at six monthly intervals for decay and gum disease. We also recommend three monthly cleans and fluoride treatments if plaque control is inadequate."

On 16 May 2001 Dr B placed acrylic appliances in Dr A's mouth.

On 27 June 2001 Dr A complained to Dr B that he could not wear his appliances all the time and that he was unable to eat or speak with them in. Dr B made modifications to the appliances and thinned them down.

On 11 August 2001 Dr B saw Dr A for a routine check. Dr A complained that during routine checks he was usually seen by Dr B for less than a minute and that unqualified or inadequately qualified dental assistants assessed, progressed and carried out the treatment.

Dr B responded that he monitors all treatment and that his assistants are trained and experienced at placing appliances under his supervision. The assistants employed by Dr B who undertake the work of placing appliances are a qualified dental assistant, an overseas trained dental surgeon currently studying towards obtaining his New Zealand dental registration, and a qualified dental hygienist. Dr B advised that he provides them all with in-house training.

On 24 August 2001 Dr A returned to see Dr B and fixed orthodontic treatment began.

On 21 September 2001 Dr B saw Dr A for a routine check.

On 19 October 2001 Dr B saw Dr A for a further routine check. Dr B stated that at this consultation Dr A said he was not wearing his appliances as they were making him gag. Dr B said that he reinforced to Dr A the importance of wearing appliances and again attempted to thin the appliances to make them more comfortable.

On 3 November 2001 Dr A returned to Dr B to have a broken wire repaired.

On 16 November 2001 Dr A saw Dr B and advised him that he was only wearing the appliances at night.

On 14 December 2001 Dr B saw Dr A and installed fixed occlusal splints (splints between the incising or masticating surfaces of the maxillary and mandibular teeth) as Dr A remained unable to use the removable acrylic appliances.

Dr A complained that the fixed occlusal plate broke one hour after it was placed and that Dr B did not provide a sufficiently prompt response to the problem, not seeing him for several days despite the considerable discomfort he experienced from a loose wire. Dr A said he contacted Dr B's clinic and was told by the receptionist that Dr B was away over Christmas/New Year and would contact him on his return, and that he was not offered any other assistance. Dr A said that he drove to a city where he saw an after-hours dentist.

Dr B advised me that if he is not available, he has staff who can see patients for urgent treatment. In this case Dr A did not bother to contact the surgery for several days to report the breakage. He said that if his clinic had been contacted, there is always someone available to provide emergency treatment and he is available for emergencies after hours. There is no record of when Dr A was seen by Dr B and when the plate was repaired.

Dr A stated that he found the fixed occlusal splints cosmetically unacceptable to the extent that he was embarrassed and restricted in his employment as an inpatient psychiatrist, and that his patients started to refer to him as "the vampire".

On 7 January 2002 Dr A consulted Dr B and complained that the treatment was not going as he had hoped. Dr B advised me that he told Dr A that the current treatment was a compromise, because Dr A was unable to wear the acrylic appliances, and was not ideal. Dr A told Dr B that he was not happy being seen by Dr B's assistants for appliance repairs and checks. Dr B undertook to carry out all future aspects of Dr A's treatment in person.

On 23 January 2002 Dr A saw Dr B at a scheduled 6.00pm appointment. The content of this meeting was recorded by Dr B and his assistant in a signed statement completed at 8.00pm that evening. Dr A complained that he could no longer wear the appliances and asked if there were any alternative treatments, or whether he could just wear a night splint. Dr A advised me that Dr B dismissed the option of a night splint and did not tell him about any other alternative treatments. Dr B recorded in his statement that he told Dr A a night splint might alleviate some of the symptoms, but would not fix the problem. Dr A said that if there was nothing more that Dr B could do, he wanted the appliances removed. Dr B noted that he advised Dr A that this would cause his teeth to go back to their former positions and that this might cause his headaches to return.

Dr B asked an assistant to remove Dr A's appliances and, when this was completed, returned to check his bite. Dr B noted that Dr A's bite was not good but improving, and that within a month it would probably be functional but not quite correct. Dr B advised Dr A that if they were lucky this might be just enough to get him functioning in a state that his body could cope with. Dr B noted in his record of the meeting that he told Dr A he needed to take impressions of the teeth to record where they stopped and that he would like to conduct another joint vibrational analysis. According to Dr B, Dr A said he did not want further impressions taken and was not prepared to undergo another joint vibrational analysis. Dr B told Dr A that he did not want to abandon his treatment and wanted to help him. He explained to Dr A that he needed to record where the treatment was stopped should further treatment be needed in the future. Dr A again declined to have the impressions and joint analysis performed. Dr B then asked Dr A to sign a letter stating that he wanted to stop the treatment and would not hold Dr B responsible for any relapse that might occur. Dr A said he did not see the need to do this and was not prepared to sign anything. Dr B said that Dr A was noticeably angry and upset and asked to leave, which he did.

Some time after terminating his relationship with Dr B, Dr A found that he had an impacted and infected lower right wisdom tooth.

On 11 October 2002 Dr A obtained advice on the treatment Dr B had provided from the oral and maxillofacial surgeon. The oral and maxillofacial surgeon advised Dr A's solicitor as follows:

"I saw Dr [A] for a consultation appointment at my [city] Clinic at […] Dental Rooms on Friday afternoon, 11 October 2002. Coincidentally, Dr [A] had been referred to me by […] (Dental Surgeon) in [another city] with regards to an impacted lower right third molar tooth which had produced pain and swelling five weeks previously.

Thank you for providing me with the written material by way of background to this case. I have had the opportunity to read through this and also to interview Dr [A] today. I have also had the opportunity to clinically examine him and review the orthodontic study models provided by [the dental surgeon] along with a bite registration from […] (Specialist Orthodontist) from [the city], and the removable appliances and fixed appliances from Dr [B].

So as to avoid unnecessary repetition, I have elected to address the specific aspect of Dr [A's] treatment about which he is most aggrieved, or which appear to you, […], to potentially give rise to concern.

1. Initial diagnosis and management advice – correct assessment of condition? Were there other/preferable treatment options?
Dr [B] diagnosed 'retroclination of the front teeth causing mal-occlusion'. Dr [B] advised Dr [A] that headaches from which he had been suffering were also attributable to this. Patients may experience temporomandibular joint dysfunction and/or myofascial pain dysfunction irrespective of whether they have a mal-occlusion. Parafunction such as nocturnal bruxism or daytime clenching, is a common cause of temporomandibular joint overload and masticatory muscle spasm and pain. There was excessive wear on Dr [A's] anterior teeth indicating probable parafunction. Rather than embarking upon a three year course of orthodontic treatment, there were other simple and effective treatment options available. The use of physical therapy, such as heat on a regular basis to the temporomandibular joint and muscles of mastication, a jaw opening exercise programme, massage of the affected muscles of mastication and the use of a simple flat plane temporomandibular joint bite raising appliance are recognised treatment modalities in the management of this condition. In addition, the use of medication such as non-steroidal anti-inflammatory drugs and/or muscle relaxants may be indicated. Lifestyle changes and the use of stress relaxation methods are other treatments commonly used in the management of stress related bruxism with pain in the temporomandibular joints and muscles of mastication.

2. No advice was given regarding alternative treatment or other means of management.
From the reading material available to me and my consultation with Dr [A] today, alternative treatment or other means of management were never suggested by Dr [B].

3. There was no discussion regarding the risks or potential shortcomings of the proposed treatment programme – inadequate information proffered prior to consent.

According to Dr [A], he was not informed of the risks of pain associated with the removable appliance and the pressure that it would generate on the teeth, along with the need for analgesics. He was also not advised that the wires that were placed for the fixed orthodontic appliances may break and require constant adjustment. In terms of verbal and/or written informed consent prior to embarking upon this course of treatment, there appears to have been none documented.

4. No suggestions of referral to a specialist practitioner (eg orthodontist) – potentially outside the area of expertise of a general dental practitioner?

A number of general dental practitioners do undertake minor orthodontic treatment using removable appliances and in some instances fixed orthodontics. Complex orthodontic treatment, likely to take three years or so, would normally be outside the area of expertise of a general dental practitioner and would be the domain of a specialist orthodontist.

5. Treatment delegated to unqualified (or inadequately qualified) dental assistants.

An important part of the monitoring of the course of orthodontic treatment is for the specialist orthodontist or general dental practitioner with an interest in orthodontics to make any adjustments themselves necessary on a regular basis. To delegate this to unqualified or inadequately qualified dental assistants is inappropriate.

6. Lack of adequate oversight or supervision by Dr [B].

Dr [A] emphasised to me his concerns regarding the lack of oversight or direct supervision by Dr [B] during his course of treatment. He mentioned to me that of a typical 20 minute appointment, Dr [B] may see him for thirty seconds or one minute or so. In order to ensure a satisfactory standard of care, adequate direct supervision by the practitioner is essential.

7. Were adequate impressions and/or x-rays taken prior to treatment? Refer file photographs – what is the relevance of Dr [A's] feet?

Records taken at the initial consultation on 11/4/01 included study models, clinical photographs including extra and intra-oral, and a Panoramic radiograph.

There is no reference to an accurate bite registration nor to the use of orthodontically trimmed study models. A lateral cephalogram radiograph would be normally taken and an orthodontic cephalometric analysis performed. I am uncertain as to the relevance of Dr [A's] feet.

8. The early failure of the first occlusal plate (only one hour after placement). The loose wires cut Dr [A's] cheek, causing him considerable discomfort until seen several days later. Delays in appropriate remedial treatment?

Acrylic occlusal plates or splints are subject to damage including facture. However, I would not have expected such a device if it was properly constructed and fitted to have lasted only one hour after placement before it failed. Loose or damaged orthodontic appliances can cause considerable oral discomfort including ulceration. Appropriate remedial treatment should have been available that day, or at least the following day. If Dr [B] was unavailable, alternative arrangements with an appropriately trained colleague should have been made. In the [e]vent of this falling on a public holiday or a weekend, there are emergency dental services available for the [city] area.

9. Wires adjusted, but subsequently broke after a very short period (two days).

Again, oral lacerations from broken wires, leading to ulceration and significant discomfort. Wires frequently require adjustment and do break during a course of orthodontic treatment. In a normal course of events, one would expect the wires to last more than two days before breaking and this raises questions surrounding their appropriateness. Again, Dr [A] should have been forewarned of the possibility of broken wires resulting in oral ulceration and significant discomfort. He should have been adequately informed as to how to deal with these including the use of appropriate analgesics, mouth rinses and perhaps the use of green wax to cover the sharp wire ends and prevent trauma to the adjacent soft tissues.

10. Heavier plates used – cosmetically unacceptable.

Dr [A] emphasised to me the embarrassment which this heavier plate caused him and his restriction in his employment as an inpatient psychiatrist. It interfered with his ability to communicate effectively with his patients and indeed he was referred by them as a 'vampire'. I find it surprising that Dr [B] recommended the use of this heavier plate and persevered with it given the sensitivity and fragility of those patients with whom Dr [A] was required to deal professionally.

11. Once Dr [A] complained, no option was given but the abrupt termination of treatment.

At that particular time, or indeed at any stage during Dr [A's] treatment with Dr [B], it would have been possible to end the orthodontic treatment and accept a minor mal-occlusion. It is likely that the teeth would have 'relapsed' back towards their original position and one could have undertaken the use of a simple night splint and other physical therapy measures outlined earlier.

12. Concern that in August [the dental surgeon] reported an infected wisdom tooth and a retained root – has this any relevance to the temporomandibular symptoms?

The infected lower right third molar teeth (wisdom tooth) and supposed retained tooth root at site 46 has no relevance to the temporomandibular joint symptoms. Infected wisdom teeth do not cause temporomandibular joint dysfunction; however, they may produce referred pain in the area of the temporomandibular joint. The

lower right wisdom tooth is a pre-existing condition and would have been identifiable by Dr [B] at the time of his Panoramic radiograph taken in April 2001. It would be normal code of practice for the clinician concerned to inform the patient of the presence of this impacted third molar tooth and provide an outline of the problems that it may cause in the future.

In addition to my comments above to your specific questions, […], I have other concerns surrounding Dr [A's] course of treatment with Dr [B]. There is no sound scientific evidence in the orthodontic, dental or oral and maxillofacial literature that supports the view that a minor mal-occlusion with retroclination of the lower incisor teeth will produce temporomandibular joint dysfunction and/or myofascial pain dysfunction. A simple occlusal bit splint would be expected to improve the symptoms without the need for an elaborate lengthy and expensive course of orthodontic treatment. The assertions that the maxillary midline suture can be 'wrong' and therefore manipulated to correct the problem, along with cranial suture manipulation with a chiropractor, is not supported in the recognised and respected dental literature. In the adult patient, the cranial and facial sutures have long since ossified and are no longer subject to manipulation as in the developing child with open sutures.

I fail to see the significance of a patient's feet and the need to photograph them in the management of temporomandibular dysfunction. Dr [A] informed me that Dr [B] claimed that the relevance of the feet was that pressures within the hypothalamus and cranium were balanced there. According to standard textbooks in human anatomy and physiology, no such connection exists and I fail to see the relevance.

I trust that my report has been of some assistance to you … I have endeavoured to be as objective as possible. Dr [A] emphasised to me in his consultation with me that he is not a vindictive person and that he does not wish to 'cause trouble'. You have also stressed … Dr [A] is not on a 'witch hunt' and I certainly would not wish to be part of such a process. I believe that in responding to your questions surrounding Dr [A's] involvement with Dr [B], there are deficiencies in Dr [B's] assessment and treatment which I believe are of professional and clinical significance."

Independent advice to Commissioner

The following expert advice was obtained from Mr David Lovrich, an independent functional orthodontist:

"I have been asked to provide an opinion to the Commissioner on case number 03/03104.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors as provided to me.

Received my Bachelor of Dental Surgery degree in 1980.

I was the acting Chairman and Chairman of the Northern Region Peer Review Committee for the New Zealand Dental Association in the years 1999, 2000, 2001 and 2002.

I have be[en] since 2002 the President of the Functional Orthodontic Society in New Zealand

I am a member of the International Orthodontic Association, New Zealand Dental Association, Auckland Dental Association and from 1995-2000 a member of the Auckland Dental Association Executive as the Complaints Officer.

I have provided orthodontics, orthopedics and temporo-mandibular dysfunction treatment to patients in my care from 1987. I have taken approx. 70 days of education in the above fields in Australia and the United States.

Referral instructions from the Commissioner

Expert Advice required

Did Dr [B] conduct a thorough enough review of Dr [A's] condition before making his diagnosis and plan for treatment?

- Should any of these tests or examinations have been offered or performed at this time:
    - An accurate bite registration
    - An orthodontically trimmed study model
    - A lateral cephalogram radiograph
    - An orthodontic cephalometric analysis

- Should Dr [B] have detected Dr [A's] infected and impacted wisdom tooth?
- Was the treatment plan proposed appropriate given Dr [A's] presentation?
- Were then any alternative treatments available that Dr [B] should have made Dr [A] aware of?
- What are the risks, short-comings and side-effects of the treatments implemented by Dr [B]?
- Were there any options other than termination which could have been raised by Dr [B] at the meeting of 23 January 2002?
- Once advised that an occlusal splint had come loose, how quickly would you expect a dentist to see his patient?

Information reviewed

- Letter from Dr [A's] solicitor […]
- Letter by Dr [A] to [the dental clinic] […]
- Letter from Dr [B] to Dr [A] […]
- Letter from Dr [A] to Dr [B] […]
- Dr [A's] statement of account at [the dental clinic] as of 7/1/02 […]
- Letter from Dr [B's] solicitor to Dr [A] […]
- An opinion on the standard of care to Dr [A] by Dr [B]. This opinion was prepared by [the oral and maxillofacial surgeon] at the request of Dr [A's] solicitor […]
- Printed copies of xrays taken by Dr [B] of Dr [A]. The xrays are as follows:- full panoramic x-ray; left sectional posterior panographic x-ray; right sectional posterior x-ray ; frontal PA skull; full lateral cephalogram x-ray; anterior cephalogram x-ray […]
- Letter of response from Dr [B] to the Commissioner […]
- Dr [B's] orthodontic analysis, chirodontic analysis, joint vibrational analysis, cephalometric analysis, photographs of Dr [A] photographs of models and questionnaire as filled in by Dr [A], clinical records and letter of findings to Dr [A] from Dr [B] […]
- Two letters to [the dental clinic] from Dr [A] […]
- Research of the scientific literature pertaining to the fusion or non-fusion of cranial sutures by myself (see bibliography for the list of scientific data reviewed)

Sequence of events

28/3/01:- Dr [A] attended [the dental clinic] for the first time and received routine dental treatment

11/4/01:- Dr [B] consulted with Dr [A] with regard to possible temporo-mandibular joint dysfunctional problems causing headaches and teeth grinding. Dr [B] performed a clinical examination and took a lateral cephalogram, a panoramic xray, frontal PA skull xray and did a joint vibrational analysis

16/5/01:- Dr [B] placed orthopedic appliances for Dr [A] and did a filling for Dr [A]

27/6/01:- Dr [A] complained to Dr [B] that he could not wear his appliances all the time and that he was unable to eat or speak with them in place. Dr [B] made modifications to the appliances in an attempt to make the appliances more comfortable to Dr [A]

11/7/01:- Dr [A] attended for a chirodontic visit

27/7/01:- Dr [A] had scaling and cleaning of his teeth

24/8/01:- an upper fixed orthodontic appliance was placed to move the upper 2 front teeth forward

19/10/01:- Chirodontic visit – Dr [A] complained that appliances were making him gag and had not been wearing the appliances. Adjustments were made to attempt to make the appliances more comfortable and to continue the treatment plan.

3/11/01:- Repair to appliance

16/11/01:- Chirodontic visit. Dr [A] informed Dr [B] that he was only wearing the appliances at night which was against instructions of Dr [B].

14/12/01:- Chirodontic visit at which time upper and lower fixed orthodontic brackets were placed and posterior occlusal build ups placed as an alternative to the appliances as Dr [A] was not wearing his appliances at all now.

The build up broke approx 1 hour after being placed according to Dr [A]

7/1/02:- Chirodontic visit at which Dr [A] complained that treatment was not going as he was hoping. Dr [B] advised that the current treatment was a compromise as Dr [A] was not able to wear the appliances of choice for this type of treatment.

23/1/02:- Dr [A] met with Dr [B] and complained that he could no longer wear the fixed appliances and asked if there was anything else that Dr [B] could do other than having the appliances. Dr [A] said that he wanted the appliance in his mouth removed. Dr [B] advised that a night splint might alleviate some of Dr [A's] problems but would not fix the problem. Dr [B] advised that removal of the appliance at this stage of treatment would cause Dr [A's] teeth to go back to their former position and that this may cause his headache to return. Dr [B] removed Dr [A's] appliances and noted that the bite was not good and advised Dr [A] that within a month the bite would be functional but not correct. Dr [B] asked Dr [A] to have impressions taken of his mouth for the records and that he would like to do a final joint vibrational analysis. Dr [A] declined both the impressions and joint vibrational analysis. Dr [B] asked Dr [A] to sign a letter stating that Dr [A] wanted to stop treatment and would not hold Dr [B] responsible for any relapse which might occur – Dr [A] declined to do this.

7/2/02:- letter of complaint by Dr [A] to [the dental clinic] detailing problems he had had and stating that he thought that the treatment he had had was not to the standards of delivering care as set by the Dental Council of New Zealand. He also threatened to publish in the [regional newspaper] and local paper in […] his experiences with Dr [B].

23/2/02:- Dr [B] replies to Dr [A's] letter denying the allegations that Dr [A] had made and advised Dr [A] to seek legal advice before going to the media.

29/4/02:- Letter to Dr [B] from Dr [A] complaining that he had treatment from Dr [B's] hygienists or assistant for adjustments and the placing of brackets, wires and a 'plate'. Dr [A] also complained that 'the heavy plate caused me embarrassment and seriously interfered with my job'. Dr [A] also stated in this letter that Dr [B] had offered him a money back guarantee. Dr [A] stated that he was saddened by the way Dr [B] had handled his complaint and the way treatment was terminated. Dr [A] stated in this letter that Dr [B] gave him no explanation or alternatives apart from the night guard and that he was effectively powerless. Dr [A] in this letter also asked

that Dr [B] acknowledge his suffering during treatment with an apology and that he wished a full refund of the money paid to Dr [B] for his dental care.

8/5/02:- Dr [B's] solicitor replied to Dr [A's] letter and in this letter the money back guarantee was denied and it also was denied that Dr [B] ever agreed to performing every step of the treatment including those normally handled by assistants on behalf of [the dental clinic]. This letter also states that Dr [B] accepts responsibility for the diagnosis. The letter states that Dr [A] chose not to follow the recommended treatment and therefore any implied agreement was repudiated. The letter also stated that there are no monies owed to Dr [A] by Dr [B] or [the dental clinic] and recommended that if Dr [A] believed that some sort of redress was required that the Disputes Tribunal was an appropriate starting point.

19/902:- Dr [A] requests that his records are sent to [the dental surgeon]. All records are sent to [the dental surgeon].

11/10/02:- Dr [A] on the recommendations of his solicitor sought an opinion on Dr [B's] treatment from […] who is an oral and maxillofacial surgeon.

27/2/03:- Formal letter of complaint to Health and Disability Commissioner from Dr [A's] solicitor

13/8/03:- Formal response to the Health and Disability Commissioner's enquires by Dr [B].

Opinion on questions posed by the Commissioner

Did Dr [B] conduct a thorough enough review of Dr [A's] condition before making his diagnosis and plan for treatment?

- **Should any of these tests or examinations have been offered or performed at this time:**
- **An accurate bite registration**
- **An orthodontically trimmed study model**
- **A lateral cephalogram radiograph**
- **An orthodontic cephalometric analysis**

I believe that from the records supplied by the Commissioner to me that Dr [B] conducted an extremely thorough review of Dr [A's] condition in fact Dr [B] exceeded what is normally appropriate for these cases by providing a joint vibrational analysis and frontal PA skull x-ray. Dr [B] conducted a thorough clinical examination judging from his clinical records, joint vibrational analysis, lateral cephalogram taken with orthodontic cephalometric analysis, a panoramic x-ray, a frontal PA skull x-ray and models.

From the prints of pictures of the models provided I have concluded that the models were not orthodontically trimmed. This I believe is not relevant as the reason why models are trimmed to a certain protocol is so that the bite can be clearly reproduced each and every time when one looks at models and in this case the bite

was very simple to locate and reproduce as there is a large amount of interdigitation of Dr [A's] upper and lower teeth which means that when someone looks at these models and puts them together they can only go together in one position. This also answers the question was an accurate bite registration required and again my opinion is no in this case from the material provided.

Should Dr [B] have detected Dr [A's] infected and impacted wisdom tooth?

From the printed copy of the x-rays taken there does not appear to be any sign of infection. The lower right wisdom tooth is impacted. In the normal course of events with a new patient in a practice a dentist would discuss the impacted wisdom tooth with a patient. Many patients that are in Dr [A's] age group elect not to do anything about an impacted wisdom tooth if it has not caused pain – there are many people in the community with wisdom teeth similar to Dr [A's] that have never had problems which is not to say that wisdom teeth such as these do not turn into acute situations. An impacted wisdom tooth such as Dr [A's] may lie dormant for all of a person's life or at some stage may turn acute. A full clinical examination was conducted prior to treatment and during a full clinical examination a dentist will look for signs of infection – it is not current guidelines to record areas that have no infection or other dental problems but to only record areas that problems such as infection, decay etc. Thus without actually [having] been there at the time of treatment I can only rely on what I see in the x-rays.

Was the treatment plan proposed appropriate given Dr [A's] presentation?

My opinion is that the treatment plan proposed was entirely appropriate for Dr [A]. In page 65[1] of the information memorandum provided by the Commissioner it is stated that Dr [A's] headaches had reduced considerably which is a clear indication that Dr [B's] treatment was having a beneficial affect that was measurable.

Were there any alternative treatments available that Dr [B] should have made Dr [A] aware of?

There are alternative treatments available that can be classified as either palliative or permanent.

The permanent treatments fall into 2 categories which are either treatments as Dr [B] recommended or surgical interceptive treatments.

Palliative treatments involve heat therapy on a regular basis, jaw opening exercises, massage of the muscles of mastication and combined with the use of a flat plane nocturnal splint. Palliative treatments as such are a[n] on-going treatment modality

[1] Dr B's statement of 23 January 2002 which includes the note "… his headaches, which had significantly reduced …"

that is designed to relieve symptoms as they flare up – was Dr [A] prepared for this? I cannot tell from the notes if this was discussed or not as there is no mention of this but Dr [B] did discuss with Dr [A] (23/1/02 – the last visit of Dr [A] to Dr [B]) the possibility of a nocturnal splint which he said may help Dr [A] (page 65 in the information memorandum[2]).

What are the risks, short-comings and side-effects of the treatments implemented by Dr [B]?

The risks of treatments implemented by Dr [B] are that the patient does not follow instructions fully i.e. the wearing of the appliances full time and as such comfort is a problem as is speech. Removable appliances need to be worn full time in order that the patient may adapt to them so that speech and comfort become acceptable. Patients that are non-compliant never adapt successfully to the appliances. A further risk is that the patient may have a cranial suture or sutures that are fused and thus treatment does not progress (recent scientific literature tends to show that fusion is the exception rather than the normal) and thus there are no resolution of symptoms.

Short-comings of the treatment are again the compliance situation, that treatment does take time to carry out successfully, that appliances may break and require repair periodically.

Side-effects of treatments implemented by Dr [B] are that wires may break or come adrift and thus causing ulceration and discomfort – these are dealt with by the issuing of wax and instruction of how to deal with the problems. Speech impediment is another side-effect that generally disappears with the patient using the appliances 24 hrs per day 7 days a week without exception. I draw a similar parallel to patients that have a new upper and lower full dentures made – initially they have all sorts of problems with speech and eating and many return complaining of these problems and again these problems do disappear. But unlike orthodontic appliances patients with dentures cannot simply take the denture out and function and thus are forced to wear the new dentures permanently and thus adapt.

Were there any options other than termination which could have been raised by Dr [B] at the meeting of 23 January 2002?

My opinion is that termination of the treatment was the only option as Dr [A] clearly demonstrated that he was unable or was not prepared to comply with Dr [B's] instruction for treatment. Dr [B] had already tried an alternative option which was not acceptable to Dr [A].

[2] Dr B's statement of 23 January 2002 which includes the note "I said that the only alternative was to make a night splint …"

Once advised that an occlusal splint had come loose, how quickly would you expect a dentist to see his patient?

All patients with treatments such as what Dr [A] had done are given wax to help when minor emergencies such as this one that happen from time to time and it is evident that in Dr [B's] notes that Dr [A] was given wax and instructed in its uses. There are also dental accident and emergency clinics that are quite capable of temporarily fixing a situation like this if there was discomfort present to Dr [A] if a situation occurred over weekend or whilst a the dentist was away. Dr [B] in his formal response to the Commissioner's enquiries states that his home telephone number is listed and he is available for emergencies after hours (page 27 information memorandums, bullet points numbers 37 and 38[3])

My opinion is that a patient with this sort of problem should be seen after reporting the problem within the approximately 7 days if possible as the problems are minor in nature and the use of wax will relieve discomfort but the timing of what is acceptable to what is not will vary from practitioner to practitioner (see item 5 in discussion)

Discussion

There are several other issues that need to be commented on:-

1) Cranial suture fusion. When I graduated in 1980 the current thinking was that all cranial sutures fused in adults and now the current thinking and this has come about in the last 10-15 years mostly is that some sutures are designed to fuse completely (e.g. the fontanelle and pre-maxillary) and others are designed to stay non-fused and that the fusion of cranial sutures is the exception rather than normal but sutures with increased age narrow. I have provided a bibliography of articles and a definitive text book that I researched to arrive at this conclusion. I have discussed this concept with several chiropractors who categorical[ly] state that the non-fusion of sutures in adults is normal in those designed to suture.

2) [The oral and maxillofacial surgeon's] opinion that the delegation of orthodontic adjustments to assistants is inappropriate is in my opinion incorrect. There are many specialist orthodontists in New Zealand and in most other countries depending on the legislation that delegate[s] the adjustment, placement and maintenance of orthodontic fixed and removable appliances to auxiliaries – this situation in the United States is the normal.

3) Is this type of treatment in the realms of a general dental practitioner? The treatment of temporo-mandibular dysfunctional problems at present is not a formally recognized sub-speciality of dentistry and the practitioners that start

[3] Dr B's letter to the Commissioner of 13 August 2003

treating these problems come from different backgrounds. Some practitioners around the world come to this type of treatment from a specialist background but the majorities come from a general dentistry background as these forms of treatments need a wide varied of skills. Three 'leading lights' in the provision of temporo-mandibular dysfunction treatments are Gelb, Stack and Voss in the U.S.A. and these three all came from a general practitioner's background but the general practitioner and the specialist that have an interest in this type of treatment must educate themselves by attending relevant programmes in the field. In the U.S.A. it appears the majority of treatments in this field are performed by general practitioners – it certainly is the case in New Zealand.

4) Dr [B's] records were excellent and very detailed.

5) A Peer Review Committee Hearing of the New Zealand Dental Association may have been be more useful to the Commissioner as mine is only one independent opinion whilst a Peer Review Committee will have three independent peers of Dr [B's] on it and a layperson. I am surprised that [the oral and maxillofacial surgeon] did not make this comment.

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There are other articles on cranial sutures that I have not listed for the sake of brevity"

On 4 March 2004 Mr Lovrich provided additional advice when asked by my investigation staff whether the diagnosis reached by Dr B was appropriate. Mr Lovrich advised:

> "Yes. It was.
>
> I was actually very impressed by [Dr B's] diagnostic protocol. I used to be chairman of a peer review committee and the information gathered by him went far beyond what most other people would collect."

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 –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Opinion: Breach – Dr B

Right 6 of the Code of Health and Disability Services Consumers' Rights (the Code) affirms a patient's right to receive information about his or her condition, including options for treatment and the associated risks and benefits.

Infected and impacted wisdom tooth
After terminating his relationship with Dr B, Dr A found that he had an impacted and infected lower right wisdom tooth. The oral and maxillofacial surgeon advised Dr A that the impacted wisdom tooth should have been identified by Dr B in the panoramic

radiograph he took in April 2001. Dr B stated that he did observe that the tooth was impacted, but that there was no sign of infection.

The oral and maxillofacial surgeon commented that it would have been normal practice in the case of noting an impacted wisdom tooth for the clinician to advise the patient of the presence of this condition and outline the problems it might cause in the future. My advisor, Dr Lovrich, said that the X-rays taken by Dr B do not show any sign of infection, but do demonstrate that the lower right wisdom tooth was impacted. In the normal course of events, my advisor would expect the dentist to have discussed this with his patient. Many people in the community have similar teeth and choose to do nothing about them.

In my opinion, Dr A was not given the chance to make a decision about whether to have his impacted wisdom tooth treated. Having detected that the wisdom tooth was impacted, Dr B should have brought this to Dr A's attention and advised him of the problems that it might cause in the future. In the circumstances, Dr B failed to provide his patient with an explanation of his condition and the options available. Accordingly, Dr B breached Rights 6(1)(a) and 6(1)(b) of the Code.

Information about alternatives to proposed treatment

Dr A complained that before commencing a three-year course of orthodontic treatment, Dr B did not provide any information about alternative treatments. The oral and maxillofacial surgeon and my advisor both explained that a range of palliative treatments are available that could have been used to treat Dr A's symptoms. They include regular heat therapy, jaw opening exercises, massage of the muscles of mastication and use of a flat plane nocturnal splint. My advisor also suggested that medication such as non-steroidal anti-inflammatory drugs and/or muscle relaxants, and lifestyle changes and the use of stress relaxation methods, could have been used. Another permanent treatment option would have been surgical interceptive treatment.

Dr B advised me that Dr A was not seeking, and he did not offer, palliative treatment. Dr A was a medical practitioner and therefore would have known how to treat painful joints and provide pain relief for muscle fatigue. I do not accept these reasons as an excuse for failing to discuss palliative options with Dr A. It appears that Dr B made an assumption about Dr A's knowledge, without confirming his assumption. There was also another permanent treatment option available to Dr A, in the form of surgical interceptive treatments. Dr B had an obligation to inform Dr A about this option and to explain what it entailed. The course of treatment Dr B proposed was lengthy, expensive and demanding and the onus on him to ensure that Dr A was aware of other options was therefore commensurately greater.

In addition to a verbal discussion, it would have been useful to include information about alternative treatments in the report Dr B completed for Dr A on 14 May 2001, which included a description of the treatment plan and an outline of some of its difficulties.

On 23 January 2002, when Dr A told Dr B that he could no longer continue with the treatment, Dr B discussed the use of a night splint as a palliative treatment but told Dr A that the orthodontic treatment he had prescribed was the only way to successfully treat the

condition and that the treatment was nowhere near finished. Dr A complained that at this point Dr B should have made him aware that there were other options and should have been more receptive to his suggestion that a night splint be used.

My advisor commented that termination of treatment was the only option at the final consultation with Dr B, as Dr A had clearly demonstrated that he was unable or not prepared to comply with the instructions for treatment. However, Dr A complained that the termination was abrupt and that he was not advised of alternative options for treatment. Clearly the final consultation was emotionally charged. However, in my opinion, before terminating treatment Dr B should have advised Dr A of all the other avenues for treatment available to him, including palliative options and surgical interceptive treatments.

Every patient has the right to an explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option. In the circumstances Dr B failed to ensure that Dr A was sufficiently informed about the treatment options available to him and therefore breached Right 6(1)(b) of the Code.

Shortcomings, risks and side effects of the proposed treatment
Prior to commencing treatment Dr B completed a report to Dr A which outlined some of the risks and side effects of the proposed orthodontic treatment. The report of 14 May 2001 stated that Dr A would initially have difficulty speaking with his appliances and that a small amount of discomfort is normal in the first week or two. The report stressed the need to care for his appliances and his teeth. Dr B stated that he also briefed Dr A in person about the discomfort he might experience as a result of treatment, and his responsibilities with regards to wearing and caring for his appliances.

Dr A complained that he was not told about the risks and potential shortcomings of the proposed treatment. He stated that while he was told about the potential for discomfort and problems speaking, he felt Dr B trivialised them. He also stated that he was not told that the wires placed in his mouth might break and required constant adjustment.

My advisor noted that the risks, side effects and shortcomings of Dr B's proposed treatment included:

- the appliances need to be worn full-time in order that the patient can adapt to them so that speech and comfort become acceptable
- if the patient has a cranial suture, or sutures, that are fused then the treatment would not progress
- the treatment takes time to be successful
- appliances may break and require care periodically
- wires may come adrift and can cause ulceration and discomfort.

Dr A was clearly surprised and distressed by the level of pain he experienced. Although Dr B did warn Dr A that he might experience some discomfort and have a temporary problem with speech, and that he needed to take care of his appliances and wear them constantly, Dr B should have taken greater care to warn Dr A that he could find the appliances painful. Dr

B should have discussed the effect fused cranial sutures might have and warned Dr A about appliance and wire breakages. In the circumstances, Dr B's failure to explain the expected risks and side effects of treatment was a breach of Right 6(1)(b) of the Code.

Opinion: No Breach – Dr B

Introduction
Under the Code Dr A had a right to receive dental and orthodontic services from Dr B provided with reasonable care and skill.

There is a divergence of views within orthodontic practice. Dr B practises functional orthodontics, a variation of practice that is not supported by many specialist trained orthodontists. The oral and maxillofacial surgeon clearly believes that the treatment prescribed and partially completed by Dr B for Dr A was not ideal. It is, however, not unusual to encounter varying opinions about decisions for orthodontic treatment. It is important to note that no judgement is being made in this report about the merits or otherwise of functional orthodontics.

In forming my opinion about the standard of clinical care provided by Dr B, I have been guided by Dr Lovrich, an independent expert functional orthodontist and a peer of Dr B.

Diagnosis
Dr A visited Dr B on 28 March 2002 because he was concerned about teeth-grinding and pain in his temporomandibular joint. Dr B examined Dr A and diagnosed retroclination of the anterior teeth causing malocclusion, incorrect jaw posture and temporomandibular joint dysfunction. Dr A advised me that he now believes that this diagnosis was doubtful. The oral and maxillofacial surgeon's view is that patients may experience temporomandibular joint dysfunction irrespective of whether they have a malocclusion. He stated that the teeth-grinding experienced by Dr A is a common cause of temporomandibular joint overload and pain, and that it can be treated with a range of simple and effective treatments.

However, in my advisor's view Dr B conducted an extremely thorough review of Dr A's condition and his diagnosis was appropriate.

Treatment plan
Having made a diagnosis, Dr B proposed treating Dr A with appliances made of acrylic and fixed orthodontic wires. The oral and maxillofacial surgeon advised Dr A that his teeth-grinding could have been treated with a range of simple and effective treatments rather than the three-year course of orthodontic treatment planned by Dr B. My advisor, Dr Lovrich, commented that the plan was entirely appropriate for Dr A.

Tests and radiographs taken prior to treatment
Dr A complained that Dr B did not undertake sufficient testing or examination before commencing treatment. In particular, Dr A was concerned that adequate radiographs were not taken. The oral and maxillofacial surgeon advised him that Dr B's records make no

reference to an accurate bite registration or to the use of orthodontically trimmed study models.

Dr Lovrich advised me that Dr B conducted an extremely thorough review of Dr A's condition, and exceeded what is normally appropriate in such cases because he provided a joint vibrational analysis and frontal PA skull X-ray. Models are usually orthodontically trimmed to ensure that the bite can be clearly reproduced each time the models are looked at. My advisor explained that while the models taken of Dr A's mouth were not orthodontically trimmed and no accurate bite registration was taken, the bite was very easy to determine from the models taken because of the large amount of interdigitation between the upper and lower teeth. Therefore it was not necessary to trim the models or complete an accurate bite registration.

Remedial treatment

Dr A complained that Dr B did not provide treatment in a timely manner when his occlusal plate broke after being installed on 14 December 2001 and that he had to wait several days before Dr B would repair his plate. Dr B advised me that he was not contacted by Dr A about the problem. He said that if his clinic had been contacted then there is always someone available to provide emergency treatment and that he is available for emergencies after hours.

In my advisor's view, the problem experienced by Dr A was minor in nature and the wax provided by Dr B should have alleviated discomfort. A patient should be seen for treatment of such a problem within seven days of reporting it. Although I am unable to establish when Dr A contacted the dental clinic about his broken occlusal plate, both Dr A and Dr B recall that it was repaired several days after it broke on 14 December 2001. On this basis I am satisfied that Dr B did repair the broken plate within one week of the problem being reported to him.

Summary

While I acknowledge the oral and maxillofacial surgeon's comments, I accept Dr Lovrich's advice that Dr B's clinical practices in treating Dr A were appropriate. For the reasons outlined above, in my opinion Dr B provided services with reasonable care and skill in relation to his diagnosis, his treatment plan, the delegation of duties to other staff, the tests and radiographs he took prior to treatment and the steps he took to repair Dr A's broken occlusal plate. In these circumstances, Dr B did not breach Right 4(1) of the Code.

Other comment

Supervision of employees
Dr A complained that Dr B delegated the job of adjusting his orthodontic appliances to an assistant, resulting in an occlusional plate being installed inappropriately on two occasions. The oral and maxillofacial surgeon advised Dr A that it is important that the orthodontist or dental practitioner responsible for orthodontic treatment makes any adjustments himself. Dr B stated that he monitors all treatment and that his assistants are trained and experienced at placing appliances under his supervision. Dr Lovrich advised me that the oral and maxillofacial surgeon's opinion is not correct and that many specialist orthodontists in New Zealand depend on legislation that allows for the delegation of auxiliaries to adjust, place and maintain orthodontic fixed and removable appliances.

Advice obtained from the Dental Council of New Zealand (the Council) is that section 11 of the Dental Act 1988 allows for the delegation of some responsibility for dental procedures to unregistered practitioners. However, the Council has not been asked to rule whether section 11 allows for delegation to adjust, place and maintain orthodontic fixed and removable appliances. I am advised by the Council that in practice such delegation does occur in New Zealand.

Regulations for the delegation of invasive and/or irreversible dental procedures are intended to be made under the Health Practitioners Competence Assurance Act, which will come into effect in September 2004.

Given the lack of certainty around the appropriateness of the delegation of responsibility to auxiliaries and the pending legislative changes, I do not consider it appropriate to take any further action in relation to this aspect of Dr A's complaint.

Actions taken

Dr B has:

- Apologised in writing to Dr A for breaching the Code.
- Developed new protocols and hand-outs to ensure that he (or his staff) provide sufficient oral and written information prior to any proposed course of treatment to comply with his obligation to adequately inform his patients, and to enable them to make an informed choice about a proposed treatment.
- Reviewed his practice in light of this report.

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.

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