Dentist, Dr B

Dentist, Dr C

A Report by the

Deputy Health and Disability Commissioner

(Case 10HDC00671)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

Complaint

1. Mrs A complained about the treatment provided to her by two dentists in April and May 2010. In particular, she considers that she was pressured into unnecessary treatment, and provided with insufficient information regarding her options, the proposed treatment, and treatment costs. She also has concerns that treatment was not carried out to an appropriate standard.

Background

2. On 19 April 2010, Mrs A consulted dentist Dr B at a dental practice. Dr B diagnosed Mrs A with attrition[1] and recommended that Mrs A have ceramic crowns put on her back teeth (initially five teeth).

3. During the initial consultation, a second opinion was sought from Dr C. He confirmed Dr B's diagnosis and agreed with her treatment plan. Mrs A was told that the cost of the five crowns would be $7000. Mrs A and her husband left the dental surgery to discuss the proposed treatment.

4. Mrs A returned the same day, having decided to proceed with the treatment. Two other patients were rescheduled so that Dr B could commence Mrs A's treatment that day. Dr B began preparing Mrs A's teeth for the crowns. Study models and diagnostic wax-ups were not made. Dr C finished the preparation and fitted temporary crowns on six teeth.

5. Mrs A consulted a dentist in her home town after losing part of a temporary crown. She became increasingly concerned that she had commenced a course of treatment that was unnecessary.

6. Mrs A returned to the dental practice on 3 May 2010 to have the permanent crowns cemented into place. A dispute arose with regard to the information and standard of care provided to Mrs A on 19 April. It was agreed that Mrs A would not have the permanent crowns fitted that day. As an interim measure, Dr C replaced Mrs A's temporary crowns. The situation was still unresolved when Mr A left the surgery, taking the permanent crowns with him. Mrs A left shortly afterwards. Mrs A later returned the crowns to the dental surgery, and completed her treatment at another dental practice.

Findings

7. There were multiple discrepancies between the accounts of events provided by those present.

8. However, the Deputy Commissioner found that Dr B failed to give sufficient, accurate or consistent information about the selected treatment and its cost, and therefore

[1] Attrition is the wearing down of teeth by friction.

breached Right 6(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

9. As Mrs A was not provided with adequate information, she was unable to give informed consent to the proposed treatment. This was exacerbated by the fact that treatment was commenced on the same day it was proposed, which did not allow Mrs A sufficient time to consider the proposed treatment. The Deputy Commissioner found that Mrs A did not give informed consent to the treatment and Dr B breached Right 7(1) of the Code.[3]

10. Dr B did not make study models and diagnostic wax-ups. The Deputy Commissioner found that this represented an inadequate level of planning and preparation and Dr B breached Right 4(1) of the Code.[4]

11. Dr B's documentation was not in accordance with professional standards. In these circumstances, Dr B breached Right 4(2) of the Code.[5]

12. Dr C failed to ensure that Mrs A had given informed consent before providing her with treatment, and therefore breached Right 7(1) of the Code.

13. Dr C should have ensured that adequate planning and preparation had taken place before commencing treatment on Mrs A. In failing to do so, Dr C breached Right 4(1) of the Code.

14. The Deputy Commissioner also made adverse comment about Dr C's handling of Mrs A's complaint.

Complaint and investigation

15. On 14 June 2010, the Commissioner received a complaint from Mrs A about the services provided by Dr B and Dr C. Mrs A complained that she was pressured into agreeing to a course of treatment that she did not need. She states that the treatment, options, and costs were not fully explained to her at the outset. Mrs A states that the permanent crowns made for her were too large and the wrong colour. In addition, she considers that the dentists reneged on an agreement to resolve the dispute that arose, and discouraged her from reporting her concerns to HDC.

[2] Right 6(2) — Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice and give informed consent.
[3] Right 7(1) — Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
[4] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill.
[5] Right 4(2) — Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

16. An investigation was commenced on 19 January 2011. The following issues were identified for investigation:

- *The appropriateness of the treatment provided by dentist Dr B to Mrs A from 19 April 2010 to 3 May 2010.*
- *The adequacy of the information provided by Dr B to Mrs A, and the steps taken to obtain informed consent.*
- *The appropriateness of the treatment provided by dentist Dr C to Mrs A from 19 April 2010 to 3 May 2010.*
- *The adequacy of the information provided by Dr C to Mrs A, and the steps taken to obtain informed consent.*

17. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Mr A	Consumer's husband
Dr B	Dentist
Dr C	Dentist
Ms D	Dental practice administrator/ dental chair-side assistant

18. Information was reviewed from Mrs A, Mr A, Dr B, Dr C, Ms D, and ACC.

19. Independent expert advice was obtained from dentist Dr Daniel McGettigan (**Appendix 1**).

20. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Information gathered during investigation

21. There are multiple discrepancies between the accounts of events provided by the parties to this investigation. For clarity, I have first briefly summarised the undisputed facts, followed by a chronology of the events, including the opposing accounts of each party in relation to key issues.

Overview

22. On 19 April 2010, Mrs A attended a dental practice for an appointment with dentist Dr B.[6] Mrs A was accompanied by her husband, Mr A. Dr B examined Mrs A's teeth and diagnosed attrition. Dr B recommended that Mrs A have ceramic crowns fitted to five of her back teeth. Dr B sought a second opinion from her husband, dentist Dr C,

[6] At the time of Mrs A's treatment at the dental practice, Dr C and Dr B were the sole directors.

who also practised at the dental practice. Dr C confirmed Dr B's diagnosis and agreed with her treatment plan.

23. Mrs A and her husband left the dental practice to consider the proposed treatment. They returned to the practice later the same day, having decided to proceed with the treatment that day. Six teeth were prepared for crowns, and six temporary crowns were fitted.[7] This work was started by Dr B and completed by Dr C. Other treatment options were not documented, and study models and diagnostic wax-ups were not made.[8]

24. On 3 May 2010, Mrs A returned to the dental practice, accompanied by Mr A. A dispute arose with regard to the information and standard of care provided to Mrs A on 19 April. Efforts were made to resolve the dispute, which were unsuccessful. Dr C replaced Mrs A's temporary crowns. Mr A took the permanent crowns and left the surgery, and Mrs A left soon afterwards. The crowns were returned to the surgery by courier at a later date.

Initial consultation — 19 April 2010

25. On 19 April 2010, Mrs A attended the dental practice for an appointment with Dr B.

26. This was Mrs A's first appointment at the surgery. Her husband had been a patient at the practice for about three years and also had an appointment with Dr B on 19 April. The practice is in the North Island, and Mr and Mrs A live in the South Island. Mrs A, Dr B and Dr C all speak the same foreign language, and had Mr and Mrs A's preferred payment option, which Mr A had used in the past.

27. Mrs A states that she made the appointment at the dental practice in order to have a sensitive tooth checked, and to have a slightly raised filling cut down. She states that she had been thinking about having her teeth whitened but, aside from this, she was not considering any other cosmetic work.

28. Dr B understood that Mrs A made an appointment because she had a problem with one tooth, and wished to talk about having some cosmetic work.

29. The dental practice's electronic appointment book shows that Mrs A's appointment was booked for 9.30–10.30am. Dr B had other patients scheduled from 10.30am–12.30pm, and from 2–3pm. Mr A had an appointment booked for 3–5.30pm.

Diagnosis and proposed treatment

30. Dr B states that she performed a full examination, and that Mrs A expressed a wish to "rehabilitate her entire smile". Dr B told Mrs A that she had "severely worn dentition with almost no enamel on the cusps of her molars". Dr B says she explained that before undertaking cosmetic restoration of Mrs A's front teeth, they would need to

[7] Preparation involves trimming and shaping the teeth so that the crowns can be made to the requisite thickness. An impression is then taken, which goes to a dental laboratory where the crowns are manufactured. Temporary crowns are fitted to protect the teeth in the meantime.

[8] Diagnostic wax-ups involve creating a model by applying wax to an impression of the patient's teeth (study model), to show the expected results of the planned restoration or repair.

address the problem of her attrition. This meant building up the worn back teeth to increase their vertical dimension, thereby creating space for veneers on the front teeth. Dr B says she described how the attrition was affecting Mrs A's teeth and her labiomental appearance,[9] and showed her that the height of the lower third of her face was not in balance.

31. Dr B states that during this consultation, radiographs were taken and she was able to show Mrs A on the X-rays that previous composite restorations of her molars had worn down. The X-rays also showed one cavity (tooth 25), and a tooth with a root canal filling that had not been crowned (tooth 26).[10]

32. In her initial response to this complaint, Dr B stated that she outlined the following treatment plan to Mrs A:

- ceramic crowns on teeth 17, 27, 36, 37 and 47 (molars);
- composite or ceramic restorations on teeth 14, 15, 16, 25, 26, 35, 44, 45 and 46 (three molars and six pre-molars) to increase or "build up" the vertical dimension; and
- Mrs A could then have composite or ceramic veneers on her front teeth.

33. Dr B states that two other treatment options were discussed. She says that she told Mrs A that she could have composite restorations rather than ceramic crowns on her back teeth, although there was no guarantee that these would last. Given that Mrs A's previous composite restorations had worn down, Dr B considered ceramic crowns were the best long-term option. The third treatment option was just to fill the cavity in tooth 25.

34. Dr B states that she told Mrs A that her teeth were not rotting, and explained many times that the proposed treatment was only necessary if Mrs A wanted cosmetic work in the future. Dr B believes that Mrs A understood this.

35. Dr B states that she spoke to Mrs A in both English and their shared foreign language. Dr B states that she spoke in English at first, but that if Mrs A asked a question in her own language, she replied in the same language, particularly to explain specialised terms. Dr B also states that the treatment plan was explained in English for the benefit of Mr A, who was present during the consultation. Dr B recalls that the appointment took about one hour.

36. Mrs A states that "before I even got on the dentist chair", Dr B told her that her enamel had disappeared, her teeth were worn, and she did not have "the right bite". Mrs A states that Dr B told her immediately that she needed crowns, and that without them she would get wrinkles around her mouth, and her lips and mouth would get smaller. Mrs A says that when she asked Dr B if crowns were necessary and whether she could just have fillings, Dr B said fillings would not stay in her mouth, there was not enough space, and her teeth were already worn. Mrs A believes Dr B told her that

[9] Relating to the lower lip and chin.
[10] The numbers correspond to specific teeth, according to the FDI World Dental Federation dental numbering system.

the treatment was urgent and without it her mouth would collapse. Mrs A recalls that her discussion with Dr B was almost entirely in their shared foreign language, and that neither Mr A nor Dr B's assistant were present during this initial discussion. Mrs A also states that X-rays were not taken until later, when she returned to the practice to commence treatment.

37. Dr B denies telling Mrs A that her face would collapse if she did not have treatment immediately.

38. The practice administrator and dental chair-side assistant, Ms D, states that she was present throughout Mrs A's appointment with Dr B. Ms D recalls that much of the discussion was in their shared foreign language, but that the diagnosis and treatment were also discussed in English with Mr A. Ms D states that Mrs A's initial concern was to have an aesthetic makeover of her front teeth, and that Dr B explained that they would first need to address the problem of her worn back teeth. Ms D states that Dr B was able to show Mrs A on the X-rays that composite fillings had been done before but had worn down. Dr B therefore recommended ceramic crowns on the back teeth as the best option. Composite material could be used to build up the other teeth. Ms D states that Dr B explained that there were several treatment options.

39. Mrs A and Dr B agree that Dr B asked Mrs A whether she was aware of "grinding" her teeth at night. Dr B talked about the need for Mrs A to wear a nightsplint or mouthguard once the restoration work was complete.

Second opinion — Dr C

40. Dr C was with a patient in another treatment room when Dr B asked him to come and give a second opinion on Mrs A's teeth. Dr C looked at Mrs A's teeth, and agreed with the treatment plan proposed by Dr B. Dr C states that this was on the basis that Mrs A wanted cosmetic work in the future. He states that when he went into Dr B's treatment room, Mr A was also present. He believes that Mrs A and her husband were fully informed about the proposed treatment.

41. Mrs A states that Dr C also said that she needed crowns, that without these she would get wrinkles and that there was no alternative. She says that they told her that she was "a beautiful girl", that without crowns her mouth would collapse, and that she needed treatment urgently. Mrs A states that Dr C told her that in order to fit the crowns, they would need to remove about half a millimetre from around the sides of the teeth, and perhaps a little from the top of one tooth. Mr and Mrs A state that Mr A was not present when Dr C came in to give his opinion.

42. Dr C denies telling Mrs A that she would get wrinkles and that there was no alternative treatment. Dr C returned to his treatment room after offering his opinion.

Verbal information about costs

43. According to Mrs A, Dr B asked: "Do you have money?" When Mrs A asked how much the treatment would cost, Dr B told her that because of where Mrs A was from she would do a good deal — $3500 by their preferred payment option and $3500 cash, for five crowns. Mrs A said she would need to talk to her husband. She states

that Dr B then told her that she had already cancelled her other patients for the day, in order to start Mrs A's treatment.

44. Dr B denies asking Mrs A if she had money as Mrs A has alleged, and states that the treatment costs were discussed with Mr and Mrs A. It was agreed that Mrs A would pay $7000 for five crowns. Dr B states that at this time, the cost of building up other molars and premolars was an estimate, as until the crowns had been cemented into place they did not know how many other teeth would need work. In addition, they had not decided whether the other teeth would be built up with composite or ceramic material. However, Dr B states that Mrs A was told that composite restorations cost $250 to $300 each, and ceramic restorations cost $1000 to $1200 each.

45. Dr B states that she and Mrs A did not specifically discuss the costs of veneers on the front teeth, aside from the fact that ceramic veneers would be more expensive than composite veneers.

Written treatment plan

46. Dr B and Ms D state that a written treatment plan was printed out and given to Mrs A.

47. During an interview with HDC staff, Dr B stated that the written treatment plan given to Mrs A would not have shown the second stage of the treatment — the build up of other molars and premolars — because until they fitted the crowns on the molars they would not know how many other teeth needed work.

48. Dr B subsequently stated that the written treatment plan would have included the information showing under "Current Treatment Plan" in the clinical records (see **Appendix 2**). This lists six ceramic crowns and seven composite restorations. Dr B stated that although this treatment plan showed composite restorations, no decision had been made at that time as to whether they would use composite or ceramic material for these. Dr B explained that the prices shown on the written treatment plan were not clearly legible because of a fault with the practice's software, which meant the tooth number at the beginning of each line was repeated at the end of the line and overlapped the price. The price for each of the composite restorations was $285. No prices were shown for the ceramic crowns.

49. In her response to my provisional opinion, Dr B states that Mrs A preferred composite restorations, because these were cheaper. She states also that the treatment plan included an estimate for composite restorations only, and did not include an initial estimate for cost of ceramic veneers to the front teeth, because Mrs A asked for this information to be omitted from the treatment plan as she was concerned that Mr A would refuse to pay for the treatment because of its expense.

50. Mrs A denies that she was given a written treatment plan. She also denies asking Dr B not to set out the full cost of her treatment because she was concerned her husband would not pay if he knew the cost. Mrs A states that she and her husband trust one another, and she considers any suggestion that she acted in this way to be insulting. Mrs A's recollection is that this initial consultation lasted 15–20 minutes, followed by a further 20 minutes while she waited for her husband to arrive. She states that during

this time, she and Dr B continued to talk about the treatment, and about other things. The treatment was then discussed with Mr A.

Decision to proceed

51. According to Ms D, Dr B told Mrs A that if she wanted to go ahead with the treatment, they would see what they could do about starting her treatment that day. Ms D states that Mr and Mrs A were concerned about the cost, and Mr A asked about ways of arranging the treatment and appointments to minimise this.

52. Mr A states that he was not present for his wife's initial consultation with Dr B, and that he became involved in the discussion when his wife and Dr B were talking in the reception area. Mr A states that Dr B showed him his wife's mouth, and said that if she did not have urgent work — crowns — the lower third of her face would collapse, she would get wrinkles, and she would look odd. He states that he was stunned and shocked, and that "the pressure came on". They were told it had to be done that day, and that other patients had been cancelled in order to start his wife's treatment.

53. Mr and Mrs A left the dental surgery to discuss what to do. Mr A recalls that he and Mrs A went to a nearby café to talk about the proposed treatment. Mr A states that his wife was "worked up about it, in a frenzy and upset". Mr A felt under pressure from the dentists and from his wife. He states that he thought: "I have a credit card, and if it's that urgent, let's do it."

54. According to Ms D, Mrs A telephoned a couple of hours after she and Mr A had left the surgery, to say she wanted to commence treatment that day. Ms D states that she passed the telephone to Dr B, who agreed to reschedule her afternoon appointments in order to start Mrs A's treatment.

55. Dr B initially stated that Mr and Mrs A had telephoned at around 12–12.30pm to say that Mrs A wished to go ahead with the proposed treatment, and that she wanted it to start that day. Dr B said that she knew that Mr and Mrs A had travelled up from the South Island, and she therefore agreed to reschedule the patients booked that afternoon to make time for Mrs A. Dr B subsequently provided HDC with information from the dental practice's electronic appointment book, and confirmed that it was the patients booked at 10.30 and 11.30am who were rescheduled so that Mrs A could begin treatment.

56. Dr B had other patients scheduled from 2pm. It was therefore agreed that Dr B would start the preparation of Mrs A's teeth, and that Dr C would continue the treatment when he had finished with his scheduled patients.

57. In response to Mrs A's allegation that she was pressured into treatment, Dr C told HDC that they gave Mrs A and her husband the options, "we did not push them", and "[w]e gave them chance to think". Dr B states that she advised Mr and Mrs A to take their time to consider the treatment and to obtain a second opinion. Dr B states that Mrs A insisted on commencing treatment because she was worried her husband might change his mind about paying for it.

Second appointment — 19 April 2010

58. Mr and Mrs A state that they returned to the dental surgery 15–20 minutes after the end of the initial consultation, having decided to proceed with the treatment. Mrs A believes they were back at the surgery between 10am and 11am. She states that they did not telephone first.

59. Ms D recalls that Mr and Mrs A returned to the surgery at about 1 or 1.30pm.

60. Mr A states that on their return to the surgery, he asked Dr B three times if there was any other way of doing the work his wife needed, and that she said no.

61. Mrs A returned to Dr B's treatment room, and Dr B began preparing Mrs A's teeth for the crowns.

Diagnostic wax-up

62. Dr B states that she told Mrs A that they needed to do a diagnostic wax-up, but Mrs A said she could not keep travelling between the South Island and the North Island. According to Dr B, Mrs A said, "Guys, I like you, I trust you, just do whatever you think."

63. Mrs A states that Dr B did not discuss diagnostic wax-ups. Mrs A thinks it is quite likely that she told Dr B she liked her and trusted her, but denies she would have said "just do whatever you think".

64. When Dr C was interviewed by HDC staff, he noted that ideally they should have made a diagnostic wax-up. He stated:

> "I know our mistake. That I didn't for example make a diagnostic wax-up. […] Sometimes we need to do that. When we are doing for this sort of restoration ..."

65. When he was asked why this was not done, he said:

> "Because it takes two days. I had to take an impressions. I had to pull the models. I had to send the models to the dental laboratory. They need to come back another extra time. So it's another expense for their treatment. … It was mainly because of that, because they are from another city."

66. He noted that they would definitely have done a diagnostic wax-up for the front teeth.

Sixth crown

67. Dr B states that they had not originally planned to put a crown on the tooth with the root canal filling, but she discussed this further with Mrs A, who agreed that this tooth should be crowned also.

68. Mrs A initially said that she was not told that she needed six crowns instead of five. She subsequently stated that it was possible that Dr B had talked about the sixth crown during the treatment, but at that point she (Mrs A) was in no position to discuss it: she had her mouth open; she was "full of painkillers", and "a bit scared".

Treatment

69. Dr B recalls that she worked on Mrs A's teeth for 1–1½ hours. Mrs A then went through to Dr C's treatment room, where he continued her treatment.

70. Dr C finished preparing Mrs A's teeth, took impressions, and fitted temporary crowns. Dr C believes that his consultation with Mrs A would have lasted approximately 2–2½ hours. Dr C and Mrs A agree that there was some discussion about the fact that temporary crowns can come off relatively easily.

71. According to Mrs A, Dr B started her treatment and was assisted at times by Ms D. Then Dr C came in and took over, with Dr B assisting. Dr B left the room, then returned and said she needed the room for another patient. Mrs A states that at that point, she and Dr C moved into the other treatment room.

72. The clinical record for 19 April states:

> "Pt [patient] has a worn dentition; all molars almost do not have an enamel. 2.5mm overbite. teeth are sensitive to cold. Coverage of molars with crowns recommended and at the same time open the bite to build up posterior teeth. Front teeth have a composite restorations and she wants to restore them with porcelain veneers later. Tx [treatment] plan was given at first appointment. Pt consented to tx."

73. Dr B states that Ms D would probably have completed this note, and that it was usual for her to do this on the basis of the discussion she hears between the dentist and the patient. Ms D believes that the dentist who provided the treatment would have completed the clinical note.

74. Mrs A denies telling Dr B that her teeth were sensitive to cold.

Payment

75. The dental practice's records show two invoices for Mrs A's treatment on 19 April. The first was for the consultation, X-rays, and a scale and clean ($245). The second invoice was for a posterior composite restoration (tooth 25), two glass ionomer restorations (teeth 26 and 27), and six ceramic crowns ($8935).

76. Mr A states that when he went to pay for his and his wife's treatment at the end of the day, he was told that she had needed an extra crown, so the cost of her crowns had increased from the $7000 initially discussed. Mr A paid $1000 cash and $4980 by their preferred payment option, leaving $3200 owing. A separate payment was made for Mr A's own treatment.

77. Dr C and Dr B state that when Mr and Mrs A left that afternoon, there were no problems. They recall that Mrs A seemed happy and said, "Oh we will be like family, like friends."

78. Mr and Mrs A were both scheduled for further treatment on 3 May 2010.

Between appointments

79. After leaving the dental practice on 19 April, Mr and Mrs A went for a meal, during which part of one of Mrs A's temporary crowns came off. She did not do anything about this at the time, as Dr C had warned her that this might happen. Mr and Mrs A returned to their home in the South Island.

80. A few days later, Mrs A lost more pieces of her temporary crowns. She believes that she lost 1½ temporary crowns altogether, and she was shocked when she saw the extent to which the teeth prepared for crowns had been ground down.

81. Mrs A telephoned the practice about the temporary crowns, and was advised to go to a local dentist to have them repaired or replaced. Dr C noted that this was one of the problems with Mrs A being in the South Island, and that had she been in the same city as the practice they could have attended to this at the practice.

82. On 24 April, Mrs A went to Dr E, a dentist in her home town. Dr E noted that Mrs A said that she went to a dentist in the North Island

> "… for an adjustment to a high filling and left two and half hours later having had treatment for six crowns. She indicated that she had been pressured into this treatment and was not aware that she needed this treatment."

83. Dr E examined Mrs A's teeth and noted that the temporary crown on tooth 47 was "… badly worn down and fragile. There are other temporary [crowns] on the 17, 26, 27, 36, 37. These are very thin and did not conform to the tooth margins." He wrote that he considered this to be "a complex case with [severe] occlusal wear of the teeth". Dr E noted that he advised Mrs A to get a second opinion from a prosthodontist, as she was not happy with the treatment she had received, but also to follow through with the treatment as she had already paid a substantial amount to the dentist.

84. Mr and Mrs A state that they had become concerned about the treatment that Mrs A had had at the dental practice in the North Island. On her return to the South Island, Mrs A had contacted the dentist who had treated her in her home country between 2000 and 2009, who said Mrs A did not need crowns or veneers.[11] Mrs A also states that it was only when they were back home in the South Island that she learned from her husband that the account for her treatment on 19 April had increased to more than $9000, because of the sixth crown.

85. Mr and Mrs A decided that as they had already paid more than $5000, Mrs A should return to the dental practice to have the crowns fitted. However, they decided that they would make no further payments and that once the crowns had been fitted they would look at taking legal action.

Third appointment — 3 May 2010

86. Mrs A returned to the dental surgery on 3 May, as scheduled. The practice's electronic appointment book shows that Mrs A was booked with Dr C from 9.30am to 1pm. Mr A was also booked for an appointment with Dr B that day.

[11] Mrs A's dentist in her home country subsequently confirmed this in writing.

87. Mrs A was unhappy and upset when she arrived. There was an initial conversation in the reception area with Dr B and Dr C. Then Mrs A and Dr C went through to his treatment room. The permanent crowns had been manufactured, along with transfer copings.[12]

88. Mrs A states that it was at this time that Dr C told her that in addition to cementing the permanent crowns into place that day, a further six teeth needed building up. He said that the cost of this would be in addition to what had been agreed previously. Mrs A states that she was shocked, and asked why she had not been told this before. Mrs A was also unhappy with the size and colour of the crowns that had been made. She thought that they were too big, and they were not white enough.

89. Dr C, Dr B, and Ms D subsequently advised HDC that the need for work on more teeth had been clearly and repeatedly discussed with Mrs A when the treatment plan was initially agreed on 19 April. Dr C also states that he is at a loss to know why Mrs A would say the crowns were not white enough, because they chose the colour together.

90. Dr C states that Mrs A began "almost yelling and screaming". He states that she accused him of not being professional, and said she would complain to the Dental Council, HDC, and the Human Rights Commissioner if they could not resolve this problem.

91. Dr C and Mrs A discussed how to proceed. The sequence of events at this point is unclear, but at various points, Dr B, Mr A and Ms D were all also involved in the discussion. All parties describe communication that was, at the very least, fraught. However, there is no consensus regarding exactly what was said by whom and in what manner.

92. Dr C explained that he would not fit the permanent crowns if Mrs A was not going to proceed with the next stage of treatment, as she would not be able to bite properly. As the discussion proceeded, he stated that he did not feel he could continue treating Mrs A, as it was clear that there was no trust between them.

93. Mrs A did not want to continue her treatment at the practice. However, she had already paid more than $5000, and her teeth could not be left as they were. Mrs A wanted to take the permanent crowns and have them fitted by another dentist. She also wanted a full refund of the money already paid.

94. At some point on 3 May, Dr B and Dr C signed a typed letter stating:

> "Re: Treatment Plan
>
> [Mrs A] came to our clinic for a full examination on 19/04/10. After this examination appointment the proposed treatment plan was:
>
> Porcelain crowns to be made for teeth 17, 26, 27, 36, 37, 47.

[12] Fittings used to secure the crown to the tooth.

> This was to open the bite to create space to rebuild 15, 16, 25, 35, 45, 46 because of worn dentition. Late[r] we will be able to restore anterior teeth with porcelain and composite veneers.
>
> I explained that if there will be sensitivity with the crowned teeth in the future, root canal treatment will be needed.
>
> We explained this treatment plan to [Mrs A] to the best of our ability and we started with her consent. We did not commence treatment immediately during her appointment, but [Mrs A] was given time to think and returned to make an appointment."

95. It was agreed that Mrs A was not going to have the permanent crowns fitted at the dental practice that day. Dr C made a new set of temporary crowns as an interim measure.

Agreement to refund

96. Dr C states that he initially agreed to give Mrs A the permanent crowns and refund the fees already paid. He states that this offer was made on the condition that Mrs A confirm in writing that she would not make a complaint or take the matter any further. Dr C wrote out a refund voucher, put this in an envelope and gave it to Mr A. He said that a cheque for $1000 would be sent the following day. Dr C states that when Mrs A began to complain again, he had second thoughts about this offer.

97. Mr and Mrs A state that Dr C agreed to give them the permanent crowns and refund the fees, but that they did not agree that they would not take the matter further. Mr A wrote a letter, signed by Mrs A, stating:

> "I have received a refund of $4980.00… (by signed [voucher]). It is agreed that [the dental practice] will pay $1000.00 as way of refund by cheque to us in the next few days. It is agreed that [the practice] will give [Mrs A] the crowns."

98. Dr B's understanding is that Dr C offered to refund the fees *or* give Mrs A the permanent crowns.

99. According to Dr C and Dr B, while they were in the reception area discussing the situation further with Mrs A, Mr A was in Dr C's treatment room. They then discovered that Mr A had left the practice, taking the permanent crowns. He left the transfer copings and the refund voucher. According to Mr A, Dr C was in the room when he took the crowns.

100. A few minutes later Mrs A received a telephone call from her husband, and she then left the practice.

Documentation on 3 May

101. The clinical record for 3 May states:

> "Pt came into the clinic. Without greeting she started to screamed and yelled on me. She said that we did not explained her everything which is not true. She

> started to threaten that I will [lose] my dental registration. I felt abused and did not want to carry on treatment for her. She asked to cement crowns only. I told her that posterior teeth will need to be built up at the same time otherwise she is not able to eat because of her opened bite. I spoke with her husband [Mr A] re this. I told her that I will refund money and given them the crowns if she will give me a letter that she will not take any action against me. Voucher $4980…given. Told that cheque $1000 send them by post because the cheque book was unavailable. She continued to threaten me telling me that she will be taking me to court. I decided to keep the crowns and asked her to calm down. I wanted to help her, but she was so aggressive. I remade temporary crowns with better fit using porcelain crowns as mock-up. We then decided to sign a mutual agreement letter. While pt and I were at the reception area discussing this — her husband who was in the surgery at the time disappeared along with the crowns which were left on the surgery bench. Transfer copings for the crowns were not taken. Pt on knowing that her husband had taken the crowns without our consent or her acknowledgment decided to abandon further treatment and discussion on the matter."

Subsequent events

102. On 5 May, Mrs A consulted, another dentist, Dr F in her home town. Dr F noted that Mrs A had presented with six temporary crowns and brought with her the six permanent crowns. His clinical note includes: "wear on teeth — very heavy with enamel erosion", "defective restorations — watch 46, 45", and "cosmetic concerns — whiter, golden proportions".

103. In correspondence to ACC, Dr F noted that he was able to offer Mrs A two treatments:

> a) to remake the six crowns and prepare the occlusal surface[13] of the teeth more so that the crowns would be thick enough but still fit within her existing bite; or
>
> b) to fit the existing crowns and make veneers with occlusal coverage 16–25 to open the bite 2mm, to match the crowns and improve the aesthetics of the upper teeth.

104. Dr F noted that he advised against composite coverage on the lower teeth, as he felt it would be technically difficult to deliver a satisfactory result, and the prognosis of the composite in this situation would be poor.

105. On 8 May, Mrs A consulted another dentist in the North Island, Dr G. Dr G noted that Mrs A had the permanent crowns with her. Dr G noted: "[I] have advised that this kind of job in my opinion is of serious matter and [I] am unable to help her as [I] strongly advise specialist — prosthodontist [advice] and treatment. … The problem is beyond my professional ability to help her. [Wishes] to bleach front teeth …"

106. On 10 May, Mrs A wrote to the dental practice, requesting the refund that she states was agreed on 3 May. On 11 May, Ms D responded on behalf of the practice. She

[13] The grinding or biting surface of the teeth.

noted that no formal arrangement had been made with regard to a refund and payment. Ms D noted that there was still an outstanding account and that they considered the taking of the crowns without consent to be an act of theft. She noted that they may consider pressing charges, and that if charges are pressed "... this may affect any applications you have with government departments". Ms D noted that Mrs A could contact HDC or the New Zealand Dental Association with her concerns, and stated: "We urge you to do so to further understand our priorities and responsibilities to you." Ms D also wrote that they still hoped to come to a mutual agreement to resolve the matter.

107. On 13 May, Mrs A returned to Dr F. Dr F tried to fit the existing crowns, but he could not get them to fit to his satisfaction, and Mrs A was not happy with the colour. They decided not to use these crowns.

108. On 17 May, Mrs A replied to the dental practice, stating that although it had been agreed on 3 May that Mrs A could take the crowns, she was returning these. The crowns were returned to the practice by courier.

109. Mrs A saw Dr F again on 20 May. Several treatment plans were outlined and discussed, and a new plan was agreed.

110. Over the weeks and months that followed, there were further unsuccessful attempts to resolve the dispute between Mrs A and the dental practice. Mrs A filed a claim with the District Court.

ACC

111. Mrs A submitted an ACC treatment injury claim. Dr H provided ACC with external clinical advice, in relation to the treatment provided to Mrs A at the dental practice. Dr H stated:

> "There were no study models taken, no comprehensive examination was provided considering the patient's oral hygiene, periodontal status, occlusal situation, possibilities of the causes of tooth wear or possibly erosion etc. Apart from this, mounted study models to assess occlusal stability and consider increasing vertical dimension are in my view a minimal standard of care before treating a patient such as this, and it is clear that none of this was done at the initial examination."

112. Dr H reviewed the copies of the photographs taken by Dr E on 24 April 2010, and stated that while these were not very clear "it is possible to see that there are some temporary crowns in place and they indeed show fracturing". Dr H reviewed the original X-rays taken by Dr E, and stated that "it is notable that the preparations seem quite short and do not appear as one might expect crown preparations would appear; however it is difficult to tell this with any accuracy from simply viewing radiographs".

113. Dr H noted a paucity of documentation, and "clear evidence that inadequate planning was done both from a clinical perspective and from the patient's perspective".

114. ACC accepted Mrs A's claim.

Provider responses to provisional opinion

115. In response to my provisional opinion, Dr B and Dr C note several points at which their recollections differ from those of Mrs A, and these have been incorporated above. In addition, Dr B states that she does not accept my conclusions, and that at no point did she intend to cause harm or pain to Mrs A or pressure her into receiving treatment. Dr B states that she accepts responsibility for not obtaining Mrs A's written consent for treatment, and regrets that she did not do so. However, she believes there was a mutual agreement with regard to the treatment, and that Mrs A was fully aware of the treatment plan. Dr B states that she accepts my findings with regard to treatment fees and costs, and in future she will ensure patients fully understand the treatment costs of all options available to them. Dr B provided a letter of apology to be forwarded to Mrs A.

116. Dr C states that at all times he was doing his best for Mrs A in terms of treatment and care, and that he only ever acted with her best interests in mind. He states that he does not accept my findings, and did not intend to harm Mrs A or pressure her into treatment. Dr C reiterates that in his view, Mrs A and her husband were fully informed about the proposed treatment and the availability of other treatment options. Dr C has reviewed the New Zealand Dental Association's Code in relation to treatment planning and while he accepts my finding in this regard, he considers that it "must be viewed in the context of this difficult case". Dr C provided a letter of apology to be forwarded to Mrs A.

Disputed facts

117. It is evident that there are multiple discrepancies between the accounts of events on 19 April 2010 and 3 May 2010 from those present. These include:

- the reason Mrs A first went to the dental practice on 19 April 2010, and the issues she presented with;
- whether Mr A was present for the duration of Mrs A's initial consultation with Dr B;
- the time at which the X-rays were taken and discussed;
- whether Mrs A was told during the initial consultation that after having crowns fitted on her molars she would need to have other molars and premolars built up;
- what Mrs A was told about the cost of the treatment;
- whether Mrs A was told that ceramic crowns were the only option, and that treatment was needed as a matter of urgency;
- whether Mrs A was given a written treatment plan and whether Dr B drew diagrams to inform Mrs A;
- the point at which Dr B's other appointments on 19 April were rescheduled to accommodate Mrs A;
- whether Mrs A encouraged Dr B to commence her treatment on the same day as her initial consultation;
- the time at which Mrs A returned to the practice on 19 April and commenced her treatment;

- whether Dr B advised Mrs A of the need for diagnostic wax-ups, and whether Mrs A declined this;
- the timing and adequacy of the discussion in relation to having tooth 26 crowned; and
- the sequence of events on 3 May 2010, and the nature of any agreement reached on this date.

118. Where necessary, factual findings in relation to these disputed facts are included in the following section.

Opinion: Breach — Dr B

119. The initial consultation on 19 April 2010 was undertaken by Dr B, during which she diagnosed Mrs A's condition, and proposed a plan for treatment. At the second appointment that day, Dr B commenced Mrs A's treatment.

120. Dr McGettigan states at the outset of his advice: "I am of the opinion this is indeed a complex case for any dentist to treat and as such requires detailed planning, patient understanding/consent and clinical expertise to achieve a satisfactory outcome."

Informed consent

121. The concept of informed consent is central to the provision of health services. It is a fundamental requirement that informed consent be appropriately obtained prior to treatment. Informed consent is a process that is embodied in three essential elements under the Code: effective communication (Right 5), disclosure of adequate information (Right 6) and, subject to certain exceptions, a voluntary decision by a competent consumer (Right 7).

122. Mrs A was undergoing extensive dental treatment at considerable personal expense. In such circumstances, she needed to be given balanced information about the costs and merits of the proposed treatment and available alternatives, and sufficient time to reflect on that information, to enable her to make considered decisions and give truly informed consent.

Information about treatment options

123. Mrs A had the right to an explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option.[14]

124. As outlined by my expert, Dr McGettigan, the treatment options available in Mrs A's case were:

[14] Right 6(1)(b) of the Code — 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 as assessment of the expected risks, side effects, benefits, and costs of each option.

- to do nothing;
- to rebuild the damaged tooth surfaces with composite; or
- to crown selected back teeth and overlay others with porcelain or composite.

125. Dr McGettigan notes that the second of these options is cheaper than the third, but would be technically difficult and there is a "high wear rate". The third option is preferable in terms of longevity, but it is more expensive and destructive of tooth tissue. Dr McGettigan considers that crowns were "the appropriate treatment of choice".

126. According to Dr B, her discussion with Mrs A covered the three options outlined by Dr McGettigan. Dr B says that they talked about leaving the back teeth as they were and just filling the cavity in tooth 25. She states that she explained to Mrs A that composite material could be used to rebuild her back teeth, but she could not guarantee that this would last. Dr B states that, given Mrs A had expressed a wish to have her front teeth improved, she recommended ceramic crowns. Dr C also states that these options were discussed with Mrs A.

127. Ms D recalls Dr B advising Mrs A that they could do composite restoration fillings, but that Dr B recommended porcelain crowns and showed Mrs A an X-ray indicating that her previous composite fillings had worn down.

128. In contrast, Mrs A and her husband state that their understanding at the end of the initial consultation was that the treatment required to fix Mrs A's attrition problem was five ceramic crowns. Mrs A maintains that Dr B presented crowns as the *only* viable option, and pressured her into the treatment by suggesting that the work was needed as a matter of urgency, to prevent undesirable changes in her appearance. Mr A states that he asked three times whether there were other alternatives, and was told there were not.

129. I note that Mrs A and Dr B were the only ones party to the full explanation and discussion.[15]

130. There is no documentation about any treatment options having been discussed with Mrs A.

131. In my view, an adequate record would have included details of alternative options discussed and the rationale for selecting the chosen treatment. While there is no such record, I note that Dr B, Dr C and Ms D have given corroborating accounts that treatment options were discussed. In such circumstances, I am unable to make a finding on whether Mrs A was provided with information about treatment options.

[15] Dr C was present for part of the consultation only. Mr A denies that he was present for the duration of the appointment, but in any case, he was not party to any information given in the foreign language. Ms D may have been present throughout the appointment but was similarly not party to any discussion in the foreign language.

Information about treatment and costs

132. Before making a choice or giving consent to the selected treatment, Mrs A had the right to information that a reasonable consumer, in Mrs A's circumstances, needed to make an informed choice or give informed consent to that treatment.[16]

133. In relation to treatment fees and costs, the New Zealand Dental Association's *Code of Practice: Informed Consent (2004)*[17] states:

> "Prior to providing treatment, the Dentist should ensure — via the informed consent process — that the consumer understands the costs (fees) involved in providing their dental treatment.
>
> It is unwise for a dentist to prejudge a patient's ability to afford a particular treatment and the value the patient puts on the treatment. The dentist must discuss the cost and determine the fee level that the patient will be comfortable with in relation to treatment options — all of which must be outlined. This means the relative value of the proposed treatment to that patient requires the dentist to contribute to the patient's understanding of the delicate balance between cost, affordability and value."

134. Dr B states that she outlined a three-stage treatment plan to Mrs A:

- ceramic crowns on six teeth;
- composite or ceramic restorations on nine teeth to increase or "build up" the vertical dimension; and
- composite or ceramic veneers on Mrs A's front teeth.

135. Dr B, Dr C, and Ms D all state that in the course of the first consultation on 19 April, it was made clear to Mrs A that after the crowns had been fitted, work would be needed on other back teeth. Dr B states that she discussed the cost of the first two stages with Mrs A. Dr B says that Mrs A was told that if they used composite material for the second stage, the cost would be $250–300 per tooth, and if they used ceramic material the cost would be $1000–1200 per tooth. Dr B states that they did not specifically discuss the costs of the third stage.

136. The cost of the first stage was initially agreed at $7000 for five ceramic crowns. Mrs A acknowledges that this is what she was told, and this is what she agreed to. However, Mrs A denies being told about the second stage of treatment, including the costs, until she returned to the practice on 3 May. Mr A states that he did not know that work was needed on more teeth until the appointment on 3 May.

137. The content of the verbal discussion about the proposed treatment is therefore in dispute. Understanding is not assisted by reference to the clinical notes for 19 April, which record: "Coverage of molars with crowns recommended and at the same time open the bite to build up posterior teeth. Front teeth have … composite restorations

[16] See footnote 2.
[17] The *Code of Practice: Informed Consent (2004)* was adopted by the Dental Council of New Zealand in March 2005.

and she wants to restore them with porcelain veneers. Tx plan was given at first appointment." This clinical note is not specific about how information about the treatment plan was provided (ie, verbally or in writing), the number of teeth requiring work, the material to be used, or the associated costs.

138. Dr McGettigan states that in circumstances such as Mrs A's, a prudent dentist would provide a detailed treatment plan with accurate costings, in writing. Dr McGettigan states further:

> "… the details of a verbally agreed treatment plan in a complex case such as this needs to be in written form along with costs. This avoids any confusion in the patient's mind and ultimately is an important adjunct to informed consent."

139. Dr B and Ms D state that Mrs A was given a written treatment plan during the first consultation on 19 April. Dr B states that this plan would have comprised the information shown under "Current Treatment Plan" in the clinical record (see **Appendix 2**). Mrs A denies being given a written treatment plan.

140. The treatment plan that Dr B says Mrs A was given does not show the price of the ceramic crowns, but shows prices for seven posterior composite restorations. The prices are not clearly legible because the tooth number and the price overlap. They do appear to show a three-figure price starting with "2". No information is included with regard to veneers on the front teeth (the proposed third stage).

141. Dr B has provided my Office with other details about Mrs A's treatment plan, which are inconsistent with the information shown under "Current Treatment Plan", as follows:

- The "Current Treatment Plan" in the clinical record includes a crown on tooth 26. However, Dr B stated that this was not part of the initial plan, and was not agreed to until Mrs A returned to the practice later that day and commenced treatment.
- There are discrepancies between the work shown under "Current Treatment Plan" in the clinical record (six crowns and seven composite restorations), and the work Dr B noted in her initial response to HDC as that which was agreed with Mrs A (five crowns and nine composite restorations).
- Dr B initially stated that the treatment plan would not have included information about the cost of building up other molars and premolars, because they were not able to say how many teeth would need work until after the crowns had been fitted. She also noted that the costs would depend on whether Mrs A chose composite or ceramic restorations.

142. On the basis of the information provided to HDC, it appears that the cost for the second stage of treatment was expected to be between $1995 (for seven teeth) and $2565 (for nine teeth) if composite material was used, and in excess of $7000 if ceramic material was used. Mrs A was not informed about the cost of veneers for the front teeth. However, a survey of dental fees conducted in April 2009, and reported on

by Consumer in 2010, found that most dentists charged between $900 and $1200 for a porcelain veneer.[18] These costs were not reflected in the treatment plan Dr B states was provided.

143. Given the extent of the work proposed and the costs involved, I consider that Mrs A should have been given a comprehensive treatment plan that outlined the proposed treatment in full, including the costs. Where there was uncertainty with regard to the number of teeth requiring work, the material to be used, or the costs of the work proposed, relevant information should have been clearly given (eg, information about how the plan may vary, the cost range, etc). Ideally, this treatment plan and associated information should have been given to Mrs A in writing. The imperative for a comprehensive written treatment plan was even stronger when it was subsequently decided to commence treatment the same day.

144. In her response to my provisional opinion, Dr B submits that she did not include information about the full cost of the treatment plan at Mrs A's request, and that Mrs A made this request because she was concerned that her husband would refuse to pay if he knew the total cost. Mrs A has denied this. I do not consider further enquiry will resolve this matter. Dr B acknowledges that the costs of the third stage were not discussed, beyond the fact that ceramic veneers would be more expensive than composite veneers. I remain of the view that Dr B had a professional responsibility to ensure Mrs A was provided with a comprehensive treatment plan, including accurate information about costs.

145. In the circumstances, given the inconsistencies in the information provided by Dr B to HDC, I am not satisfied that Mrs A received adequate information either verbally or as a written treatment plan at the first consultation. I do not accept that she was given the written treatment plan which Dr B has referred to, as it contains details of the molars and premolars that would require building up, and yet Dr B has said that she could not know which of those teeth would require treatment until the first stage had been completed. However, even if Mrs A was given this written treatment plan, it is clear that it did not contain sufficient or accurate information about the nature and costs of the treatment Mrs A was to receive. Given the lack of a comprehensive record of the information provided to Mrs A about the proposed treatment, I am not satisfied that Dr B fully informed Mrs A.

Consent to treatment

146. As outlined above, I do not consider that Mrs A was adequately informed about the nature and costs of the proposed treatment. As Mrs A did not receive adequate information, she was not in a position to give informed consent.

147. Mrs A's ability to give informed consent was compromised further by the fact that treatment began on the same day it was initially proposed. Dr McGettigan notes that in circumstances such as these a "cooling off" period is a good idea. This allows the patient to absorb the information and ask any questions prior to giving consent and starting treatment. The issue of allowing patients adequate time to reflect on

[18] http://www.consumer.org.nz/reports/dentists/dentists-fees

information provided to them prior to surgery has been highlighted in previous investigations.[19]

148. As outlined above, there is disagreement in relation to the circumstances that led Mrs A to commence treatment on 19 April. Mr and Mrs A state that they were effectively pressured into starting treatment that same day; first by advice from the dentists that Mrs A needed the work as a matter of urgency, and secondly when Dr B told Mrs A that she had already cancelled other appointments in order to start Mrs A's treatment.

149. Dr B and Ms D state that once Mrs A had decided to proceed with the proposed treatment, she wanted to get started that day in order to minimise the number of times she had to return to the North Island. Dr B also states that Mrs A was concerned that her husband would change his mind about paying for the treatment. Dr B denies telling Mrs A that the proposed treatment was needed as a matter of urgency, and states that she made it clear to Mrs A that it was only necessary if she wished to have her front teeth fixed in the future.

150. There is also disagreement in relation to the length of time between Mrs A's initial appointment and the start of her treatment. The dental practice's appointment book shows that Mrs A's first appointment was scheduled for one hour, from 9:30am, and the accounts from both Mrs A and Dr B indicate that the appointment did take 50–60 minutes. Mr and Mrs A recall that they returned to the dental practice 10–15 minutes after the initial consultation. Ms D recalled that they returned 2½–3 hours after they had left. Dr B initially stated that Mr and Mrs A returned about two hours after they had left, but later stated that it was the patients scheduled at 10.30am and 11.30am who were rescheduled to accommodate Mrs A. Given this, I am not able to determine precisely the time at which Mrs A returned to the dental practice to commence treatment. However, my concern in this regard stands irrespective of whether it was ten minutes or three hours between the initial consultation and the start of treatment on 19 April.

151. I accept the possibility that once Mrs A decided to proceed with the proposed treatment, she expressed a wish to start that day. Even if this were so, I consider that Dr B should not have commenced treatment without first ensuring that Mrs A had had a reasonable period of time in which to consider information about the proposed treatment. Notwithstanding the travel issue, I find it somewhat odd that Dr B agreed to reschedule other patients at very short notice, to commence Mrs A's non-urgent treatment. The fact that this was to embark on a complex course of treatment, costing thousands of dollars, for a problem that Mrs A had just learned of, and without the provision of adequate information, was unacceptable.

Written consent

152. Mrs A's consent to treatment is recorded in the clinical note for 19 April where it states "Pt consented to tx". Written consent was not obtained.

[19] Opinion 09HDC01691 (6 April 2011), Opinion 08HDC20258 (11 November 2009), Opinion 05HDC07699 (31 August 2006).

153. The *Code of Practice: Informed Consent (2004)* sets out the circumstances in which written consent must be obtained.[20] It states further:

> "A signed consent form can only be regarded as evidence that the person has made an informed decision where it can be shown that the decision is the outcome of discussion about the proposed procedure. It is therefore important for the dentist to keep accurate contemporaneous written records of the discussion that has taken place prior to the provision of treatment.
>
> Where the person giving the consent is conscious and does not object, oral consent is sufficient for minor procedures, which include most services carried out by general practitioner dental surgeons.
>
> When in doubt about whether a procedure is major or minor, get written consent. If verbal consent is all that is deemed necessary, it is prudent to note this in the records.
>
> In all situations keep careful, clear, written records."

154. I agree with Dr McGettigan that it would have been reasonable to accept Mrs A's verbal consent to a detailed written treatment plan. In the circumstances, Dr B was not subject to a legal or professional obligation to obtain Mrs A's written consent, although I consider that it would have been prudent for Dr B to have done so.

155. The greater problem here is that, as I have outlined above, Mrs A was either provided with no written treatment plan, or she was provided with a plan that did not contain sufficient, correct or consistent information about the treatment or its cost.

Summary — information and consent

156. On 19 April 2010, Dr B commenced a complex and costly course of treatment, having discussed this with Mrs A for the first time only a short time prior to commencing the treatment.

157. Given the discrepancy in accounts, I have not made a finding about whether Dr B discussed treatment options with Mrs A. However, by failing to give sufficient, accurate or consistent information about the proposed treatment and its cost, I find that Dr B breached Right 6(2) of the Code.

158. As Mrs A was not provided with the required information, she was unable to give informed consent to the proposed treatment. This was exacerbated by the fact that treatment was commenced on the same day it was proposed, which did not allow Mrs A sufficient time to consider the proposed treatment. I find that Mrs A did not give informed consent to the treatment, and Dr B breached Right 7(1) of the Code.

[20] These are (i) when the consumer is to participate in research; or (ii) when the procedure is experimental; or (iii) when the consumer will be under general anaesthetic; or (iv) when there is a significant risk of adverse effects on the consumer. These requirements reflect Right 7(6) of the Code.

Treatment

159. Mrs A had a right to have treatment provided with reasonable care and skill.[21] Accordingly, before providing treatment to Mrs A, Dr B needed to undertake the necessary preparation.

160. Dr McGettigan states that it would be best practice to take impressions so that study models can be made. He notes that in a case such as this, the study models could have been used to demonstrate the wear to the patient's teeth. They are then used to make diagnostic wax-ups. Moulds of the wax-ups "enable the dentist to gauge the heights of tooth reductions and provision of temporary crowns to facilitate desired bite opening".

161. I note that ACC's expert advisor, Dr H, considers that in a case such as this, preparing study models is the minimum standard of care expected.

162. Dr B states that she discussed making diagnostic wax-ups with Mrs A, but Mrs A wanted to minimise the number of times she would need to travel between the South Island and the North Island, and asked Dr B to "just do whatever you think". I accept that Mrs A may well have sought to minimise the cost of her treatment, including the costs associated with travelling up from the South Island. This was no excuse for Dr B to take shortcuts with Mrs A's treatment.

163. Making study models and diagnostic wax-ups would also have served to ensure Mrs A had a "cooling-off" period, as discussed above. Dr McGettigan also notes that study models and wax-ups would have eliminated the problem of inadequate temporary crowns. I will comment further on this issue in relation to Dr C.

164. Dr B did not undertake the necessary and appropriate level of planning and preparation by making study models and diagnostic wax-ups. In these circumstances, Dr B did not provide treatment with reasonable care and skill and I find that she breached Right 4(1) of the Code.

Documentation

165. As stated in a previous investigation regarding dental treatment:[22]

> "Health professionals are required to keep accurate, clear, legible and contemporaneous clinical records. They are a record of the care provided to the patient and clinical decisions made, and enable other health professionals to provide co-ordinated care. Furthermore … records are important in verifying the facts once a complaint has been made."

166. The Dental Council of New Zealand and the New Zealand Dental Association's *Code of Practice: Patient Information and Records (2006)* similarly highlights the importance of documenting a patient's treatment. It states:

> "1.1 The patient's treatment record is legally regarded as 'health information' and is an integral part of the provision of dental care. A record of each encounter with

[21] Right 4(1) of the Code.
[22] Opinion 09HDC01081 (21 May 2010).

a patient will improve diagnosis and treatment planning and will also assist with efficient, safe and complete delivery of care considering the often chronic nature of dental disease. The treatment record will also assist another clinician in assuming that patient's care.

1.2 The treatment record may also form the basis of self protection in the event of a dispute associated with any treatment provided and it may also form the basis for some types of self monitoring or audit systems used in quality review systems."

167. It states further:

"2.7 [The treatment] record **must** include:

…

(f) "details of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon;"

And that,

"2.8 The record **should**, in the interests of best practice, also include:

…

(l) Any treatment advised by the dentist that the patient has declined

…

(n) Estimates or quotes for fees involved;"

168. I note that Dr B thinks it likely that the clinical note entered on 19 April was completed by Ms D, while Ms D believes it would have been completed by Dr B. Irrespective of who wrote the note, it was Dr B's responsibility to ensure that it included the requisite information.

169. Dr B's record of Mrs A's initial consultation on 19 April included insufficient and inaccurate information with regard to the examination findings, the information provided to Mrs A about treatment and costs, and detail about the terms of Mrs A's consent and treatment recommendations that were declined. While the clinical record for 19 April documents that Mrs A consented to "treatment", there is no detail as to what this treatment was. Nothing was documented in relation to the cavity in tooth 25. In addition, Dr B states that she told Mrs A that they needed to do diagnostic wax-ups, but Mrs A's preference was to proceed without these. Dr B did not document this. The recording of estimates and fees was incomplete.

170. In these circumstances, I do not consider that Dr B's documentation was in accordance with professional standards and I find that she breached Right 4(2) of the Code.

Opinion: Breach — Dr C

171. Dr C had a significant level of involvement in Mrs A's treatment on 19 April and 3 May 2010. He offered a second opinion on the treatment plan proposed by Dr B during Mrs A's initial consultation on 19 April, and agreed with the treatment proposed. After Mrs A subsequently decided to proceed with the treatment and Dr B commenced it, Dr C took over treatment, finished the preparation and placed temporary crowns.

Informed consent

172. The extent to which Dr C was present for, and participated in, the planning of Mrs A's treatment is not entirely clear. However, the information Dr C provided during his interview with my staff indicates that he was aware of, and involved in, the discussions prior to the start of treatment. Dr C, as a treating dentist, needed to satisfy himself that Mrs A had given her informed consent to the proposed treatment when he took over her treatment on 19 April.

173. As I have already discussed above in relation to Dr B, Mrs A was not in a position to give informed consent, as she had not been provided with adequate information about the proposed treatment and associated costs, or a reasonable period in which to consider the proposed treatment and any information provided to her.

174. Even if Dr C was under the impression that Dr B had provided adequate information to Mrs A, Dr C knew, prior to taking over Mrs A's treatment, that Mrs A had had her first consultation that morning and only a short time to consider the treatment before it was commenced.[23] As such, Dr B should have known that Mrs A had not had sufficient time to consider any information provided and therefore could not have given fully informed consent.

175. For failing to ensure Mrs A had given informed consent before providing her with treatment, it is my opinion that Dr C breached Right 7(1) of the Code.

Treatment

176. Dr C was responsible for finishing the preparation of the teeth to be crowned, and making and fitting temporary crowns. When Dr C took over Mrs A's treatment on 19 April, he knew that crown preparation had commenced without study models or diagnostic wax-ups. Dr C advised HDC that "he knew [his and Dr B's] mistake", and that ideally he should have made diagnostic wax-ups. He said that the main reason he proceeded without these was to minimise the number of times Mrs A needed to come up from the South Island, in order to keep the expense to a minimum.

177. Before Dr C provided treatment to Mrs A, he had a personal responsibility to ensure that appropriate preparation had taken place. He should have recommended that study

[23] As noted in paragraph 150, the time Mrs A had to consider the proposed treatment is disputed but was, at most, three hours.

models and diagnostic wax-ups be made in the first instance, and declined to commence treatment until appropriate preparation had been completed. As it was, Dr C was involved in, and therefore also responsible for, the decision to commence treatment for which there had been inadequate planning and preparation.

178. I accept Dr McGettigan's advice that, in failing to ensure adequate preparatory work was done, Dr C failed to provide an appropriate standard of treatment. Therefore, in my opinion, Dr C breached Right 4(1) of the Code.

Other comment — temporary crowns

179. The dentists who saw Mrs A after her treatment at the dental practice made some observations about the adequacy of the temporary crowns fitted by Dr C on 19 April and on 3 May. On 24 April, Dr E stated that the temporary crowns were very thin and did not conform to the tooth margins. On 5 May, Dr F noted "defective restorations — 46, 45".

180. I note that ACC's expert, Dr H, stated: "The margins on these temporary crowns appear poor, and it is notable that the preparations seem quite short and do not appear to be as one might expect crown peparations would appear; however it is difficult to tell this with any accuracy from simply viewing radiographs."

181. Given the difficulty of relying on X-rays, I do not consider that I have sufficient evidence to conclude on the quality of the temporary crowns. However, I note Dr McGettigan's advice that in a situation such as Mrs A's, it is not uncommon to build up the back teeth with composite as a temporary measure to gauge the patient's tolerance to increasing the vertical dimensions, prior to the provision of permanent crowns. He states:

> "Adequate bulk/thickness of temporaries would have been best achieved by opening the bite with the support of temporary build ups on the adjacent pre-molar teeth. Again, this would have been best achieved if study models and wax ups were done."

Adverse comment — Complaint handling

182. As noted previously, HDC has been provided with differing accounts in relation to what occurred on 3 May, and I do not consider that I can establish the sequence of events, or exactly what was said.

183. I accept that Dr C endeavoured to resolve the dispute that arose with Mrs A. Dr C states that once it had become clear that Mrs A was not going to have the permanent crowns fitted at the dental practice that day, he initially agreed to remake temporary crowns, refund the money she had paid, and give her the permanent crowns. Dr C said that this offer was made on the condition that Mrs A confirm in writing that she would not make a complaint or take the matter any further. Dr C states that when Mrs A continued to complain, he withdrew this offer.

184. Right 10 of the Code provides that every consumer has the right to complain about a provider, and that a provider's complaints procedure should inform the consumer of

the availability of the HDC process.[24] The Code also states that every provider is subject to the duties described in the Code, and is required to both inform consumers of their rights and to enable them to exercise their rights.[25] While this Office recognises that effective complaint resolution can be achieved through an agreement between the provider and the consumer, providers should be mindful of their obligations under the Code. In any event, I note that any agreement that a provider makes with a consumer that claims to divest a consumer of his or her right to complain does not prevent the Commissioner exercising his or her discretion to commence an investigation or take action if he or she considers this necessary.

185. I note that in subsequent correspondence from Ms D on behalf of the dental practice, Mrs A was encouraged to contact HDC or the New Zealand Dental Association with her concerns.

Recommendations

186. I recommend that Dr B:

- review her practice in light of these findings and update HDC by **17 July 2012** on the changes she has made, particularly in relation to:
  - obtaining informed consent;
  - the provision of written treatment plans;
  - ensuring there is an appropriate period of time for patients to contemplate proposed treatment before major treatment is commenced;
  - the use of study models and diagnostic wax-ups; and
  - keeping accurate and adequate documentation.

187. I recommend that Dr C:

- review his practice in light of these findings and update HDC by **17 July 2012** on the changes he has made in relation to:
  - obtaining informed consent; and
  - appropriate planning and preparation for patients undergoing major dental work.

[24] Right 10(1) — Every consumer has the right to complain about a provider in any form appropriate to the consumer.
[25] Clause 1(3) of the Code.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Dental Council of New Zealand, and it will be advised of the names of Dr B and Dr C, with a recommendation that it consider whether any further action is warranted.[26]

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the relevant District Health Board, and it will be advised of the names of Dr B and Dr C.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Dental Association and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[26] The Dental Council is already aware of this complaint.

Appendix 1 — Independent advice to the Commissioner

The following expert advice was obtained from dentist Daniel McGettigan:

"Expert Advice Report: Complainant [Mrs A], Ref: 10/00671

In compiling this report I have read the following:

[List of documents reviewed omitted for brevity.]

I have been requested to advise on the appropriateness and standard of the services provided by [Dr B and Dr C] to [Mrs A].

I am a general dentist with 35 years experience in private practice. I am familiar with complex restorative procedures and am a member of the Central Peer Review committee of the NZDA as well as an Examiner of overseas dentists seeking NZ registration.

OVERVIEW:
Before answering the above, I am of the opinion this is indeed a complex case for any dentist to treat and as such requires detailed planning, patient's understanding/consent and clinical expertise to achieve a satisfactory outcome. As a peer I can only judge [Dr B and Dr C] from their clinical notes and X-rays as there appears to be a great disparity in the verbal descriptions by both parties. The following is a summary of what I would consider the necessary steps or standards a diligent dentist would follow in treating such a case.

1. Examination and Diagnosis — as with any new patient a thorough medical and dental history should be taken, with notes on the patient's reasons for attending. Oral examination and X-rays usually lead to diagnosis of the problem. In this case, [Mrs A] was found to have extensive wear on the biting (occluding) surfaces of her posterior teeth. If the cause and effect of this wear is left unattended, the patient will eventually be left with stumps and exposed nerves to chew on. X-rays should be taken to eliminate hidden decay and determine bone levels supporting the roots of the teeth. For future reference it would be best practice to take impressions so that study models can be made.

2. Treatment Options — having diagnosed the problem, the dentist is now in a position to discuss with the patient the options available to correct/repair the damaged dentition. In [Mrs A's] case the options could range from doing nothing, to rebuilding the damaged tooth surfaces. In a complex case such as this it would be desirable to use the study models to demonstrate the wear to the patient. It appears [Mrs A] opted to repair the worn dentition and indicated she may wish to improve the cosmetics of her front teeth in the future.

The cheapest option would involve building up the worn back teeth with composite material. The downside of this option is that it is a technically difficult procedure and has a high wear rate.

The second option would involve crowning selected back teeth and overlaying others with either porcelain or composite. This procedure has the benefit of longevity but is more expensive and destructive of tooth tissue. This appointment can take considerable time and expertise by the dentist to thoroughly explain the various options and talk through the procedures, costs and timing involved. By the end of this appointment a decision and approximate costs is usually achieved and a prudent dentist would then put in writing the detailed treatment plan along with accurate costing. A 'cooling off' period is also a good idea for the patient to absorb the information from the written plan and ask any questions prior to consent and starting treatment. A brief description of options and agreed treatment plan should be included in the dentist's clinical notes, but I would consider the more detailed written treatment plan being verbally agreed to by the patient should suffice as informed consent.

3. Delivery of Treatment: Prior to commencing treatment, best practice would be to do diagnostic wax ups on the study models. Moulds of these would then enable the dentist to gauge heights of tooth reduction and provision of temporary crowns to facilitate the desired bite opening. It's not uncommon to build up the back teeth with composite as a temporary measure to gauge the patient's tolerance to increasing the vertical dimensions, prior to provision of permanent crowns.

FINDINGS:

From the outset, it is apparent that the reason for both parties finding themselves in this situation is irreconcilable breakdown of trust between patient and dentist. As is often the case, this situation has arisen due to several factors, but the major contributing issue appears to be failure by the dentist to communicate adequately with the patient.

In answering whether the services provided to [Mrs A] were appropriate, I believe the examination and diagnosis of her condition to be accurate. The flattened appearance of her posterior teeth from the X-rays and the fact two other dentists concurred with this diagnosis would confirm this.

The question of options given for treatment of the worn dentition, I have outlined in previous discussion. Judging solely on [Dr B and Dr C's] clinical notes, there is no mention of options being discussed, only the fact that crowns were recommended to open the bite. That aside, I believe the options of crowns were the appropriate treatment of choice and again this was verified by [Dr F].

As stated, the details of a verbally agreed treatment plan in a complex case such as this needs to be in written form along with costs. This avoids any confusion in the patient's mind and ultimately is an important adjunct to informed consent. [Mrs A] may well have been given a written printout of a simple treatment plan, but I consider this inadequate in complex cases. Likewise, study models and subsequent wax ups should have been taken. I have no doubt these would have eliminated the problem of inadequate temporary crowns.

In hindsight, commencement of treatment on 19th April was foolhardy in light of the last two issues as study models and wax ups require time to complete.

According to [the dentist in Mrs A's home town, Dr E] the temporary crowns were very thin. These are usually made of an acrylic type material and cemented with a soft cement to facilitate easy removal. Adequate bulk/thickness of temporaries would have been best achieved by opening the bite with the support of temporary build ups on the adjacent pre-molar teeth. Again, this would have been best achieved if study models and wax ups were done.

Fundamentally, I see no issues arising from the involvement of two dentists, provided one dentist is seen as the primary provider. In this instance I would consider the dentist of first contact to be responsible for overall treatment unless it is clearly stated to the patient she is delegating future treatment to a second dentist.

There seems to be confusion over who refused treatment on 03.05.2010, but I have no doubt [Mrs A] was in a very volatile state of mind. Given the circumstances it is quite within the dentists' rights to refuse further treatment. The offers to repay all fees received and give [Mrs A] the crowns, I consider to be more than adequate compensation for her inconveniences.

Sadly, this offer failed to eventuate due to threats made by [Mrs A] and the perceived or otherwise theft of the crowns.

In [Dr C's] defence, he remade the temporary crowns to make [Mrs A] more comfortable, knowing he would receive no payment.

It is my belief [Dr B and Dr C] failed to provide an appropriate standard of treatment. Their failures primarily relate to inadequate communication in that they failed to provide a written description of the treatment plan along with full costing options. They also failed to do the necessary study models and wax- ups for such a complex case.

In deciding the severity of the case, I take into account [Mrs A] was left no worse off in the long run, bearing in mind she accepted a very similar treatment plan from [Dr F] to that proposed by [Dr B and Dr C].[27]

In conclusion, I would view the departure from appropriate standards as moderate.

This completes my report.

Dan McGettigan B.D.S."

[27] Dr McGettigan subsequently confirmed that Mrs A had no option but to proceed with crowns at that stage.

Further advice

Dr McGettigan was subsequently asked how he would assess the severity of the departure from appropriate standards without the benefit of hindsight, that is, disregarding the decisions made and treatment received by Mrs A subsequently, and focusing only on the concerns he had identified in the course of Mrs A's treatment at the dental practice.

Dr McGettigan stated:

> "Having considered your request to reassess the severity of departure from expected standards without the benefit of hindsight, I now place the departure to be in the moderate to severe category."

Appendix 2 — Clinical Records

Ltd.

Patient Details

Printed On 21/07/2010 11:06am
Printed By

Patient Details

Code:
School:
Dentist:
Infectious Notes:
Med History:
Address:

Name:
Date of Birth:
Recall Date:

Work Address:

Phone:
Paying Pat.:

Work Phone:

Patient Notes

Transactions	Type	No.	Details	Debit	Credit
19/04/10	Invoice	12562	Consultation	45.00	
			Bitewing Radiograph	50.00	
			PA Radiograph	25.00	
			Scale And Prophy	125.00	
			Notes		
19/04/10	Invoice	12563	Posterior Composite Restorati	250.00	
			Glass Ionmer Restoration	160.00	
			Glass Ionmer Restoration	125.00	
			All Ceramic Crown Prep	1400.00	
			All Ceramic Crown Prep	1400.00	
			All Ceramic Crown Prep	1400.00	
			All Ceramic Crown Prep	1400.00	
			All Ceramic Crown Prep	1400.00	
			All Ceramic Crown Prep	1400.00	
19/04/10	Receipt	9419			4980.00
19/04/10	Receipt	9420			1000.00
03/05/10	Invoice	12565	Notes		
			Temporary Crown/Inlay/Bridge		
			Temporary Crown/Inlay/Bridge		
			Temporary Crown/Inlay/Bridge		
			Temporary Crown/Inlay/Bridge		
			Temporary Crown/Inlay/Bridge		
			Temporary Crown/Inlay/Bridge		
			Balance:	3200.00	

Treatment History	Details	Done	Debit	Credit
Historical:				
19/04/10	CEMPREP 36, All Ceramic Crown Prep 36		1400.00	
19/04/10	X-BW (x2), Bitewing Radiograph (x2)		50.00	
19/04/10	X-PA, PA Radiograph		25.00	
19/04/10	HYG-S&P, Scale And Prophy		125.00	
19/04/10	FLG-C-P 25 DO, Posterior Composite Restoration		2850.00	
19/04/10	FLG-GI 26 MO, Glass Ionmer Restoration 26		160.00	
19/04/10	FLG-GI 27 O, Glass Ionmer Restoration 27		125.00	
19/04/10	CEMPREP 17, All Ceramic Crown Prep 17		1400.00	
19/04/10	CEMPREP 26, All Ceramic Crown Prep 26		1400.00	
19/04/10	CEMPREP 27, All Ceramic Crown Prep 27		1400.00	
19/04/10	CONS, Consultation		45.00	
19/04/10	CEMPREP 37, All Ceramic Crown Prep 37		1400.00	
19/04/10	CEMPREP 47, All Ceramic Crown Prep 47		1400.00	
19/04/10	NOTES, Notes			

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ltd.

Patient Details

Clinical Notes: Pt has a worn dentition, all molars almost do not have an enamel. 2.5mm overbite. teeth are sensitive to cold . Coverage of molars with crowns recommended and at the same time open the bite to build up posterior teeth . Front teeth have a composite restorations and she wants to restore them with porcelain veneers later . Tx plan was given at first appoinment. Pt consented to tx.

03/05/10	TEMP1, Temporary Crown/Inlay/Bridge
03/05/10	TEMP1, Temporary Crown/Inlay/Bridge
03/05/10	TEMP1, Temporary Crown/Inlay/Bridge
03/05/10	TEMP1, Temporary Crown/Inlay/Bridge
03/05/10	TEMP1, Temporary Crown/Inlay/Bridge
03/05/10	TEMP1, Temporary Crown/Inlay/Bridge
03/05/10	NOTES, Notes

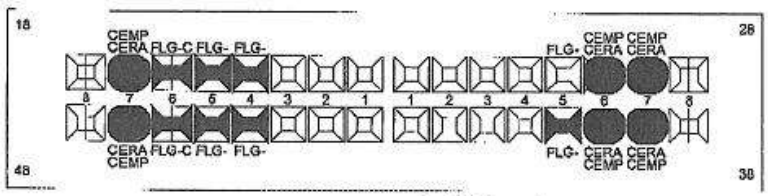
Clinical Notes: Pt came into the clinic. Without greeting she started to screamed and yelled on me. She said that we did not explained her everything which is not true . She started to threaten that I will loose my dental registration. I felt abused and did not want to carry on treatment for her. She asked to cement the crowns only, I told her that posterior teeth will need to be built up at the same time otherwise she is not able to eat because of her opened bite. I spoke with her husband re this. I told her that I will refund money and give them the crowns if she will give me a letter that she will not take any action against me . $ 4980 for given. Told that cheque $1000 send them by post because the cheque book was unavailable. She continued to threaten me telling me that she will be taking me to court .I decided to keep crowns and asked her to calm down. I wanted to help her, but she was so aggressive . I remade temp crowns with better fit by using porcelain crowns as a mock up. We then decided to sign a mutual agreement letter . While pt and I were at the reception area discussing this - her husband who was in the surgery at the time disappeared along with the crowns which were left on the surgery bench. Transfer copings for the crowns were not taken. Pt on knowing that her husband had taken the crowns without our consent or her acknowlegment decided to abandon further treatment and discussion on the matter

Current Treatment Plan:
Treatment Plan 1
Appointment 4

19/04/10	CERAMICCEM 26, All Ceramic Crown Cementation 26
19/04/10	CERAMICCEM 27, All Ceramic Crown Cementation 27
19/04/10	CERAMICCEM 36, All Ceramic Crown Cementation 36
19/04/10	CERAMICCEM 37, All Ceramic Crown Cementation 37
19/04/10	CERAMICCEM 47, All Ceramic Crown Cementation 47
19/04/10	FLG-C-P 14 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	FLG-C-P 15 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	FLG-C-P 16 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	FLG-C-P 35 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	FLG-C-P 45 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	FLG-C-P 46 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	FLG-C-P 44 MOD, Posterior Composite Restoration 2[illegible]5.00
19/04/10	CERAMICCEM 17, All Ceramic Crown Cementation 17

Ltd.

Patient Details



--End Of Report--