Dentist

Report on Opinion - Case 99HDC01055

Complaint

A consumer complained to the Commissioner concerning the treatment provided by her dentist. The complaint is that:

- *During November 1998 the dentist did not provide the consumer with the discussed adequate pain relief medication during the extraction of her wisdom teeth.*
- *Further to this, when the consumer requested that the operation be stopped, she was restrained and the dentist continued with the operation.*

Investigation

The complaint was received by the Commissioner on 20 January 1999. An investigation was undertaken on 26 February 1999 and this was extended on 7 May 1999 to cover the issue of the consumer being restrained. Information was obtained from:

The Consumer
The Provider/Dentist
The provider's Dental Assistant

Dental records relating to the consumer's treatment were obtained and reviewed. The Commissioner sought advice from an independent dental advisor.

Information Gathered During Investigation

During a consultation with the dentist in late November 1998, the consumer agreed to have four wisdom teeth removed. Pain relief options were discussed and the consumer agreed to be treated under local anaesthetic and intravenous sedation. The dentist informed the consumer this would remove any pain and reduce her knowledge of what was happening around her. The dentist informed the Commissioner he spoke to the consumer, for around 15 minutes, on sedation and on the risks, effects, and benefits of each option.

The consumer made an appointment to have her wisdom teeth removed by the dentist two days after her initial appointment.

Continued on next page

Dentist

Report on Opinion – Case 99HDC01055, continued

Information Gathered During Investigation, *continued*

On the day of the procedure the dentist first sedated the consumer and then administered local anaesthetic injections. The consumer was given a total 7mg of *midazolam* (*hypnovel*, a sedative) and 30mg *pentazocine* (*fortral*, an analgesic) intravenously during the procedure. She was also administered 8mg of *dexamethasone* (*decadron*, to treat inflammation) after sedation was induced, but prior to surgery. Local anaesthesia was administered using six cartridges of *lignocaine* 2% with 1:80,000 adrenaline (*xylocaine* 2.2ml cartridges) and one cartridge of 0.5% *bupivicaine* with 1:200,000 adrenaline (*marcain* 2.2ml cartridges. Adrenaline is used to prolong the anaesthesia). The dentist administered the anaesthesia to produce a series of nerve blocks in the consumer's mouth. A nerve block is a method of producing anaesthesia in a particular part of the body by blocking the passage of pain impulses in the sensory nerves to it. Specifically, to each side of the mouth the dentist administered one cartridge of *lignocaine* for an inferior alveolar nerve block. One cartridge was split between a separate lingual nerve block, long buccal nerve infiltration, and to the ascending branches of the deep cervical nerve. A further half cartridge of *bupivicaine* was administered for an inferior alveolar nerve block on each side. Each upper wisdom tooth was anaesthetised by local buccal and palatal infiltrations with one cartridge of *lignocaine*. The dentist checked local anaesthesia was achieved at each site prior to the commencement of surgery.

The dentist reported to the Commissioner that the two right side wisdom teeth were extracted without any problems. During the extraction of the next tooth, the lower left wisdom tooth, the consumer complained of pain, started to cry and became distressed. The consumer stated to the Commissioner that she swore and raised her left arm in an attempt to stop the procedure. She recalls that her left arm was restrained. The dentist stopped the surgery and administered one further cartridge of *lignocaine*. He stated the consumer then settled and the tooth was extracted successfully. During the extraction of the remaining upper left wisdom tooth the consumer again became distressed. The consumer stated she again raised her left arm to her face. The consumer stated she cried "no, stop". The dentist administered a further cartridge of local anaesthetic. The consumer again settled and the tooth was extracted.

Continued on next page

Dentist

Report on Opinion – Case 99HDC01055, continued

Information Gathered During Investigation *continued*

The dental assistant stated to the Commissioner she is confident that neither the dentist, nor herself, restrained the consumer's arm. She stated that when a patient is under intravenous sedation their right arm is strapped down to prevent them from pulling out the IV line. The left arm remains free, but if the arm is raised towards the mouth or the IV line, then she advised she may use her arm as a barrier. Both she and the dentist wear sterile gloves, and using their hands to restrain someone would necessitate a change in gloves.

Post-operatively the consumer was given *metronidazole, diflunisal* and *panadeine*.

During the course of this investigation the advice of an independent dental advisor was sought. In her report my advisor reported that:

> *"I believe that* [the dentist] *did treat* [the consumer] *appropriately ... Quite appropriately* [the dentist] *advised* [the consumer] *that it would be sensible and* [there would be] *very little additional cost to remove the upper third molars at the same time as the lower third molars. The dentist did not make the decision for* [the consumer] *but gave her time to consider this information before coming to a decision.*
>
> *I believe that* [the dentist] *administered appropriate anaesthesia to* [the consumer]. *The dentist could do such a surgical procedure under local anaesthesia (with or without intravenous sedation) or general anaesthesia. This decision is a judgement call by both patient and dentist. In this case it appears that the patient would have been more suited to a general anaesthetic but this can only be said with the benefit of hindsight. Local anaesthesia with IV sedation has less risk associated with it as compared to general anaesthetic and is commonly used for third molar surgery.*

Continued on next page

Report on Opinion – Case 99HDC01055, continued

Information Gathered During Investigation *continued*

The amount of local anaesthesia that can be administered is dependent on the size of the patient – a smaller weighted patient will be overdosed at a lesser number of cartridges of local anaesthesia than a heavier patient. [The dentist] *states that he initially gave* {the consumer] *7 cartridges (6 xylocaine 2.2ml and 1 marcain 2.2ml). After administering the anaesthesia* [the dentist] *checked and was satisfied that sufficient anaesthesia had been attained. When it became apparent that* [the consumer] *was suffering "break through pain"* [the dentist] *administered a further 2 cartridges of local anaesthesia. There is no record of the patient's weight but 8 cartridges of local anaesthesia would have to be nearing the upper limits that could be administered.* [The consumer] *states that* [the dentist] *said "I was pumping you with as much anaesthesia as possible." This statement would be correct* [as the dentist] *could not keep adding more local anaesthesia. He was also, quite correctly, aware that not all patients under intravenous sedation who appear distressed are in fact in pain. Some patients under intravenous sedation appear distressed but afterwards do not recollect this. For this reason* [the dentist] *may not have realised that* [the consumer] *was conscious and genuinely wished to stop the procedure. He also could not have been sure that* [the consumer] *was conscious and cognisant of the pain. When* [the consumer] *attempted to stop the procedure on the two occasions* [the dentist] *stopped working and administered more local anaesthesia in case she was in pain. He felt he had settled the patient and so continued to operate. A patient who is intent on stopping the procedure is generally near impossible to work on …"*

Dentist

Report on Opinion – Case 99HDC01055, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

...
7) Every consumer has the right to refuse services and to withdraw consent to services.
...

Opinion: No Breach The Dentist

Right 4(2)
In my opinion the dentist did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights as he took reasonable actions to provide pain relief for the consumer.

My advisor informed me the use of local anaesthetic and intravenous sedation was an appropriate choice for pain relief in third molar surgery. The dentist administered an appropriate level of pain relief. When the consumer demonstrated "break through pain" he administered further pain relief. The dentist could not administer more pain relief after this as he was approaching the upper limits of the consumer's tolerance to anaesthesia.

Right 7(7)
In my opinion the dentist did not breach Right 7(7) of the Code of Health and Disability Services Consumers' Rights as the consumer was sedated and the dentist could not determine whether she was actually conscious and cognisant of the pain. My dental advisor informs me that not all patients under intravenous sedation who appear distressed are in fact in pain. Both *hypnovel* and *fortral* effect the ability of consumers' to make rational decisions. When the consumer attempted to halt the procedure, the dentist stopped working and administered further anaesthesia. In the circumstances - that the consumer was under intravenous sedation – this action was reasonable.

Actions

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