Dental Service

Dentist, Dr C

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC00134)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the services provided to a woman by a dentist in 2019.

2. The woman first saw the dentist about pain in her lower left wisdom tooth on 20 February 2019. At this appointment, the dentist discussed possible removal of the wisdom tooth and referred the woman for an X-ray of her teeth.

3. On 5 March 2019, the dentist sent an email to an oral and maxillofacial surgeon at another dental service, asking whether he would consider removal of the woman's wisdom teeth. On 6 March 2019, the oral surgeon's receptionist/surgical assistant advised that they would consider removing the wisdom teeth and asked for a referral to be sent through. The complainant (the woman's mother) said that she received a call confirming that the oral surgeon had agreed that the dentist could remove both the lower wisdom teeth.

4. On 16 March 2019, the dentist removed the woman's lower right wisdom tooth, but not her lower left wisdom tooth as planned. The woman felt a lot of discomfort and distress during the surgery, and following the surgery she felt very unwell. After the surgery, the practice manager called the woman to check on her recovery, and she had two follow-up appointments. The woman was experiencing a tingling/burning sensation on the right-hand side of her lip. The dentist referred the woman to an oral and maxillofacial surgeon for a review and scan.

5. Subsequently, the woman underwent surgery to clean out the wound bed, remove bone fragments, and decompress the inferior dental nerve.

Findings

6. The Deputy Commissioner found the dentist in breach of Right 4(1) of the Code for failing to carry out the treatment with reasonable care and skill, resulting in nerve injury and an increased chance of infection and pain, and anxiety for the woman. In addition, the dentist did not clarify his request for a second opinion, and therefore proceeded to remove the woman's wisdom tooth without a second opinion.

7. The Deputy Commissioner was also concerned about policy documents not being localised at the dental service.

Recommendations

8. The Deputy Commissioner recommended that the dentist develop a system for the assessment of patient complexity for surgery; implement a system where consultations with a specialist for an opinion are recorded in the dental records; undergo further training on the removal of wisdom teeth; audit a sample of ten patient records to ensure that all records are dated; and provide a written apology to the woman.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her daughter, Ms A, by Dr C at Dental Service 1. The following issues were identified for investigation:

- *Whether Dr C provided Ms A with an appropriate standard of care between 20 February 2019 and 28 March 2019.*
- *Whether Dental Service 1 provided Ms A with an appropriate standard of care between 20 February 2019 and 28 March 2019.*

10. This report is the opinion of Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Ms A	Consumer
Mrs B	Complainant/consumer's mother
Dr C	Provider/dentist
Dental Service 1	Provider/dentistry practice

12. Further information was received from:

Dr D	Oral and maxillofacial surgeon, Dental Service 2
Dr E	Oral and maxillofacial surgeon
Two medical centres	

Also mentioned in this report:

Ms F	Practice Manager
Dr G	Dentist
Dr H	Oral and maxillofacial surgeon, Dental Service 2

13. Independent expert advice was obtained from a general dentist, Dr Robin Whyman (Appendix A).

Information gathered during investigation

Introduction

14. This report considers the care provided to Ms A by dentist Dr C and Dental Service 1 between February and March 2019.

Background

15. On 30 January 2019, Mrs B contacted Dental Service 1 to enquire whether the practice was taking new patients, and the approximate cost for wisdom teeth extraction, as her daughter, Ms A (in her late teens at the time of events), was experiencing a "wisdom tooth problem on the bottom left side". The Practice Manager, Ms F, arranged an appointment for Ms A.

Initial appointment with Dr C at Dental Service 1

16. Ms A first attended Dental Service 1 on 20 February 2019, and saw dentist Dr C. Dr C documented that Ms A had been experiencing jaw pain for about a week, and there was pain to touch associated with an erupting lower left wisdom tooth. Dr C also documented that he discussed the possible consequences of non-removal, such as crowding and slight rotation of the teeth, and the benefits, risks, and approximate costs if Ms A chose to go ahead with the extraction at Dental Service 1.

17. Ms A was then referred to the "next door surgery" for an X-ray of the teeth in the upper and lower jaw.[1]

Appointment with Dr G at Dental Service 1

18. On 1 March 2019, Ms A was seen by Dr G at Dental Service 1. Mrs B told HDC that Dr G showed them the X-ray and told them that there was a wisdom tooth on both sides. Mrs B said that Dr G advised them that "neither [was] ready to come out so neither should be extracted".

19. Dr G no longer works at Dental Service 1 and was unable to provide the notes associated with this appointment. The dental service told HDC that it cannot find any of Dr G's notes associated with Ms A's appointment, in either the patient history or its physical records.

20. Following the appointment with Dr G, Mrs B rang Dental Service 1 and explained that she was "not confident about the last consultation as she was expecting [Ms A] to have [the troublesome] tooth removed". Mrs B asked for a second opinion from Dr C about whether to remove the tooth.

21. On 5 March 2019, Ms F apologised to Mrs B and Ms A for the confusion, and advised that Dr C was waiting on a second opinion from an oral and maxillofacial surgeon, Dr D at Dental Service 2.

Second opinion sought by Dr C

22. On 5 March 2019, Dr C sent an email to Dr D explaining that he had a patient who was "complaining of pain associated with the [lower wisdom teeth]". Dr C noted that these teeth were "not fully formed". He provided Dr D with a copy of the X-ray and asked whether he would "consider removal of the wisdom teeth now?".

23. On 6 March 2019, the receptionist/surgical assistant from Dental Service 2 responded: "Yes we would consider taking out her wisdom teeth. If you could send the referral through and

[1] An OPG radiograph/orthopantomograph.

we can contact the patient." Ms F emailed Dr C the response from Dental Service 2. Dr C replied to Ms F:

> "[P]robably they misunderstood our question … I will remove them I can start with the two lower ones. I can do them for $900 for two that is a $200 discount let them know. 1 [hour] 30mins [appointment]."

24. Dr D told HDC that he agreed to accept a referral from Dr C, but a referral was not forthcoming. Dr D explained that he would have considered taking out the teeth if Dr C had referred the patient to him at his practice, but ultimately it was up to the dentist and the patient to make the decision together on whether or not to go ahead with a referral to another dentist.

25. Dr C told HDC that he was seeking a second opinion from Dr D, rather than asking whether he should refer Ms A to Dental Service 2. Dr C recorded that Dr D advised that he "would consider [extraction]".

26. Mrs B said that they received a telephone call[2] from Dental Service 1 confirming that the oral surgeon had agreed that Dr C could remove the teeth. The surgery was confirmed for 16 March 2019.

Wisdom tooth surgery with Dr C

27. On the day of the surgery (16 March 2019), prior to the extraction, Dr C had a discussion with Mrs B and Ms A about extracting the teeth himself versus a referral. Dr C confirmed that he had sought a second opinion, and that the oral surgeon would also "consider" extraction. Dr C recorded, "pros cons all well informed", and that they agreed to extract both the lower wisdom teeth.

28. Mrs B told HDC that on the day of the surgery, they again told Dr C that it was the lower left wisdom tooth that was causing the problem, and they "weren't bothered about getting the other one removed", but Dr C advised that "he would have both out within 45 minutes so [he] may as well take both at the same time". In response to the provisional opinion, Mrs B said that Dr C never discussed the referral to the specialist, but mentioned it only to dismiss it as unnecessary, as the specialist had agreed that Dr C could remove the teeth himself at Dental Service 1.

29. Ms A signed the consent form to remove both the lower left and right wisdom teeth, but the form is undated. The form lists potential complications of surgery, including postoperative infection or inflammation, delayed healing, and "damage to the nerves during tooth removal resulting in temporary or permanent numbness or tingling of the lip, chin, tongue or other areas".

30. Dr C recorded that he used a local anaesthetic, and started on the lower right wisdom tooth first. He documented that the procedure involved "gentle careful [extraction], [and] took a bit of time [approximately] 45 mins". Dr C told HDC that there was "no specific reason" he

[2] The exact date of the telephone call is unclear from records.

decided to extract Ms A's right wisdom tooth first, but he explained that normally he starts on the right and then moves to the left side. Dr C said that he "did not get any further concerns" from either Ms A or Mrs B regarding discomfort during the surgery.

31. Mrs B told HDC that she returned to Dental Service 1 45 minutes after dropping off Ms A, and waited in the reception area. Mrs B said that she could hear Ms A "sounding distressed", and shortly after this Dr C appeared in the reception area and advised that "he had had trouble removing the tooth and was getting a bone saw". In response to the provisional opinion, Mrs B clarified that Dr C retrieved the bone saw from a cupboard in the reception area, and explained that the reason he was taking some time to complete the surgery was because he had to be very careful not to damage any nerves. Mrs B stated that when Dr C returned to the surgery room she could hear Ms A crying. Mrs B told HDC that during this time, Ms A was trying to say, "it hurts, it hurts". Ms A told HDC that she felt a lot of discomfort and distress during the surgery, which took over an hour.

32. Once the surgery had finished, Dr C advised that he had been able to remove only one tooth (the lower right wisdom tooth). Mrs B said that after the surgery Ms A was "very pale, sweaty and shaking". Dr C prescribed paracetamol and ibuprofen for pain relief, and provided advice on how to use an antiseptic mouth rinse.

33. Dr C documented that he advised Ms A to allow three weeks before booking in for extraction of the left lower wisdom tooth. Dr C also recorded that he offered to refer Ms A to a specialist to remove the other wisdom tooth, but that she agreed to go ahead with removal at Dental Service 1. In response to the provisional opinion, Mrs B told HDC that after the surgery Dr C did not offer to refer Ms A to a specialist to remove the other tooth, but rather he suggested that she make an appointment to return for the second extraction.

34. The dental service provided a statement from the dental assistant who assisted Dr C with the extraction. The dental service also provided the sterilisation log dated 16 March 2019 with the dental assistant's signature.

Post-surgery care

35. Ms A said that she felt very unwell after the surgery, and after leaving Dental Service 1 she found a piece of jawbone in her mouth. After the anaesthetic started to wear off, she had no feeling in her right lip, chin, and lower cheek. Ms A told HDC that in the days following the surgery, she felt in shock and was still feeling extremely unwell.

Follow-up phone calls from Dental Service 1

36. After the surgery, Ms F called Mrs B and Ms A a number of times to check on Ms A's recovery.

37. On 18 March 2019, Ms F called Ms A and was advised that she still had some numbness in her lower lip. Mrs B rang back the same day and raised concerns about the swelling and numbness. Ms F advised that she would be monitoring Ms A during the week, but if Ms A's condition worsened in between the phone calls, Mrs B should call straight away. Ms F left a message offering Ms A an appointment for that afternoon.

38. On 19 March 2019, Mrs B told Ms F that Ms A was doing fine, but was still swollen and experiencing pain and numbness in her lip. Mrs B advised Ms F that they would come into the practice to see Dr C.

Appointment 21 March 2019

39. On 21 March 2019, Ms A saw Dr C for a follow-up appointment. Dr C removed the sutures. He noted that the area was swollen and painful, and that Ms A was not able to open her mouth fully and was experiencing numbness around her chin and lip area on the lower right-hand side. Mrs B told HDC that when they asked Dr C about the infection, he told them that Ms A needed to clean out the wound better, and they received "more antibiotics [but] no other treatment was offered or suggested".

Appointment 28 March 2019

40. On 28 March 2019, Ms A saw Dr C for another follow-up appointment. Dr C recorded that the swelling had "subsided dramatically" but that Ms A now felt a tingling/burning sensation on the right-hand side of her lip. Dr C referred Ms A for a review and scan with oral and maxillofacial surgeon Dr H at Dental Service 2.

Subsequent events

41. On 7 April 2019, Mrs B took Ms A to an urgent care clinic as she felt that the infection had worsened. Ms A was seen by a doctor who prescribed antibiotics. The doctor noted that Ms A had a dental specialist appointment booked for the following week. In response to the provisional opinion, Mrs B explained that at this appointment they learned about the severity of the injury Ms A had sustained during the extraction of her wisdom tooth.

42. Ms A saw Dr H at Dental Service 2 on 11 April 2019. He carried out some nerve testing on Ms A and noted some sensory loss in the right-hand lower lip. Dr H referred Ms A to oral and maxillofacial surgeon Dr E at another service.

43. Dr E saw Ms A for an initial consultation on 24 April 2019. He noted his impression that Ms A had "a crush/compression injury of the right inferior dental nerve, sustained at the time of removal of tooth 48 [lower right wisdom tooth], five weeks ago".

44. On 24 May 2019, Dr E cleaned out Ms A's wound bed and removed bone fragments (debridement), and decompressed the inferior dental nerve. ACC covered the costs of the surgery, and Dental Service 1 covered the shortfall costs associated with the consultations.

Further information

45. Ms A told HDC:

> "[The] experience was terrifying and I felt so much anxiety during and afterwards, I was really shaken up. … Two years on I still have [only] about 70% of the feeling back, pins and needles and occasionally pain in the nerve damage part of my face … [It] can occasionally affect my speech at times."

46. At the time of events, Ms A was studying and working. She said that as a result of the surgery, she missed a lot of classes, her grades fell, and she found it difficult to work given the pain.

Mrs B said that Ms A still has no feeling in her chin and has been experiencing significant pain in her lip.

47. Dental Service 1 expressed its deepest sympathies to both Mrs B and Ms A. Dr C stated:

> "[T]his has been an extremely stressful and deeply concerning incident for both my staff and myself. I always strive to provide my patients with the best services and treatments possible."

48. Dr C told HDC that the team has reviewed this incident thoroughly to see where improvements can be made. The changes made are discussed at paragraph 72.

Responses to provisional opinion

49. Dr C was given an opportunity to respond to the provisional opinion, and commented that he fully accepts the report.

50. Ms A and Mrs B were given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, their responses have been incorporated into this report.

51. Mrs B provided a response on behalf of Ms A. Mrs B told HDC that she felt misled by Dr C, and he broke their trust when he assured them — both over the phone and in person — that he did seek a second opinion from a surgeon, who agreed that he could remove the teeth himself. Mrs B reiterated the impact this experience has had on Ms A. Mrs B stated: "[Ms A] still has the left lower wisdom tooth and pain flare ups from it but is unable to seek dental treatment of any kind as she is too traumatised by this experience."

Opinion: Dr C — breach

52. This case highlights the importance of undertaking an appropriate assessment of the complexity of a procedure, so that the dentist who is to carry out the procedure can be satisfied that their skills match the procedure. My expert advisor, dentist Dr Robin Whyman, has concerns about aspects of the care Dr C provided to Ms A, including the method used to remove Ms A's wisdom tooth, and Dr C's reliance on the email from Dental Service 2, which Dr C said was a second opinion.

Reliance on email from Dental Service 2

53. On 5 March 2019, Dr C sent an email to oral and maxillofacial surgeon Dr D asking whether Dr D would "consider removal of the wisdom teeth now?". On 6 March 2019, the receptionist/surgical assistant from Dental Service 2 responded to Dr C: "Yes we would consider taking out her wisdom teeth. If you could send the referral through and we can contact the patient." Dr C replied to Ms F stating: "[P]robably they misunderstood our question … I will remove them I can start with the two lower ones." Dr D told HDC that he agreed to accept a referral, but a referral was not forthcoming.

54. The response to Dr C's email is from the receptionist/surgical assistant at Dental Service 2. Dr Whyman noted:

> "No correspondence directly from [Dr D] is evident in the documents … The email received was not from a clinician, but rather from a staff member at [Dental Service 2] who had spoken to [Dr D]. It indicates to me that they, as specialist clinicians, would consider removing [Ms A's] wisdom teeth."

55. Dr Whyman advised:

> "[T]he email correspondence does not appear to support [Dr C's] contention that [Dr D] supported his proceeding with the surgery. Rather [Dental Service 2] appear[s] to have indicated that they would have considered proceeding with surgery following a consultation with the patient.
>
> … [T]he responsibility was firmly with [Dr C] to be confident in his assessment of the need for surgery, the patient's acceptance of the balance of considerations for proceeding with surgery and his experience, confidence and competence to complete the surgery successfully."

56. Dr Whyman considers that Dr C's reliance on the email as indicating that he should proceed with Ms A's surgery, rather than refer her to Dental Service 2, was a significant departure from the standard of care. Dr Whyman advised that dentists need to assess the complexity of the procedure and the patient appropriately, to match the approach of the surgery. Dr Whyman noted that the complexity of the planned surgery is based on factors such as medical history, patient anxiety, mouth opening, access to the posterior of the mouth, and jaw size. Dr Whyman considers that "[Ms A's] wisdom teeth would be within the scope of practice of an experienced general dentist but they were moderately to significantly complex" given that jaw bone would need to be removed or the tooth cut into parts for removal. Dr Whyman noted that Dr C appears to have underestimated the complexity of Ms A's surgery.

57. I accept Dr Whyman's advice that the email from Dental Service 2 did not amount to a second opinion that supported Dr C to proceed with the surgery. Based on the evidence before me, I find it more likely than not that Dr C realised that Dental Service 2 had misinterpreted his request for a second opinion, and that Dr C decided to proceed with the surgery anyway without clarifying his request.

58. As highlighted by Dr Whyman, it is important for practitioners to ensure that they have assessed the complexity of the procedure and patient appropriately to satisfy themselves that they are practising within their professional knowledge, skills, and competence as set out in the New Zealand Dental Council's professional standards (included at Appendix B). I am critical that as part of this assessment of the procedure and patient, Dr C, having recognised that he required a second opinion before progressing, did not clarify his request with Dental Service 2 to ensure that he had a second opinion before proceeding with the surgery.

Wisdom tooth removal surgery

59. On 16 March 2019, Ms A presented to Dental Service 1 for the removal of her wisdom teeth by Dr C. Dr C recorded that he used a local anaesthetic, and started on the lower right wisdom tooth first. He documented that the procedure involved "gentle careful [extraction], [and] took a bit of time [approximately] 45 minutes". Dr C removed only the lower right wisdom tooth. Mrs B told HDC that during the surgery Ms A sounded distressed and felt a lot of anxiety.

60. Following the surgical complication, Dr C referred Ms A to oral and maxillofacial surgeon Dr H at Dental Service 2. Dr H then referred Ms A to oral and maxillofacial surgeon Dr E at another service. On 24 April 2019, Dr E cleaned out Ms A's wound bed and removed bone fragments, and decompressed the inferior dental nerve.

61. Dr Whyman advised that Dr C's decision to start on the right-hand side did not fall below the standard of care, and it was prudent for him not to continue with the left-hand side given that the procedure did not proceed as smoothly as anticipated. Dr Whyman also advised that the initial prescription for pain relief and the management of the complications post-surgery were within an acceptable standard of care. Dr Whyman noted that Dr C made a timely referral of Ms A to a specialist following the surgical complication. Dr Whyman concluded that "the management of the complications was within an acceptable standard of care".

62. However, I am concerned about how the lower right wisdom tooth was removed by Dr C.

63. Dr Whyman advised that Dr E's findings were "consistent with a traumatic removal of the lower right wisdom tooth, incomplete debridement (cleaning, irrigation and shaping) of the socket and/or trauma occurring to the inferior dental nerve during the removal of the lower right wisdom tooth". Dr Whyman explained that "standard practice is to thoroughly irrigate the surgical site following the surgery and check that residual loose bony fragments and tooth fragments have been removed as this minimizes the risk of infection or of reactive tissue forming that can prevent or slow healing, or impinge on the nerves associated with the wisdom teeth".

64. Dr Whyman advised:

> "[Ms A's] wisdom teeth fell into the category of surgery of moderate to significant complexity for a general dentist experienced with wisdom tooth surgery. [Dr C] had the responsibility to understand and plan for that."

65. Dr Whyman noted that "[Dr C] appears to have underestimated the complexity of [Ms A's] surgery". Dr Whyman considers that Dr C's removal of Ms A's lower right wisdom tooth was not of an acceptable standard, and that his surgery was a moderate departure from the standard of care. I accept Dr Whyman's advice.

Conclusion

66. In summary, I consider that Dr C had a responsibility to provide services to Ms A with reasonable care and skill and, in my opinion, he did not do this. Dr C:

a) Proceeded with the surgery without clarifying his request for a second opinion from Dental Service 2, and therefore proceeded without a second opinion; and

b) Failed to carry out the treatment with reasonable care and skill, resulting in nerve injury, an increased chance of infection and pain, and anxiety for Ms A.

67. Accordingly, I find that Dr C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[3]

Opinion: Dental Service 1 — adverse comment

68. As a healthcare provider, Dental Service 1 is responsible for providing services in accordance with the Code. In this case, I consider that the error that occurred did not indicate broader systems or organisational issues at the dental practice.

69. In my view, Dr C's errors were the result of individual clinical decision-making, and were not due to any shortcomings in the policies and procedures of Dental Service 1. My dental expert, Dr Robin Whyman, advised:

> "[T]he responsibility was firmly with [Dr C] to be confident in his need for surgery, the patient's acceptance of the balance of considerations for proceeding with surgery and his experience, confidence and competence to complete the surgery successfully."

70. Dr Whyman advised that Dental Service 1's policy documents[4] are appropriate for a dental practice and for oral health practitioners. I accept this advice. I note Dr Whyman's advice regarding policies specific to the dental practice, that these localised policy documents may assist practitioners to improve their record-keeping. I encourage Dental Service 1 to reflect on Dr Whyman's advice in this regard, specifically the benefits of localised policy documentation.

71. I note that following the events in 2019, Dental Service 1 updated its written consent forms for teeth removal and provided evidence that staff have read the Code and the New Zealand Dental Association informed consent practice standard. As highlighted by Dr Whyman, I acknowledge that the level of postoperative telephone contact with Mrs B by Dental Service 1 was high.

[3] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[4] Dental Service 1 provided the following policy documents to HDC: [Dental Service 1's] consent form for tooth removal, HDC's "Your Rights" poster, the Code of Health and Disability Services Consumers' Rights Regulations, and the Informed Consent Code of Practice of the New Zealand Dental Association, and reference was made to the Dental Council's Standards Framework for Oral Health Practitioners.

Changes made

72. Since the events in 2019, Dental Service 1 has made the following changes:

a) Updated the tooth removal consent form to include a space to date the form and a space to note that a discussion around referral to an oral surgeon has taken place.

b) Provided evidence that staff have read the Code of Health and Disability Services Consumers' Rights and the informed consent code of practice of the New Zealand Dental Association.

Recommendations

73. I recommend that Dr C:

a) Provide a written apology to Ms A for the breach of the Code identified in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Develop a system for the assessment of patient complexity for surgery, as recommended by Dr Whyman. Dr C should provide HDC with evidence that this has been completed, within six months of the date of this report.

c) Implement a system where consultations with a specialist for an opinion are recorded in the dental records, as per Dr Whyman's advice. Dr C should provide HDC with evidence that this has been completed, within six months of the date of this report.

d) Undergo further training on wisdom teeth removal, and provide HDC with evidence that this has been completed, within six months of the date of this report.

e) Audit a sample of ten patient records to ensure that all of the clinical records are dated. Dr C is to report back to HDC within three months of the date of this report summarising the results and the steps being taken to address any issues.

74. I recommend that Dental Service 1 review the Dental Council publication "Patient records and privacy of health information practice standard" and provide training to staff on the importance of maintaining patient records. Dental Service 1 is to provide HDC with evidence of the staff training, within six months of the date of this report.

Follow-up actions

75. 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 Dr C's name.

76. 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, for educational purposes.

77. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from general dentist Dr Robin Whyman:

"1. I was requested by … for the Health and Disability Commissioner (HDC), to provide expert advice regarding the care provided by [Dr C] to [Ms A] on 16 March 2019 and issues related to that care.

2. I am registered with the Dental Council as a general dentist and a dental specialist in public health dentistry. I was employed by Hawke's Bay District Health in January 2013 as Clinical Director Oral Health and since February 2019 I have been Chief Medical and Dental Officer. Both roles have involved my continuing to undertake clinical dentistry, in addition to my dental and medical administration responsibilities.

3. I have been employed as a senior dentist/dental specialist/clinical director oral health providing hospital-based dental services since 1995. I have been employed at a variety of district health boards, but principally Hutt Valley DHB between 1997 and 2000 and again between 2004 and 2012. I was Dental Director at Capital and Coast DHB between 1995 and 2000. I was also Chief Dental Officer for the Ministry of Health in the period 2005–2009.

4. I was a member of the Dental Council between June 2011 and June 2021 but [Dr C], and the complainants (the patient and her mother) are not known to me through that role. I am no longer a member of the Dental Council.

5. I am not aware of any conflict of interest in this matter.

6. I am basing this opinion on the information available to me in documents provided by the office of the Health and Disability Commissioner.

7. These documents include copies of letters of complaint by [Ms A] (patient) and [Mrs B] ([Ms A's] mother). An undated letter from [Dr C] to the Health and Disability Commissioner, clinical notes from [Dr C] including an OPG radiograph, email correspondence between [Dr C] and [Dr D], email correspondence between [Dental Service 1] and [Mrs B], a statement from [the] dental assistant for [Dr C], sterilisation logs for dental equipment, [Ms A's] consent form and a referral from [Dr C] to [Dr H].

8. I also received copies of clinical notes, the operation report, an assessment and treatment plan for ACC and the OPG radiograph from [Dr E]. [Dr E] is the oral and maxillofacial surgeon who undertook a second procedure for [Ms A] on 24 May 2019.

9. The key issues for [Ms A] and [Mrs B] are that [Dr C] continued with the removal of [Ms A's] tooth despite objections about which tooth was to be removed, pain and distress, [Dr C] not being assisted during the consultation or extraction, he was

practising outside his scope and ability when he continued with the extraction and that [Ms A's] healing was poor. She developed an infection and required a second surgical procedure to address ongoing damage to the nerve causing facial pain and loss of feeling in her face, lip and chin.

10. This report focuses on the issues requested in the letter from [HDC] and has been divided into sections to address those specific areas.

Whether [Dr C] provided [Ms A] with care of an acceptable standard

11. Based on the email correspondence and dental records from [Dental Service 1] the initial enquiries regarding management of [Ms A's] lower wisdom teeth occurred in an email enquiry on 30 Jan 2019 from [Mrs B].

12. Subsequently [Ms A] attended for an examination visit on 20 February 2019. A discussion is recorded which mentions pain to touch associated with an erupting lower left wisdom tooth. Possible consequences of non-removal are recorded. It is notable that the word possible is capitalised in the record suggesting that some emphasis was placed on the uncertainty of predicting outcomes with erupting lower wisdom teeth.

13. [Ms A] was then referred to the "next door surgery" for an OPG radiograph. No further discussion with the patient appears to have occurred until the day of surgery which was 16 March 2019.

14. The procedure was undertaken under local anaesthetic alone. The clinical notes indicate that the patient elected to have both lower wisdom teeth removed on the same day. A signed consent form is contained in the records that records the agreement to remove teeth '38/48' which is the lower left and right wisdom teeth. Unfortunately the form is undated. The form does record potential complications of surgery including post-operative infection or inflammation, delayed healing and damage to the nerves that can result in temporary or permanent numbness or tingling of the lip, chin, tongue or other areas.

15. The notes also indicate that [Dr C] had intended to undertake the surgery on both the left and the right side on 16 March and local anaesthetic appears to have been placed on both sides. The notes are not entirely clear on this point as they state 'IDNx2+B infiltration'. This would appear to indicate both sides were anaesthetised but only records the number of anaesthetic cartridges placed, not the sides.

16. The notes then indicate that the right sided tooth was surgically removed with bone removal. The notes indicate that the procedure involved "gentle careful exo, took a bit of time aprox [sic] 45 minutes".

17. The notes at the end of the procedure state "leav [sic] for 3 weeks then other one exo again offered specialist/pat all ok go ahead with us".

18. The clinical notes do not indicate why the decision was taken not to proceed with both sides on the same day. However, I note the statement from [Ms A] indicates that the intention was to remove both lower wisdom teeth, that [Ms A] felt that the procedure ran into trouble and she was in a lot of discomfort and distress, she felt anxiety afterwards and was unwell over the following 3 days.

19. [Ms A] also reports that after the anaesthetic wore off she remained numb on her right sided lip, chin and lower cheek.

20. [Mrs B's] statement recalling the day of surgery indicates that after the surgery [Ms A] was pale, sweaty and shaking, distressed and in pain.

21. I draw the conclusion from the records of [Dr C] and the statements of [Ms A] and [Mrs B] that while the intention was to remove both the lower left and right wisdom teeth on 16 March, surgery was discontinued after the right sided surgery alone. The procedure had taken longer than expected and had been more complex than anticipated. Having removed the right sided tooth the decision was made not to proceed with the left sided tooth at that time.

22. It is my experience that from time to time a plan to remove more than one tooth can be modified on the day of surgery when surgery is more complex than anticipated or the patient does not tolerate the procedure as well as had been anticipated.

23. While it was unfortunate that [Ms A] had been experiencing pain with her left lower wisdom tooth and the surgery commenced with the right tooth, it is not uncommon that dentists have a routine of starting on one side and proceeding to the other side in a certain order to standardise the procedure and minimise complications. Given [Dr C's] plan had been to remove both lower teeth in one day at the start of surgery I do not believe the decision to commence with the right side falls below the acceptable standard of care. I also believe that when the procedure did not proceed as smoothly as anticipated it was prudent not to continue with the left side at that time but to cease surgery at that point and plan for a second procedure.

24. A recent Cochrane review of the literature examining surgical techniques for the removal of lower wisdom teeth indicates that the incidence of infection following surgery is in the range of 1.5–5% and nerve damage causing partial number is in the range 2–9%. It is therefore realistic to anticipate that infection in the tooth socket or partial numbness of the lip could occur after wisdom tooth surgery[1].

25. However, I am concerned that the post-operative OPG film obtained from [Dr E], who saw [Ms A] 5 weeks following the surgery indicates a mottled appearance

[1] Bailey E, Kashbour W, Shah N, Worthington HV, Renton TF, Coulthard P. Surgical techniques for the removal of mandibular wisdom teeth. Cochrane Database of Systematic Reviews 2020, Issue 7. Art. No.: CD004345. DOI: 10.1002/14651858.CD004345.pub3. Accessed 05 August 2021.

within the tooth socket. [Dr E's] notes indicate that bony fragments remained in the tooth socket following the removal of the tooth.

26. Following surgical removal of a tooth the surgical site, including the tooth socket should be checked for debris, including bony fragments or tooth fragments, that can occur when drilling to remove bone and elevating or sectioning the tooth for removal. In [Ms A's] case the notes indicate the tooth was removed intact. However, fragments can still separate from the tooth as it is elevated from the socket.

27. It is standard practice to thoroughly irrigate the surgical site following the surgery and check that residual loose bony fragments and tooth fragments have been removed. This minimises the risk of infection or of reactive tissue forming that can prevent or slow healing, or impinge on the nerves associated with the wisdom teeth.

28. Bony fragments can also separate within a tooth socket during healing if the bone is not appropriately cooled during drilling or the socket is not smooth and sharp edges removed to ensure the bone heals with a suitable blood supply.

29. [Dr E's] notes indicate that at the second operation he found infected soft bone within the socket, bone compressing the nerve (this would have been the inferior dental nerve at the base of the tooth socket), and that the nerve was traumatised with either neuroma formation or GT [granulation tissue] attached.

30. These findings are consistent with a traumatic removal of the lower right wisdom tooth, incomplete debridement (cleaning, irrigation and shaping) of the socket and/or trauma occurring to the inferior dental nerve during the removal of the lower right wisdom tooth.

31. [Ms A] also reports she had a bad taste, bony fragments appearing from the socket and prolonged nerve numbness following the surgery.

32. Infection of the socket, bony fragments and periods of temporary or permanent numbness are recognised complications following the removal of lower wisdom teeth. However, the findings of [Dr E] at the second operation indicate that the surgical removal of the lower right wisdom tooth was undertaken in a traumatic way that damaged the jaw bone, created multiple bony fragments that were not removed from the socket after the surgery and that following the surgery an incomplete debridement of the socket occurred. These issues would have all increased the likelihood of post operative infection and damage to the inferior dental nerve.

33. I draw the conclusion that [Dr C's] removal of [Ms A's] lower third molar tooth was not at an acceptable standard and that his surgery was a moderate departure from the accepted standard of care.

34. [Dr C] prescribed paracetamol and ibuprofen for pain relief following the surgery. These are accepted medications for the post operative management of pain following third molar surgery[2]. Practitioners may utilise an opioid analgesic (pain reliever) such as codeine or tramadol following wisdom tooth surgery in the presence of severe pain and these could also have been considered. However, I draw the conclusion that [Ms A's] pain following the surgery for her lower right wisdom tooth was a consequence of the traumatic way in which the surgery was performed, the failure to debride the socket and the trauma incurred in the inferior dental nerve.

35. I do not believe [Dr C's] initial prescription for pain relief was below the accepted standard of care.

36. Following [Ms A's] surgery on 16 March 2019 [Ms A] was seen again by [Dr C] on 21 March and 28 March and on 28 March [Dr C] referred [Ms A] for a review and scan with [Dr H] at [Dental Service 2]. Given the ongoing issues with altered lip sensation 12 days following the surgery and severity of those symptoms it was appropriate that a referral was made to an oral and maxillofacial surgery specialist at that point.

37. A series of phone conversations occurred between [Dental Service 1] and [Mrs B] between 18 March 2019 until 8 August 2019 including checking with her regarding [Ms A's] progress once she was seen by [Dr E] and following the surgical procedure to manage the lip numbness.

38. The level of post operative telephone contact with [Mrs B] by [Dental Service 1] appears to have been high and [Dr C] made a timely referral of [Ms A] to a specialist following the surgical complication. I conclude that the management of the complications was within an acceptable standard of care.

The appropriateness of [Dr C] removing the tooth following the email advice from [Dr D]

39. In the period between [Ms A's] consultation on 20 Feb 2019 and the date of surgery on 16 March 2019 [Dr C] contacted [Dr D] at [Dental Service 2] and asked him whether he would consider removing the wisdom teeth now. My reading of that question to the specialist dental practice is seeking advice regarding timing of the removal of the lower wisdom teeth. The response to the email is from [the receptionist/surgical assistant] at [Dental Service 2], who appears from the documents to be a receptionist not a clinical member of staff. No correspondence directly from [Dr D] is evident in the documents.

40. Decisions regarding timing and appropriateness of removal of lower third molar teeth are not clear cut. A series of factors will need to be weighed by the patient

[2] Bailey E, Worthington HV, van Wijk A, Yates JM, Coulthard P, Afzal Z. Ibuprofen and/or paracetamol (acetaminophen) for pain relief after surgical removal of lower wisdom teeth. Cochrane Database of Systematic Reviews 2013, Issue 12. Art. No.: CD004624. DOI: 10.1002/14651858.CD004624.pub2. Accessed 06 August 2021.

and the clinician including history of symptoms associated with the erupting teeth, history of infection, age, stage of development of the wisdom teeth, damage or potential for damage from dental caries (decay) or periodontal disease (gum disease) to associated neighbouring teeth, potential for damage to associated anatomical structures in particular the inferior dental nerves (which supply sensation to the lip, chin, part of the cheek and face) and to the lingual nerves (which supply sensation to part of the tongue), social factors including support through the time of the surgery and financial issues.

41. The decision about whether to proceed or not with surgery will come down to an informed consent discussion, weighing the factors discussed above, between the patient, the clinician and their support person or people.

42. It is not uncommon for young adults in their late teens or early twenties to proceed with removal of unerupted and/or mildly symptomatic third molar teeth as surgery can be more straightforward with the teeth partially developed, bone less dense and social and financial support from family can be more readily available.

43. It appears from the email correspondence and clinical notes that these factors were considerations in [Ms A] and [Dr C] deciding whether to proceed to surgery.

44. However, the email correspondence does not appear to support [Dr C's] contention that [Dr D] supported his proceeding with the surgery. Rather [Dental Service 2] appear to have indicated that they would have considered proceeding with surgery following a consultation with the patient.

45. In this circumstance the responsibility was firmly with [Dr C] to be confident in his assessment of the need for surgery, the patient's acceptance of the balance of considerations for proceeding with surgery and his experience, confidence and competence to complete the surgery successfully.

46. Removal of wisdom teeth is within the scope of practice of an appropriately experienced and competent general dentist.

47. However, it is also frequently undertaken by specialist oral surgeons or oral and maxillofacial surgeons. This is because the difficulty of removing wisdom teeth, particularly lower wisdom teeth, ranges from straightforward to complex depending upon a range of factors including the management of the patient's anxiety, medical conditions and the position of the lower wisdom teeth.

48. [Dr C's] notes provide limited information prior to the day of surgery about the anxiety of [Ms A]. Indeed they rather indicate that [Ms A] and her mother were keen to proceed with surgery because of a concern about crowding of lower front teeth that may occur and a history of pressure and/or pain from the lower left wisdom tooth.

49. [Dr C] made the decision with [Ms A] to proceed with removal of the lower wisdom teeth under local anaesthetic alone. The alternative would have been to have considered a form of sedation to reduce anxiety associated with the procedure. Common sedative medications can also provide a level of amnesia (loss of memory) of the procedure. A further alternative would have been to proceed to a general anaesthetic. Sedation or general anaesthetic were not techniques [Dr C] offers as a general dentist, according to his letter to the HDC.

50. Alternative approaches would more commonly occur when the surgery occurs with a specialist oral surgeon or oral and maxillofacial surgeon. This would have involved referral of the patient.

51. Although removal of wisdom teeth under local anaesthetic alone is acceptable practice, and within the scope of practice of a general dentist, it requires the dentist to have appropriately assessed the complexity of the procedure, and the patient, to match that approach to the surgery.

52. Complexity of the planned surgery is based both on the clinical assessment including factors such as medical history, patient anxiety, mouth opening, access to the posterior of the mouth and jaw size. No information is available from the notes about any issues with these factors.

53. It is also based on an assessment of the position of the lower wisdom teeth based on the OPG radiograph. A number of long standing assessment techniques of wisdom teeth from their radiographic appearance are available including Winter classification[3] and the Pell and Gregory assessment[4].

54. These techniques consider the angulation of the lower wisdom tooth relative to the second molar tooth, the depth of the tooth in the bone relative to the position of the molar teeth already in the mouth and the size of the crown of the wisdom tooth relative to the lower jaw.

55. On these assessments I consider that [Ms A's] wisdom teeth would be within the scope of practice of an experienced general dentist but they were moderately to significantly complex. The teeth have an angulation that is generally considered as favourable (mesio angular) but they are both relatively deep with the crown (top) of the wisdom teeth still in the middle half of the roots of the second molar tooth in front. This means that bone would have to be removed to create a point to elevate (lift) the tooth and they would require bone removal around the crown of the teeth to create enough space to free the tooth in the jaw and enable it to be lifted. Alternatively the tooth would need to be cut into parts to remove it.

[3] Winter GB. Impacted mandibular third molars. American Medical Book Co. St. Louis, MO, USA, 1926
[4] Pell GJ and Gregory GT. Impacted mandibular third molars: Classification and modified technique for removal The Dental Digest 39(9) 1933.

56. Either way the dentist could have predictably expected that the surgery would involve a procedure that required a moderate amount of removal of bone around the wisdom tooth before it could be removed. This is most commonly undertaken with a surgical drill and can be unpleasant for the patient to experience under local anaesthetic alone. It is for this reason that surgery is frequently undertaken with the support of sedation or general anaesthesia.

57. Favourable aspects of the planning of surgery for [Ms A] would have been her age, that the teeth were still only partially formed and were above the inferior dental nerve.

58. In my opinion [Ms A's] wisdom teeth fell into the category of surgery of moderate to significant complexity for a general dentist experienced with wisdom tooth surgery. [Dr C] had the responsibility to understand and plan for that.

59. In my opinion his advice from [Dental Service 2] did not indicate that they were suggesting [Dr C] should or should not proceed with the surgery. The email received was not from a clinician, but rather from a staff member at [Dental Service 2] who had spoken to [Dr D]. It indicates to me that they, as specialist clinicians, would consider removing [Ms A's] wisdom teeth.

60. In any event the New Zealand Dental Council's professional standards are clear that practitioners must practise within their professional knowledge, skills and competence, or refer to another health practitioner (Standard 8).[5]

61. I am of the opinion that [Dr C] appears to have underestimated the complexity of [Ms A's] surgery either because he underestimated the behavioural factors associated with removing the teeth or he underestimated the technical complexity associated with removing the teeth, or both.

62. I am of the opinion that [Dr C's] reliance on the email from [Dental Service 2] as indication he should proceed with [Ms A's] surgery rather than refer her was a significant departure from the standard of care.

Any other matters in this case that warrant comment.

63. I recommend that [Dr C's] practice in the removal of wisdom teeth would be enhanced by his familiarising himself with objective assessment of mandibular wisdom teeth for surgery using established criteria, such as those described in this report.

64. He should develop a system for the assessment of the patient complexity for surgery to satisfy himself that his case selection matches his level of experience and ensure these factors are documented in the records.

[5] https://www.dcnz.org.nz/assets/Uploads/Practice-standards/Standards-Framework-for-Oral-Health-Practitioners.pdf Accessed 5 August 2021

65. I also recommend that all of his clinical records must be dated. I note this is particularly relevant to the consent form which is undated but is a key clinical record associated with this particular episode of care for [Ms A]. His other records appear appropriately time and date bound.

Dr Robin Whyman
BDS, MComDent, FRACDS, FRACDS (DPH)"

The following further expert advice was obtained from Dr Whyman:

"1. I was requested by … for the Health and Disability Commissioner (HDC), to provide expert advice regarding the care provided by [Dr C] to [Ms A] on 16 March 2019 and issues related to that care.

2. My original opinion was provided to the HDC on 6 August 2021.

3. I was subsequently asked by … to review [Dr C's] response to my opinion and consider

   a. Whether any information changes my original advice and any departures from the expected standard of care.

   b. Any further comments or recommendations

   c. Provide comment on the adequacy of the policies provided by [Dental Service 1]

Whether any information changes my original advice and any departures from the expected standard of care

4. I have considered [Dr C's] responses to my original opinion. The additional information does not change my original advice.

Further comments or recommendations

5. I note that [Dr C] has provided further information, to the best of his recollection, of the process he underwent to discuss the removal of [Ms A's] wisdom teeth and subsequently remove the lower right wisdom tooth.

6. While the information indicates [Dr C] feels he did undertake a thorough discussion and informed consent process with [Ms A] and [Mrs B] (patient's mother) it does not provide any further documentation of these discussions or considerations. As noted in my original opinion a signed but undated written informed consent form is contained within in the records.

7. With regard to [Dr C's] discussion of the removal of [Ms A's] wisdom teeth with the specialist [Dr D] no further documentation of the interaction is provided.

8. I do note that in [Dr C's] response he reports that he emailed [Dr D] on 5 March 2019. This email was in the original documents supplied. However, I remain of the view that the documentation does not record the response from, or the interaction with [Dr D]. The response from [Dental Service 2] is not from [Dr D].

9. When [Dr C] consults with a specialist for an opinion then it would be wise for him to record that interaction, the discussion and outcome in the dental records.

10. I remain of the view recorded at paragraph 59 and 60 in my original report. Regardless of consulting for a further view about the planned care, and the fact that this can be a wise and appropriate thing to do, the decision whether or not to proceed and to provide care of appropriate standard remains with the treating practitioner.

The adequacy of the policies provided by the [Dental Service 1] practice

11. I have reviewed the policy documents provided for [Dental Service 1].

12. I note that the consent form for tooth removal has been updated to include a space to date the form, this is sensible and responds to the concern in my original opinion that the form for [Ms A] was undated.

13. The advice in the form, including the risks recorded, have been updated and are appropriate to the removal of teeth. It would be important that this form is completed in conjunction with a thorough discussion with the patient. On its own the form could be considered quite legalistic but it does cover the sensible considerations that should be worked through.

14. I am unsure what the statement at the end of the form '... and have NOT been offered any guarantees." means. I would not include it in the form.

15. The other documents provided are not documents specific to [Dental Service 1]. They comprise

    a. The Health and Disability Commissioner 'Your Rights' poster, which appears appropriately displayed although the photograph gives a limited view of the context.

    b. The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulations.

    c. The Informed Consent Code of Practice of the New Zealand Dental Association.

    d. A photograph of the front page of the Dental Council's Standards Framework for Oral Health Practitioners and a folder entitled H&S Protocols and Standards and NZ Dental Council. Photographs appear to be pages from that folder.

    e. A written record that staff have signed indicating they have read the documents.

16. The document indicating that staff have read the documents has been instituted since the events associated with this case occurred. Therefore it appears [Dental Service 1] have acted to ensure that staff are updated, have acknowledged reading the documents and that the practice has a record.

17. All of the documents provided are appropriate policy documents for a dental practice and for oral health practitioners. It is necessary to use these documents and be familiar with them.

18. However, I would recommend that the practice considers localising policy documentation for the dental practice as these are all policies provided by external advisory or regulatory agencies. They are strengthened by consideration for the context of each practice.

Any other matters in this case

19. I have no further recommendations to make.

20. I do note that [Dr C] accepts and acknowledges the advice of my opinion dated 6 August 2021 and I wish him the best with learning from this event and continuing to improve his practice.

21. I also acknowledge that this was a difficult period for [Ms A] and I wish her the best with her recovery.

Dr Robin Whyman
BDS, MComDent, FRACDS, FRACDS (DPH)"

Appendix B: Relevant standards

Dental Council — Standards Framework for Oral Health Practitioners

The Dental Council publication "Standards Framework for Oral Health Practitioners" states:

> "**8 You must practise within your professional knowledge, skills and competence, or refer to another health practitioner**
>
> Guidance
>
> - Practise safely and competently to ensure you do not cause harm to your patients.
> - Only carry out a task or a type of treatment if you have the knowledge and skills to do so competently within your scope of practice.
> - Recognise your own limitations and the special skills of others in diagnosis, prevention and treatment, and refer patients accordingly. Such referral might be to an oral health practitioner or other health professional."

The Dental Council publication "Patient records and privacy of health information practice standard" states:

> **"Retention of patient records**
>
> 11 You must ensure that your patients' records are retained for a minimum of 10 years from the day following the last date on which care was provided, or the records are properly transferred.
>
> Note: Under the Public Records Act 2005 patient records held by DHBs are considered public records, and may not be disposed of without the authorisation of the Chief Archivist.
>
> Guidance
>
> - You may retain patient records for longer than 10 years if it is anticipated that they might be needed for future diagnosis and care, and are kept securely.
> - Patient records do not need to be retained in any particular form. Electronic copies of records may be made as long as the information is reproduced accurately and is accessible.
> - You may, within the 10 year period, transfer original patient records to the patient, their representative, or another practitioner or dental practice. Typically this would be on the patient's request.
>
> Once you transfer the complete, original record to the patient or their representative, you no longer have any obligations related to the retention of

that record. This is also the case if the record is transferred to another practitioner or dental practice — the practitioner or dental practice receiving the record now has these obligations.

- If you transfer the original record, it is recommended that you retain a copy of the record for situations such as a future complaint regarding the quality of care provided, or financial auditing purposes.

- Arrange the transfer of patient records before retiring. This will involve informing patients of your plans for the transfer of their health information to another practitioner on the sale or closure of your practice. This provides the opportunity for the patient to request that their personal information is instead transferred to them, an alternative dental practice or practitioner."