Dentist, Dr B

A Report by the

Health and Disability Commissioner

(Case 02HDC18228)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Dentist / Provider
Mrs C	Dental Assistant
Mr D	Clinical Dental Technician

Complaint

On 5 December 2002 the Commissioner received a complaint from Ms A about Dr B. The complaint is summarised as follows:

On 28 November 2002, Dr B did not provide services of an appropriate standard to Ms A, in that he removed 14 teeth rather than 4 teeth as planned.

On 28 November 2002 Dr B did not seek or obtain Ms A's informed consent for the removal of 14 teeth.

An investigation was commenced on 13 February 2003.

Information reviewed

- Letter of complaint, dated 3 December 2002
- Further information from Ms A, received 10 and 21 February 2003
- Letter of notification, dated 13 February 2003
- Response from Dr B, dated 24 February 2003, including:
  - dental records
  - X-rays
  - sedation consent sheet
  - copy of a letter sent to Ms A on 12 December 2002
- Further response from Dr B, dated 27 March 2003, including:
  - a dental prescription form
  - further dental records
- Letter from Mrs C, dental assistant, undated
- Letter of response, from Dr B, to the Commissioner's provisional opinion, dated 2 September 2003.
- Independent expert advice obtained from Dr Dan McGettigan.

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Information gathered during investigation

On 25 August 2000, Ms A attended the surgery of Dr B and had X-rays taken. A locum dentist for Dr B undertook a surgical removal of one of Ms A's lower wisdom teeth.

On 8 November 2002, Ms A attended an appointment with Dr B and Mr D, a clinical dental technician. During this consultation, Dr B and Mr D discussed with Ms A the options for treatment. There is dispute as to whether a full clearance of Ms A's lower teeth was discussed. It is not recorded in the clinical records. At that consultation it was agreed that Ms A would have four lower incisors removed later in the month.

Dr B advised me that "of course an X-ray was suggested when Ms A returned for treatment in 2002", but Ms A denies this stating "at no stage was an X-ray suggested. Dr B just put up the X-ray that was taken in 2000 and made no comment about requiring a new one." The suggestion of a further X-ray is not documented.

On 14 November, Ms A had an appointment with Mr D, where he took impressions to make a partial plate for her lower four incisors.

On 28 November, Ms A returned to the surgery for the extractions. Mrs C, dental assistant, brought up Ms A's records on the computer in the surgery. She then brought through Ms A from the waiting room. Ms A told her that she was nervous about the treatment. Ms A said that when she was taken into the surgery she "saw the image on the screen with 4 X's where the extractions were to be made".

Dr B advised me that he consulted the records on the screen page called 'Details' and then sighted medical history details. He then reviewed the scanned IV sedation consent on the computer and finally loaded the treatment page with two different treatment plans. He then double clicked the IV sedation treatment code box to open it and record baseline parameters for IV sedation.

Ms A then signed the consent form for her intravenous (IV) sedation, prior to treatment.

Dr B states that he would normally check lab-work (in this case the partial plate) the night before an appointment. However, in this case, Ms A's plate did not arrive until lunchtime on 28 November and he did not check it at the start of the procedure.

Prior to beginning treatment Dr B asked Ms A the usual question he asks all patients who will have IV sedation: "Do you know what we are going to do?", or words to that effect. Ms A recalls that she replied, "Clean the lower teeth, extract the four lower teeth and fit the plate", or words to that effect. Dr B's recollection is that Ms A said "these teeth", not "four teeth". He believes he repeated her answer, "all of the teeth", to Ms A and she agreed. Ms A's recollection is that Dr B did not repeat what she said. Mrs C states that she did not hear Ms A clearly say "just four teeth", but said that she found it hard to understand clearly what Ms A said. Mrs C believes she heard Dr B say the word "all", to which Ms A agreed.

Dr B then sedated Ms A and began the procedure. During the procedure Mrs C asked why he was cleaning Ms A's teeth prior to extracting them. Dr B explained that it lessened the

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risk of infection. He added that he would need a lower molar instrument to extract some of the teeth. Mrs C then obtained this instrument from a nearby cupboard.

Dr B advised me that although Ms A's teeth had no fillings or decay, their periodontal health was poor and the extractions were easy to perform. Ms A stated that following the extraction her face and jaw were severely bruised.

After the extraction, when Ms A woke up, they discussed what had happened. During this discussion Ms A said that she had wanted only the four incisors taken out. Dr B replied that this was not what he had heard. Nonetheless, on observing the plate that was to be fitted, Dr B realised his error.

Independent advice to Commissioner

The following independent expert advice was received from Dr Dan McGettigan, dentist:

"This report has been compiled after viewing:

1. Written reports from [Ms A].
2. Written reports from [Dr B] including I/V consent form, & report from his dental assistant.
3. Various correspondence between [Dr B] and [Ms A] following the treatment.
4. Treatment notes from [Dr B] as well as pre-op panorex radiograph (dated 08/2000) and post-op panorex dated 20/12/2002)

I have been asked to report on the following issues:

On the basis of the x-rays provided, was the periodontal health of [Ms A's] teeth poor?

Any response to this question must be viewed in light of the fact that the panorex x-ray provided was taken two years prior to the treatment. Radiographs alone cannot be taken as evidence of active periodontal disease – they only show bone loss and evidence of calcified deposits (calculus) on the teeth. Clinical examination of the periodontium (gums teeth and bone levels) in conjunction with x-rays would be necessary to accurately evaluate periodontal status. No such evaluation was noted pre operatively by [Dr B].

Having qualified my response I can make the following evaluation from the x-ray.

a) Generalised horizontal bone loss about all teeth with evidence of total bone loss about 48 (this tooth was extracted in 2000).

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The four lower central incisors look to have extensive vertical bone loss and this in context with the information from [Ms A] that they were loose, I am confident in assuming they were periodontally unsavable.

b) In light of [Ms A's] age, the remaining teeth may well have been of acceptable periodontal health to retain. Again, the lack of any notes on pre-operative periodontal assessment by [Dr B] creates difficulty in accurately assessing her periodontal health.

Treatment

a) [Dr B's] provision of services by his own admission was unsatisfactory i.e. he failed to follow the treatment plan consented by the patient. I find nothing wrong with the skill and care with which he carried out the procedure on the day, but that is not the point in question.

b) A dental surgeon using reasonable care and skill in the same circumstances would be unlikely to make the same error. A prudent dentist would initially have consulted his treatment plan and notes before proceeding with the operation. These would have alerted him to any possible conflict between the planned treatment and verbal consent. Simply, viewing the prosthesis (partial denture) prior to the operation would also have alerted him to any possible conflict. Further questioning at this stage would have averted the error.

c) Despite [Dr B's] claim that the back teeth had poor periodontal health, removing all 14 teeth was not reasonable without consent from the patient. Thorough pre-op examination should have alerted him to the necessity for their extraction and provided the opportunity to obtain consent.

Consent Process

a) According to the New Zealand Dental Association Code of Practice on informed consent, the dentist has an ethical responsibility to inform his/her patient on treatment options. On the basis of this information, consent can be in the form of a signed consent for major procedures or verbal consent for minor procedures. When verbal consent is given it is prudent to note this in the records and in all situations keep careful, clear written records.

I would classify [Ms A's] treatment as being minor, and verbal consent (this was apparently given in front of the dental technician) as being adequate.

Judging from [Dr B's] notes from the initial consultation appointment on 08/11/02 he 'discussed about immediate lower partial and cost'. The significant word here is 'partial', which meant a full lower clearance was not intended. I note that neither his notes nor the estimate to [Ms A] actually state which teeth are to be removed.

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I also note that an ‘estimate for proposed treatment as at 08/11/02’ involving removal of four teeth, scale and polish, intravenous sedation, provision of partial denture etc. was given to [Ms A] on this date.

b) [Dr B] failed to take reasonable steps to comply with the agreed treatment plan (i.e. [Ms A] gave consent for removal of only four teeth). Informed consent does not appear to have been given for removal of 14 teeth. This is further confirmed by a lack of any notes to verify a change in treatment plan prior to the operation.

Other Matters

With regard to the scale of severity, I consider [Dr B] provided a standard of care that moderately departs from the standard of dental care by a dentist to his patient. No one can return [Ms A’s] teeth, but [Dr B] readily admitted his error and his handling of the situation post operatively was appropriate in the circumstances.”

Response to Provisional Opinion

In response to my provisional opinion, Dr B made the following submissions:

“ …
Comment has been made that it is difficult to assess [Ms A’s] periodontal state and so on based solely on the 2000 x-ray. Of course an x-ray was suggested when she returned for treatment in 2002, however this was declined by [Ms A].

We use five codes for proposed periodontal treatment and the use of this code was our assessment of [Ms A’s] periodontal condition.

In charting treatment for periodontal conditions we have five treatment codes:
1. no treatment
2. grade one scale and clean – simple prophylaxis,
3. grade two scale and clean – some calculus with bleeding, gingivitis,
4. hygienist scale – gross calculus, periodontal disease probably with tissue loss, gross bleeding, gingivitis and periodontitis.
5. perio surgery – usually involving lifting a flap and hygienist level scaling.

Throughout all [Ms A’s] treatment plans the fourth degree of severity, the Hygienist scale was used, indicating that her periodontal state was poor.

The following comments relate to the paragraph beginning, ‘[Ms A] *returned on 28 November …*’ and your breach findings as to a failure to check the records.

I accept that I did not see the records stating that four teeth were to be extracted, however I do not accept your statement that I failed to check the treatment plan or other notes. After [Mrs C] brought [Ms A’s] records onto the computer screen (which

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is in the surgery two, my practice has four surgeries and six linked computers on our Local Area Network), I certainly did consult the records on the screen page called Details and then sighted medical history details.

I then reviewed the scanned IV sedation consent on the computer (this was recorded on another page so I had to physically open it at the time, clicking on the tab with the mouse) and finally loaded up the treatment page with two different treatment plans. I then double clicked the IV sedation treatment code box to open it and record baseline parameters for IV sedation.

In our clinical management software package, 'Exact', a user has to use the mouse and/or keyboard to change from data fields and for each patient record. There are up to seven full screens of patient data (more for scanned documents or referral letters). I viewed three of [Ms A's] patient record screens at the beginning of the consultation prior to confirming the procedure with her verbally.

The panorex x-ray was mounted on the viewer in the surgery. When I viewed it I noted the bone loss around the lower anteriors and posterior molars and the impacted upper canine tooth.

The principal fact is that I misheard [Ms A's] verbal consent, twice. My initial question to her was open-ended, in that I asked [Ms A] to tell me what she expected we were going to do. Thinking she had said we were to remove '*all of the teeth*' I repeated this back to her, and she agreed with me. I then established that [Ms A] wanted to retain the upper canine tooth.

Accordingly, this was not a case of forging ahead with a procedure with absolutely no consideration of patient notes, or no discussion with the patient.

I sedated [Ms A] via an IV cannula in the right ante-cubital fossa by slow titration. Then I administered local anaesthetic in the mouth (left and right inferior dental blocks both with separate injections of Lignocaine and Marcaine). After administering local anaesthetic but prior to extraction I examined [Ms A's] mouth and noted gross calculus, very poor gum health and that the majority of her teeth were splinted by calculus. In my own mind, this confirmed that a full lower extraction was reasonable.

While waiting for the local anaesthetic to work, I recorded my understanding of the verbal consent by activating the relevant treatment codes (by ticking on the relevant treatment code tick boxes, by clicking box with mouse) 'Full Clearance Per Arch' and 'Full Lower Denture'. I then entered further intravenous sedation parameters into the 'IV sedation' text box template.

After the extractions, while waiting for haemostasis after suturing, I charged these three items through. … This is our normal practice as the escort often pays the bill (as per our sedation consent) because the patient is unfit for business transactions. Additional clinical notes are added in treatment code 'notes'. When I went to fit the plate after haemostasis my initial thought was that the wrong plate had been supplied. I then realised that the error was mine.

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…

I have reviewed my procedures and record keeping in accordance with [Dr McGettigan's] comments, so that something like this cannot happen again. This includes written informed consent for major procedures and showing patients any plate or the like intended to be fitted.

…

We have had comprehensive discussions regarding [Ms A's] case and your investigation. As a result, some relevant changes that have been made can be summarised as follows:

1. Policy of recording more notes.

2. Clinician the patient is booked in with to take primary responsibility for the notes including ensuring medical history is updated, all treatment plans are charted and the plan chosen is clearly indicated.

3. Where a patient is seen by both a clinical dental technician and me, the clinical dental technician's prosthesis prescription (paper based pad) and any additional treatment plan notes to be entered or scanned into Exact.

4. Written consent to be obtained for all sedation procedures, all major surgical procedures, all non-conventional treatment requested by a patient.

5. A formal review of procedures every three months to ensure they are being implemented and are working, and any changes that need to be made."

Further independent advice to Commissioner

The following additional independent expert advice was obtained from Dr Dan McGettigan:

"This report has been compiled after viewing

1) Letter of response from [Dr B]

2) Copy of my expert advice

3) Other relevant documents included in my original report.

I have been asked to provide an opinion as to whether there are any issues raised by [Dr B] which serve to mitigate the error in his response to the Commissioner's Provisional Opinion. In particular, the comments made by [Dr B] in relation to his software package 'Exact' is to be considered.

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I am a general dentist of 28 years experience, the last six of which I have operated the same clinical management software package 'Exact' as referred to in this report.

In this letter of response, [Dr B] has raised several points which may be viewed as mitigating circumstances.

(a) Paragraph five to eight relating to periodontal assessment. Not really relevant to the outcome but I do note that no reference was made to [Ms A's] declinature of x-rays nor periodontal status in any of the notes submitted.

(b) The remaining possible mitigating circumstance revolves around [Dr B's] contention that he failed to check records and other notes. This area is somewhat confused by terminology between records and treatment plan. With reference to the 'Exact' software package, the dentist has the ability to formulate several optional treatment plans (tabs) to present to the patient, thus enabling an informed decision to be made on the grounds of appropriateness and cost. Once the decision is made to proceed with one particular treatment plan (in this case to extract four lower teeth as decided on 08/11/02), the dentist must clearly indicate this decision in his notes (or delete the irrelevant treatment plans) to avoid possible confusion at the time the operation is to be carried out.

The computer must be viewed as merely a tool to store and facilitate rapid access to patient information. The information obtained from it is totally dependent on the information entered and use or otherwise of a computer as a clinical tool in dentistry should in no way alter the treatment provided to the patient.

I can only assume that [Dr B] made the error of failing to check the agreed treatment plan on his computer prior to commencing treatment. Alternatively, the consented treatment plan was not clearly indicated in his notes.

Other matters raised in [Dr B's] response bear no relevance if the above is true.

In conclusion, I can find no issues raised by [Dr B] which serve to mitigate the error made."

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Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

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

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.*

…

6) *Where informed consent to a health care procedure is required, it must be in writing if*

…

d) *There is a significant risk of adverse effects on the consumer.*

Opinion: Breach – Dr B

Inadequate check prior to treatment
I accept my expert advice that a dental surgeon using reasonable care and skill is unlikely to have made the error Dr B made in concluding that Ms A was to have all her lower teeth extracted.

Dr B admits that he did not see the records stating that Ms A was to have four teeth extracted. However, he says that he did check the treatment plan and other information on his computer screen. I note the comments made by my dental advisor that the clinical software programme 'Exact' (which Dr B was using) allows a clinician to formulate several optional treatment plans. Once a plan is selected, the clinician must indicate this preference in the clinical notes or delete the other treatment plans. It appears that Dr B may have failed to note the preferred treatment plan or to delete its unnecessary counterparts.

Whatever the cause of Dr B's misapprehension, it is obvious that his check of Ms A's electronic records was inadequate to alert him to the actual treatment plan for extraction of four lower teeth. Nor did Dr B view the partial plate that was to be fitted; had he done so, the error would have been obvious. In these circumstances, Dr B undertook an inadequate

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check prior to treatment, and did not provide dental services with reasonable care and skill. Accordingly, Dr B breached Right 4(1) of the Code.

Failure to gain informed consent
On 8 November, at her meeting with Dr B and Mr D, Ms A made an informed decision to have her four lower incisors removed on 28 November. The option of a full lower clearance was also discussed, but Ms A decided against it.

On 28 November, when Dr B reviewed his treatment plan, he formed the mistaken view that the treatment that had been decided on was a full lower clearance. Unfortunately, he then failed to take adequate steps to confirm that both he and Ms A understood the procedure to be done. Ms A did not sign a document recording her consent to a full lower clearance. Instead, Dr B relied on a brief oral conversation, which carried the risk of misunderstanding. I am satisfied that, although Dr B 'heard' Ms A agree to have "all of the teeth" removed, Ms A was referring only to the four teeth that she had previously agreed (on 8 November) to have extracted.

Dr B therefore failed to obtain Ms A's consent prior to removing all of her lower teeth and breached Right 7(1) of the Code.

I note that Right 7(6)(d) of the Code states that where there is a "significant risk of adverse effects on the consumer", consent must be in writing. The requirement of writing provides an additional level of protection for consumers. It provides an opportunity to be doubly sure that a consumer wishes to proceed, notwithstanding the significant risk. The New Zealand Dental Association 'Code of Practice on Informed Consent' similarly recognises the need for written consent for all "major procedures".

In my opinion, the removal of all of Ms A's lower teeth did carry a significant risk of adverse effects. Such effects included a higher risk of infection and dry socket, increased bleeding, and possible problems with the fitting and wearing of a full lower denture. I consider that, from a consumer's perspective, a full lower clearance carried risks that were sufficient to activate Right 7(6)(d) and require Dr B to record Ms A's consent in writing, prior to undertaking the treatment. Had he done so, the error could have been avoided.

It follows that Dr B also breached Right 7(6)(d) of the Code.

Other comments

Response to this incident
I note that following this incident Dr B quickly admitted his error and has made some efforts to remedy it. He has apologised unreservedly to Ms A and provided her with some follow-up treatment at no cost. He also contributed to the transport costs for her initial treatment in 2002.

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Dr B has reviewed his procedures to ensure that a similar error does not occur. In particular he has:

- Instituted a policy of recording more comprehensive dental notes (this includes allowing patients to view any denture prior to beginning treatment).
- Instituted a policy that the clinician the patient is booked with takes primary responsibility for the clinical notes, including ensuring medical history is updated, all treatment plans are charted and the plan chosen is clearly indicated.
- Where a patient is seen by both the clinical dental technician and a dentist, the clinical dental technician's prosthesis prescription (paper based pad) and any additional treatment plan notes are to be entered into the computer system.
- Instituted a policy of obtaining written consent for all sedation procedures, all major surgical procedures, and all non-conventional treatment requested by a patient.
- Instituted a formal review of the procedures set out above every three months to ensure they are being implemented and are working, and any changes that need to be made are implemented.

Follow-up actions

- A copy of my report will be sent to the Dental Council of New Zealand.
- A copy of my report, with identifying details removed, will be sent to the New Zealand Dental Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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