Dentist, Dr B
District Health Board

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC00033)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 3 December 2020, a man underwent a tooth extraction because he had a sore, loose tooth and he wanted it removed.

2. During the operation, the man became concerned that the dentist had not identified the correct tooth to be removed. The dentist stopped the extraction mid-way, as he encountered resistance, and he then realised that the wrong tooth was being extracted. The dentist asked the man to confirm which tooth he wanted to be removed, and, despite the man identifying another tooth, the dentist continued with the initial extraction before proceeding to extract the correct tooth.

Findings

3. The Deputy Commissioner considered that the dentist did not obtain an adequate history from the man or conduct an appropriate clinical examination prior to proceeding with the extraction, and, consequently, failed to identify the correct tooth for extraction. The Deputy Commissioner found the dentist in breach of Right 4(1) of the Code.

4. The Deputy Commissioner also considered that the dentist did not provide adequate information to the man about his diagnosis, the options available for the management of his tooth, and the plan to extract the first tooth the dentist extracted. This was information that the man could reasonably have expected to receive in the circumstances. Accordingly, the dentist was found in breach of Right 6(1) of the Code. Because the dentist extracted a tooth without the man's consent, the dentist was found in breach of Right 7(1) of the Code.

5. The Deputy Commissioner also considered that the dentist did not maintain adequate and accurate records, and so did not comply with the professional standards set by the Dental Council. Accordingly, the dentist was found to have breached Right 4(2) of the Code.

Recommendations

6. The Deputy Commissioner recommended that the dentist apologise to the man and undertake further training. She recommended that the Dental Council consider whether a review of the dentist's competence is warranted. The Deputy Commissioner also recommended that the DHB undertake an audit of the dentist's recent tooth extractions and use an anonymised version of this case for educational purposes.

7. The Deputy Commissioner referred the dentist to the Director of Proceedings.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Dr B. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care in December 2020.*
- *Whether the district health board provided Mr A with an appropriate standard of care in December 2020.*

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

10. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	Provider/dentist
District health board (DHB)	Group provider/hospital

11. Further information was received from:

Dr C	Service Clinical Director/prosthodontic specialist
Ms D	Dentist assistant
Dr E	Duty dentist

12. Independent dental advice was obtained from Dr Andrea Cayford, a general dentist (Appendix A).

Information gathered during investigation

Introduction and background

13. Mr A (in his forties at the time of events) was booked for a tooth extraction with Dr B at a dental service[1] at 10.00am on 3 December 2020. Mr A's right "upper front tooth" (tooth 52[2]) was sore and loose, so he wanted it to be removed. However, Dr B removed both tooth 52 and tooth 17.[3]

14. This case relates to the adequacy of communication and the obtaining of informed consent prior to the provision of dental services by Dr B to Mr A on 3 December 2020.

[1] A regional service managed by the DHB, which provides routine dental services to people with a Community Services Card.
[2] Under the FDI World Dental Federation notation, tooth 52 refers to the maxillary lateral incisor.
[3] Under the FDI World Dental Federation notation, tooth 17 refers to the maxillary second molar.

15. Prior to the appointment, Mr A saw Dr B at the dental service on 5 November 2020 to have both his left molar teeth (tooth 27 and 28) extracted owing to soreness. During this surgery, a dental X-ray[4] (OPG) was taken.

Tooth extraction on 3 December 2020

Pre-extraction checks and conversation

16. At 10.00am on 3 December, Mr A presented to the dental service for his appointment with Dr B. Dr B asked the dentist assistant, Ms D, to escort Mr A from the waiting area into the dentist surgery room. Dr B was not present in the room at this time.

17. As Ms D was escorting Mr A to the surgery, she asked him where the toothache and the tooth to be extracted was located. Mr A recalls stating to Ms D that it was the tooth "top to the right".

18. Mr A then asked Ms D whether an X-ray could be taken so that he could point out to Dr B which tooth he wanted extracted. However, Ms D declined Mr A's request because Dr B had advised her that there was already a dental X-ray of Mr A's mouth from November to which they could refer.

19. Whilst Mr A was sitting on the dentist chair, Ms D asked again which tooth needed to be extracted. Mr A again responded "top to the right". Dr B then entered the room, having overheard Mr A speaking to Ms D, and reportedly repeated "top to the right". Ms D then began to prepare for the surgery.

20. Mr A recalls Dr B asking him to open his mouth before a light was shone inside. According to Mr A, Dr B took a "very quick glance" before walking away. Mr A told HDC that at this point he had some concerns because his interaction with Dr B had been very short. Mr A stated to HDC: "Was that it? We did not discuss anything." Specifically, Mr A told HDC that Dr B did not explain the procedure in detail, including any risk of the tooth operation.

21. Dr B told HDC that he asked Mr A which tooth he wanted to be removed, and Mr A gestured to his right and allegedly pointed to the back. However, Mr A told HDC that at no point prior to the tooth being removed did Dr B ask which tooth was to be removed. Dr B viewed the previous OPG from November to consolidate his observations of Mr A's mouth and what he believed at the time was the current defective "upper right second molar" (tooth 17), which he assumed Mr A wanted to be removed.

22. Dr B acknowledged to HDC that he made an incorrect assumption when deciding to operate on tooth 17, because he had remembered from Mr A's November appointment that he had a decayed tooth on his right. Dr B had observed that the OPG showed that no further restorative work[5] was possible for tooth 17 (as it was decaying), and he assumed that "this was the most likely reason for [Mr A's] dental visit that day". Dr B acknowledged that he

[4] An orthopantomogram is a type of X-ray that produces a panoramic view of the jaw.
[5] Dr B identified from Mr A's OPG that the palatal cusps for tooth 17 were missing, and thereby no further restorative dental work was possible.

failed to ask Mr A to show him the correct tooth to be removed, because of "poor communication".

23. Dr B's clinical notes record that the procedure was explained to Mr A in detail, including the risks of the operation.[6] The clinical notes of the examination document: "EO[7]: NAD,[8] IO[9]: (brief to site of complaint only)." Dr B also documented that verbal consent was obtained for both tooth 17 and tooth 52.

24. Mr A told HDC that when Dr B returned with the anaesthetic injection, there was no further discussion or confirmation about which tooth he (Mr A) wanted to be extracted, including whether he had consented to the procedure.

25. After the anaesthetic injection was administered on both sides of the incorrect tooth, Mr A raised his hand in an attempt to point to the correct tooth that was loose. Mr A stated:

> "I raised my hand to attempt to point to the tooth and said it's very loose and [Dr B] interrupted me and said, please put your hand down as he had the needle to inject a second shot of [anaesthetic] …"

26. As a result, Mr A was unable to point to the correct tooth, but said that Dr B told him that he knew which tooth to pull out.

27. In contrast, Dr B told HDC that he cannot recall Mr A pointing to the loose tooth in the front. Dr B stated:

> "At no time during this initial procedure did [Mr A] stop me or say anything that I was in the wrong area. In retrospect he probably assumed this was the normal part of the numbing procedure, or that he was too polite to remonstrate."

28. Dr B began the extraction procedure on tooth 17. Mr A told HDC: "[A]t this point, I thought I'd just put my faith in [Dr B] as he is the specialist and maybe I'm just overreacting."

Extraction of wrong tooth

29. Once the extraction procedure had commenced, Dr B found resistance in loosening the roots for tooth 17. Mr A told HDC that he felt Dr B struggling with the tooth, and recalls thinking, "[W]hy is there a struggle as I could have done this at home, it was very loose." During the extraction, the crown[10] of tooth 17 was fractured. Mr A recalls hearing "a loud snap". Dr B immediately removed the equipment from Mr A's mouth.

[6] The risks include bleeding, swelling, pain, bruising, infection, numbness, oroantral fistula, and risk of surgical extraction.
[7] "EO" stands for "extraoral examination". This is an examination of the outside of the oral cavity.
[8] No abnormality detected.
[9] "IO" stands for "intraoral examination". This is an examination of the cheeks, hard palate, tongue, and gingiva.
[10] A "crown" refers to a dental restoration used to cap a tooth or implant.

30. At this point, Mr A's face was still numb, but he could feel that the loose tooth 52 was still present. Mr A expressed to Dr B that the wrong tooth had been extracted, and Dr B asked Mr A which tooth needed to be removed. Mr A stated that this was the first time Dr B had asked him which tooth was to be removed.

31. Dr B insisted to Mr A that the remaining tooth 17 still needed to be removed, as it could become infected. Although Mr A told HDC that at this point, he was shocked and in distress that he was not informed of the continued surgical extraction of tooth 17, Dr B specifically recalled to HDC:

> "I told the patient that the 17 was so badly decayed, that it was good that we removed it to save [Mr A] the hassle of coming in again when it became symptomatic, but he was obviously traumatised by the event, so he didn't accept this."

32. Once tooth 17 had been extracted, Dr B and Ms D proceeded to remove tooth 52. This was completed quickly and without any further complications. Dr B's clinical notes do not include any details about the wrong tooth having been removed, and he told HDC that he did not charge Mr A for the extraction of tooth 17.

33. Mr A told HDC that after the completion of the tooth extraction, whilst he was waiting for his prescription he overheard Dr B mention to his assistant that the incident was a "good wake up for the morning". However, neither Dr B nor Ms D can recall this comment.

34. Mr A told HDC that he was devastated, disappointed, and disgusted with the care he received from Dr B.

Subsequent events

35. On the morning of 4 December (the day after the extraction), Mr A made a complaint to the dental service. At 4.00pm, the duty dentist, Dr E, sent an email to the Clinical Director, Dr C, which detailed Mr A's complaint as well as a conversation she had had with Dr B about the complaint, and the plan to contact Mr A the following week. According to Dr C, Dr E also advised Mr A of the complaints process via the DHB website.

36. Mr A told HDC that he found it disappointing that by 10 December, he had still not been contacted about his complaint. He called the dental service again and left a message asking to be contacted urgently. The DHB acknowledged that there was a delay in responding to the complaint.

37. On the morning of 11 December, Dr C called Mr A and apologised for the delay in contact and for the care that he had received. Dr C documented that he explained to Mr A his options for making a formal complaint, and told him that the relevant staff would be interviewed, and Mr A was agreeable to this. At 11.30am, Dr C called Dr B about Mr A's complaint. Dr B acknowledged and accepted Mr A's version of events, and accepted his error. Dr C documented that Dr B was happy for his apology to be passed on to Mr A. At 12.40pm, Dr C called Mr A and relayed his conversation with Dr B. Dr C documented that he asked Mr A

whether he wanted to take matters further or if he wanted anything else, and Mr A said that he was happy at this stage. Dr C then relayed this to Dr B.

38. On 15 December 2020, Dr C telephoned Mr A to check on the extraction site. During the conversation, Mr A expressed that he remained devastated and dissatisfied with the current state of affairs. Mr A told HDC:

> "I asked whether ACC will cover this, [Dr C] replied No … I was disappointed and angry and replied 'Should I seek legal advice'. [Dr C] said well if you want to pay for a lawyer, he knows I'm a low income earner because only community service holders can receive tooth extraction at [the dental service] … that was intimidating me … [Dr C] then replied he won't email anything regarding this complaint if I seek legal advice."

39. Dr C's documentation of this telephone call noted that ACC was raised, and that he told Mr A that he did not think the tooth would be covered by ACC in terms of replacement. However, Dr C also noted that he could not say whether ACC would accept his claim, and that he would need to look into it. In respect to Mr A's statement about seeking legal advice, Dr C stated that he did not say this. Dr C's documentation does not mention discussion about legal advice.

40. Mr A told HDC that Dr C could have handled his complaint in a more professional way. Dr C told HDC that there was a misunderstanding of his statements and intention.

41. On 16 December 2020, a formal incident report was raised about Dr B's care, and Mr A was advised by email of the different ways he could lodge a formal complaint. An ACC form for the incident was lodged on 19 January 2021, as staff had been on annual leave.

Process of consent for tooth extraction

42. The DHB has no formal protocol with respect to tooth extractions, but stated that the usual process for tooth extraction is to:

a) Identify the patient's presenting complaint;

b) Take a medical and dental history;

c) Undertake a clinical examination and determine the care needed;

d) Discuss with the patient the problem identified, the treatment options, and the risks and benefits of treatment; and

e) Obtain the patient's informed consent for the care.

43. The clinical records on the day suggest that this process was followed by Dr B, but the subsequent complaint by Mr A and the follow-up discussion with Dr B indicate that this process was not followed.

44. The DHB told HDC that dental practitioners are expected to comply with both DHB policy (see Appendix B) and the Dental Council of New Zealand Practice Standard relating to informed consent (see Appendix C).

Further information

Mr A

45. Mr A has consistently told HDC and the DHB about the distress that the incorrect extraction has caused and continues to cause him. In particular, Mr A told HDC that he had not experienced any issues or pain with the molar tooth (tooth 17) before it was removed by Dr B incorrectly. Mr A said that he was not informed of the condition of the tooth prior its removal, and Dr B raised this only after he removed it. Mr A stated:

> "I would [like] to add that at the time of the extraction [Dr B] misled me in believing that his decision was part of the extraction and [he] only admitted he failed to receive consent or inform me of the condition 10 days after I made the complaint, and not at the time of the extraction. … Again we did not have any consultation of the condition and options prior to the extraction or consent of the molar tooth extraction."

46. Mr A told HDC that on 16 December 2020 when he was receiving a follow-up review with another dentist at the dental service, he saw the dentist assistant, Ms D. According to Mr A, she apologised about the incident in person and felt responsible for the incident.

Dr B

47. In a response to HDC, Dr B stated:

> "I acknowledge the communication with [Mr A] was poor and despite him not being forthcoming, it was my duty to elicit as much information [as possible from] my patient and obtain … his consent, before proceeding. I am very sorry that [Mr A] has had this experience under my care."

48. Dr B said that he has taken further remedial actions since the incident (discussed further below). Dr B stated: "I unfortunately did not consider the patient's wishes adequately."

DHB

49. The DHB sincerely apologised to Mr A for the dental extraction of the incorrect tooth without consent. It acknowledged the distress this has caused Mr A.

50. The DHB told HDC that Dr B has been asked to reflect on his clinical practice and ensure that he asks patients to indicate clearly which tooth requires extraction, and to reconfirm this tooth with the patient before he undertakes the extraction.

Documented clinical notes

51. The treatment plan recorded in the clinical notes on 3 December 2020 was identical to the treatment plan in the clinical notes taken on 5 November 2020. In addition, the clinical notes contain no documentation about tooth 17 having been removed in error on 3 December 2020.

Responses to provisional opinion

52. Mr A was given an opportunity to comment on the "information gathered" section of the provisional decision. He re-emphasised to HDC that Dr B did not ask him which tooth he

wanted to be removed until tooth 17 was broken from the gum during the extraction. Mr A said that Dr B did not explain the procedure in detail, including the risk of operation. Mr A feels that his concerns were ignored, and that Dr B made a wrong assumption. Mr A also reiterated aspects of his dissatisfaction when he lodged his complaint with Dr C. Mr A noted that this was an experience he did not wish upon anyone else.

53. Dr B was given an opportunity to comment on the relevant sections of the provisional decision. He told HDC that he has changed his practice by following a set of essential steps.[11] Regarding his documentation, Dr B accepts that the "copy and paste" method was used, and that he did not read the document notes thoroughly, which was an oversight. However, Dr B said that there was no conscious intent to falsify records. He accepts that his poor communication with Mr A on the day led him to misconstrue that consent had been provided.

54. The DHB was given an opportunity to comment on the provisional decision, and advised that it had no further comments to make.

Opinion: Dr B — breach

Introduction

55. Dentists must ensure that they provide treatment with reasonable care and skill, and they must obtain informed consent for the treatment they provide. Having the consumer identify which teeth he or she wants to be extracted is a basic step in obtaining informed consent for a tooth extraction.

56. On 3 December 2020, Mr A attended an appointment with Dr B, with the intention of having his right front tooth 52 removed, as it was sore and loose. Throughout the process, Dr B only briefly asked Mr A about the location of the tooth he wished to have extracted, provided minimal information about the treatment proposed, and made assumptions about Mr A's wishes and expectations for care. As a result, Dr B mistakenly assumed that Mr A wanted tooth 17 to be extracted, and extracted it without Mr A's consent.

57. My independent advisor, Dr Cayford, considers that specific issues in the care provided to Mr A by Dr B were departures from a reasonable standard of care. These are outlined below.

Inadequate history-taking and clinical examination

58. It is vital that dentists obtain an adequate history from their patients and conduct a robust clinical examination of the presenting problem.

59. Dr Cayford advised that on seeing Mr A, the expected standard of care was for Dr B first to have asked Mr A basic questions such as: "[W]here [is] the problem …, how long has it been

[11] These include reviewing the reason for the patient's visit, the history of the complaint, the clinical state of the tooth, the results of investigations carried out, the options available, and the treatment plan.

a problem, what causes it to be a problem, what relieves the pain etc." As Dr Cayford stated, an adequate initial history gives important information to help determine what the problem is.

60. Dr Cayford also advised that as the previous OPG from 5 November 2020 was available, Dr B should have referred to it and explained to Mr A that it was being used that day.

61. Dr Cayford said that once the history had been taken, Dr B needed to conduct a clinical examination to check the state of the tooth, including checking its mobility and vitality.

62. There is little evidence of such history-taking from Dr B. Mr A considers that his interactions with Dr B were brief, with no chance to ask further questions. There is a paucity of clinical documentation to support any information having been obtained about the reason for Mr A's visit, the clinical state of the tooth, and any testing carried out or plan for treatment.

63. Had Dr B obtained an adequate history and conducted an adequate examination, this would have involved checking which tooth Mr A wanted to have extracted. As Dr Cayford notes, the pre-procedural checks should have included Dr B concluding his history and clinical examination by identifying which tooth to extract, and either indicating it on the X-ray or showing Mr A the tooth in a mirror. Dr Cayford stated: "[T]he resulting discussion if it was accurate and robust would have alerted [Mr A] that [Dr B] was dealing with the wrong tooth …" I accept Dr Cayford's advice and am critical that Dr B failed to take an adequate history and conduct an adequate clinical examination.

Information provided and consent

64. As Dr Cayford identifies, the clinical history, examination, and testing informs the diagnosis and treatment for a patient. Once the diagnosis had been made, whether in relation to tooth 52 or tooth 17, Dr B needed to explain it to Mr A and outline the options available for treatment. There is no evidence that this took place. Dr Cayford suggested that in this case, it may have been possible, for example, to save tooth 17 with a root filling and crown.

65. According to Dr Cayford, this was another missed opportunity for Dr B to have recognised that he had identified the wrong tooth, as it would have been obvious if a discussion had taken place with Mr A that tooth 52 would not need a surgical extraction.

66. As a consequence of Dr B failing to provide Mr A with information about his diagnosis and options, and plan to extract tooth 17, Mr A did not have sufficient information to give consent. Subsequently, tooth 17 was removed without his consent.

Actions after extraction — adverse comment

67. After the crown of tooth 17 had been fractured by Dr B during the extraction, Mr A immediately made Dr B aware that he had attempted to extract the wrong tooth.

68. Dr Cayford advised that the accepted standard of care would have been for Dr B to have offered Mr A an immediate apology and to have taken some time with the patient to decide the best way forward. However, Dr B's response was to say that tooth 17 needed to be

extracted anyway. Dr Cayford considers that although it was appropriate that Dr B went on to extract the correct tooth 52 and did not charge Mr A, there was a lack of care and concern shown towards Mr A. Dr Cayford stated that this would have been viewed poorly by her peers. I agree.

Documentation of care provided by Dr B

69. The Dental Council's relevant standard regarding patient records[12] states:

> "You must create and maintain patient records that are comprehensive, time-bound and up-to-date; and that represent an accurate and complete record of the care you have provided."

70. The relevant standard also notes that a record must be kept of any proposed care that is declined by the patient, along with any complaints made or concerns expressed regarding the care provided.

71. The clinical notes documented by Dr B — "Verbal consent gained for extraction of 17, 52" — indicate that consent for the extraction of tooth 17 was given, despite this being a mistake in light of Mr A's complaint. Furthermore, once the error was discovered, no clinical notes were made about Dr B's error in identifying the wrong tooth. Therefore, Dr B's incorrect documentation is misleading.

72. Dr Cayford advised that the appropriate standard of care is to note the reason for the visit, the history of the complaint, the clinical state of the tooth, the results of tests carried out, the options given, and the resulting treatment plan. As noted above, I am critical that Dr B failed to carry out these essential steps and document that he did so.

73. Dr Cayford specifically commented on the following documentation procedures carried out by Dr B:

- The documented treatment plan was a "cut and paste" from a previous appointment.
- The notes indicate that there was verbal consent for the extraction of teeth 17 and 52, despite no consent having been given for the extraction of tooth 17.
- There is no recorded note about the wrong tooth having been removed in error.

74. Dr Cayford advised that the lack of detail in the clinical notes is a mild departure from the appropriate standard of care, and that her peers would disapprove of the clinical notes. Specifically, Dr Cayford stated:

> "In future, the notes need to include the reason for the visit, history of the complaint, options given to the patient and any cut and paste notes need to be modified for

[12] Standard 1 of the Dental Council's "Patient records and privacy of health information practice standard" (1 February 2018). See: https://dcnz.org.nz/assets/Uploads/Practice-standards/Patient-records-and-privacy-of-health-information-practice-standard-1Feb18.pdf.

appropriateness. The consent needs to be accurately recorded. The incorrect extraction needed to be documented and the resulting discussion and plan with the patient."

75. Although I accept Dr Cayford's assessment that Dr B's lack of detail in the clinical documentation amounted to a mild departure from the appropriate standard of care, I remain concerned that the misrepresentation of the interaction with the patient that verbal consent had been obtained for the extraction of tooth 17 and the inaccurate recording of events were documented by Dr B but were not corrected. Dr B has told HDC that he did copy and paste the previous notes and had failed to read through them thoroughly, which was an oversight. However, Dr B maintains that there was no conscious intent to falsify the records.

76. I am inclined to view that this misrepresentation amounted to the falsification of records. Whilst Dr B may not have intended this, or may simply have forgotten to correct his notes, I believe that, given the immediate aftermath of this incident and noting that Dr B describes Mr A as "being traumatised by the event", a competent dentist in Dr B's position would have taken active steps to ensure that his documentation was correct, and I am critical that this did not occur.

Conclusion

77. The care provided by Dr B to Mr A on 3 December 2020 neglects the most basic requirements of a competent dentist. Dr B did not obtain Mr A's history adequately or conduct an appropriate clinical examination, and, consequently, he failed to identify the correct tooth that Mr A wanted to be extracted. Accordingly, I consider that Dr B did not provide dental services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[13]

78. Dr B also failed to provide information to Mr A about his diagnosis, the options available for the management of his tooth, and the plan to extract tooth 17. This was information that Mr A could reasonably have expected to receive in the circumstances. Accordingly, I find Dr B in breach of Right 6(1) of the Code.[14]

79. It follows that tooth 17 was extracted without Mr A's consent, and therefore I also find that Dr B breached Right 7(1) of the Code.[15]

80. Dr B also failed to maintain adequate or accurate records, and so did not comply with the professional standards set by the Dental Council of New Zealand. Accordingly, I find Dr B in breach of Right 4(2) of the Code.[16]

[13] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[14] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive."
[15] Right 7(1) states: "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."
[16] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Opinion: DHB — educative comment

81. Mr A immediately raised a complaint about Dr B's medical error to the dental service and to the DHB. Largely, the complaint was managed by the service's Clinical Director, Dr C, about whom Mr A has raised further complaint, as set out in paragraphs 35 to 41 above.

82. In general, the management of the complaint by Dr C was appropriate.

83. Right 10(6) of the Code stipulates:

a) Every provider must have a complaints procedure that ensures that the complaint is acknowledged in writing within five working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and

b) The consumer is informed of any relevant internal and external complaints procedures; and

c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and

d) The consumer receives all information held by the provider that is or may be relevant to the complaint.

84. Furthermore, Right 10(7) stipulates that within 10 working days, the complainant must be given written acknowledgement of the complaint. The provider must also decide whether or not the complaint is justified, and determine the time needed to investigate the complaint, including informing the consumer if the additional time needed is more than 20 working days and the reasons for this.

85. First, I am satisfied that the complaints process was handled appropriately by both Dr E and Dr C, and generally was in accordance with the Code. Dr E did acknowledge Mr A's complaint on 4 December and advised him of the complaints process via the DHB's website. Although it took six working days before Dr C called Mr A to explain his options further, I accept that Dr E's initial conversation with Mr A on the same day was in compliance with Right 10(6) of the Code, as the complaint was acknowledged.

86. The conversation between Dr C and Mr A on 11 December included the acceptance of Mr A's account of events, which complies with the timeframe of 10 working days as set out in Right 10(7). Mr A was reportedly content with the process at that stage. By 16 December, a written acknowledgement had been sent, which falls within the 10 working days' timeframe as stipulated by the Code.

87. I note that on both 4 December and 11 December, the conversations with Mr A were not confirmed in writing, but communicated only over the phone. On reflection, the provision of written confirmation to Mr A following telephone conversations may have added a level of formality to the process, and could have reinforced that the complaint had been taken

seriously. I do note that initially Mr A was accepting of Dr B's apology via Dr C, but later requested communication in writing and decided to take matters further.

88. I note that Mr A became dissatisfied with the process when an apparent breakdown in communication occurred between Mr A and Dr C. Whilt advice around ACC claims is not within this Office's jurisdiction, this case does highlight the importance of clear communications during a complaints process. I also acknowledge that there was a delay in the ACC forms for Mr A's claim being submitted until 19 January 2021 because staff were on annual leave. I trust that the DHB and Dr C will use Mr A's experience as a learning opportunity to improve their management of complaints.

Changes made since events

Dr B

89. Dr B told HDC that since this incident, he has undertaken the following approach when providing care to patients (although there is insufficient detail on whether these procedures are adhered to):

a) He engages with the patient politely and establishes an initial sense of contact.

b) Once respectful rapport is established, he then asks the patient to indicate the troubling tooth.

c) He asks the patient to place a finger on the tooth to be extracted, before inspecting the tooth visually and tapping it for confirmation.

d) If there is uncertainty on the patient's part, he will use a radiograph for confirmation.

e) He will then confirm that he has the patient's consent to proceed with treatment on the particular tooth. If there is any doubt, he will obtain written consent.

DHB

90. The DHB issued a formal letter of apology to Mr A acknowledging that Dr B extracted Mr A's right second molar tooth without Mr A's knowledge or consent. As part of the improvement process, Mr A's care was discussed by the wider dentistry team to re-emphasise the requirement that teeth need to be identified correctly, with the correct consent obtained before extractions are undertaken.

Recommendations

91. I recommend that Dr B:

a) Provide a written letter of apology to Mr A for the breaches of the Code identified in this report. The apology letter should include details of the changes made by Dr B. The letter should be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Participate in training relevant to the issues raised in this case (communication, informed consent, and record-keeping), and provide HDC with evidence of his attendance and reflections from the training, within three months of the date of this report.

c) Reflect on the advice provided by Dr Cayford, and report back to HDC on whether any further changes could be made to his practice, within three months of the date of this report.

92. In light of the concerns I have around Dr B's documentation, I recommend that the Dental Council of New Zealand consider whether a review of Dr B's competence and conduct is warranted. The Dental Council should advise HDC of the outcome of its consideration within three months of the date of this report.

93. I recommend that the DHB:

a) Undertake an audit of Dr B's recent extractions, including a review of the adequacy of documentation and a follow-up contact with the consumer, to confirm that communication was effective and that informed consent was obtained prior to the extraction. The DHB should report back on the outcome of the audit within four months of the date of this report. Where there is not 100% compliance, the DHB is to advise what further remedial actions have occurred, or will occur.

b) I recommend that the DHB use an anonymised version of this case for the wider education of the dentistry team, specifically in relation to open communication with patients, the gaining of consent prior to treatment, and the maintenance of accurate documentation.

Follow-up actions

94. Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken. In taking this action, I have considered the following:

a) Dr B did not consult with his patient about the procedure, and he had access to recent X-ray information to confirm with Mr A the correct tooth to be extracted.

b) Dr B did not obtain Mr A's informed consent before extracting tooth 17.

c) Dr B created false clinical records by incorrectly documenting that he had obtained consent for the extraction of tooth 17, and not noting that tooth 17 was removed in error, although this was evident from Dr Cayford's assessment.

d) Dr B failed to give due consideration to the distress this situation caused his patient, and did not consult him about remedial actions at the time the error was identified.

95. 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 B's name.

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

Appendix A: Independent clinical advice to Commissioner

The following clinical advice was obtained from Dr Andrea Cayford:

"I have been asked to provide an opinion to the Health and Disability Commissioner on case C19HDCO2155. Patient: [Mr A]/Dentist: [Dr B]. I have read and agree to follow the 'Guidelines for Independent Advisors'.

I am a General Dentist. I graduated from Otago University Dental School in 1983. In my first year I worked as a Dental House Surgeon in Christchurch Public Hospital. Since then I have worked in several practices in London and New Zealand. For the last 25 years I have been part of a large group practice in New Zealand.

Documents Provided:

1. Letter of complaint 6 January 2021
2. [Dr B's] response 25 March 2021 including his further correspondence to HDC
3. [The DHB's] response 12 April 2021 including 11 attachments
4. Clinical records from Oral Health Regional Services
5. [The DHB's] Clinical Records Department's attachments including the Oral Health Event Summary, registration form and pre-assessment health questionnaire

Outline of the treatment provided

[Mr A] attended [the dental service] to have a tooth removed that was causing some discomfort. Tooth 17 was removed by the dentist [Dr B] instead of tooth 52.

Expert advice requested

1. Adequacy of communication. The nature of an emergency dental appointment should not vary from any other dental appointment in regard to good communication. The patient should be greeted and made comfortable by the dentist. If they had not met previously an introduction of all staff in the room is required. Then the dentist should ask 'What is bothering you today?' Or 'What brings you to see us today?' This would promote some description of the problem. The dentist needs to know where the problem is, how long has it been a problem, what causes it to be a problem, what relieves the pain etc. These are all basic questions and do not take much time but aid the diagnosis. The patient may or may not be able to point to the tooth causing the problem. If the patient can identify the tooth that should be done. Patients often get their left and right side mixed up so getting the patient to indicate the side and tooth if possible is important. This initial history taking gives important information to help determine what the problem is which can lead to a treatment plan. It is essential the patient and dentist agree on the treatment plan.

In this case there was an appropriate radiograph already and this should be referred to and commented on. It would be appropriate to explain to the patient that the existing radiograph was adequate for that day's treatment.

Then a clinical examination is required to check the state of the tooth and again make sure the dentist and patient both have the correct tooth to deal with at that time. If necessary other tests should be carried out to check mobility, vitality etc of the tooth. This would be normal procedure and the diagnosis and treatment would follow. If [Dr B] decided (as he says) that it was tooth 17 that needed treatment he could then explain this to the patient and give the options available. It may have been possible for example to save the tooth 17 with a root filling and crown. The patient can then choose what they want to have done. When tooth 28 was extracted previously the patient was given a choice of a root filling in private or extraction. However this was not done for tooth 17.

After gathering this information the resulting discussion if it was accurate and robust would have alerted [Mr A] that [Dr B] was dealing with the wrong tooth prior to any local anaesthetic being placed as it would be obvious that tooth 52 would not need a surgical extraction and a root filling and crown as a possible treatment option would be nonsensical.

I understand this was a relief of pain clinic and they are busy. However in private practice we would routinely get just a 30 minute appointment for a 'toothache' patient also. We would ensure the history of the condition and clinical presentation were thoroughly checked. This is accepted practice.

[Dr B] has departed from accepted standard of care with this patient due to poor communication in a moderate way.

My peers would disapprove.

In future [Dr B] needs to spend adequate time getting a thorough history and then after a clinical examination he can give treatment options. Then the dentist and patient can both decide what is the best treatment plan.

2. Pre procedural checks. The adequacy and appropriateness of [Dr B's] pre procedural checks was poor as has been admitted. If a thorough history and clinical exam had been done then the pre procedural checks could include a summary from [Dr B] and a statement like 'Ok we can take this tooth out now then' and point to the tooth and maybe also indicate it on the x-ray. [Mr A] says that after the local anaesthetic was placed he asked [Dr B] if he had the correct tooth. This could have been a prompt to double check. [Dr B] could have pointed to it and shown the patient in the mirror. [Dr B's] pre procedural checks depart from accepted practice in a moderate way.

   It would be viewed poorly by my peers.

In future [Dr B] needs to summarise the discussion to the patient, explain the treatment plan and clearly indicate which tooth is to be removed.

3. The reasonableness of [Dr B's] response. According to the patient [Dr B's] response was flippant and 'well the other tooth needed extraction anyway …'. It may have been correct that another tooth in the mouth needed removal but it in no way mitigates the error.

   [Dr B] says he did not realise the seriousness of the situation from [Mr A's] point of view. He thought in fact he had done a favour as the tooth 17 needed removal anyway and he did not charge the patient. This may be correct but that patient wasn't given the option to save tooth 17 and it is wrong to extract a tooth prematurely against the patient's wishes.

   [Dr B] says he didn't realise the importance of teeth in the Māori culture. However teeth and choices about people's bodies are important to all cultures.

   A dentist can't jump to conclusions that the patient wouldn't have wanted a root filling at 17 in the future. The patient had not intended that 17 be removed at that time. The patient felt dismissed after the wrong tooth was taken out.

   Accepted care would have been an immediate apology and to take some time with the patient to decide the best way forward. Tooth 17 now was a more complicated surgical extraction. Did the patient want that done now? Did the patient want 52 removed now? [Mr A] did consent to tooth 52 being removed and allowed the additional local anaesthetic required.

   According to [Mr A], [Dr B's] lack of care was unreasonable and is a moderate departure from accepted standard of care. The lack of care and concern shown towards the patient after extracting the wrong tooth would be viewed poorly by my peers.

   Hopefully [Dr B] will not be in this position again. There is never going to be a good outcome for the dentist or patient in this event but immediately admitting fault and a genuine apology would have helped. Following this the patient and dentist can then decide the best way to proceed.

4. Steps taken after the wrong tooth was extracted. Accepted practice would have been an immediate apology as described and asking the patient how best to rectify the situation. This could include removing tooth 52 (the tooth the patient presented with) and this did occur. Appropriate not to charge the patient and this also occurred.

   As described in question 3 the attitude of [Dr B] in the situation was inadequate but the clinical work delivered was appropriate.

There was therefore a departure of an accepted standard of care in a moderate way relating to the communication and care with the patient.

There was no departure of accepted practice in the clinical care after the error was evident.

My peers would view the lack of communication and apology as poor but view the clinical work after the error as reasonable.

In future, honesty and being able to apologise for any error are the elements which must be improved.

5. Documentation. The clinical notes are very brief and inaccurate. There are sparse notes about the reason for the patient's visit, the clinical state of the tooth, the history of the complaint or any options given. If care and attention had been paid to this the mistake may not have happened as the dentist would have had to ask more questions to gain the history and what the patient wanted.

   Appropriate standard of care is to note the reason for the visit, the history of the complaint, the clinical state of the tooth and results of tests carried out to check vitality of the tooth etc, the options given and the treatment plan resulting.

   The plan provided here is a cut and paste and identical to a previous appointment. If the dentist had said about the risk of surgical extraction this may have alerted the patient to the incorrect treatment as tooth 52 was quite loose and the patient was expecting a very easy extraction.

   The notes say there was verbal consent for the extraction of tooth 17 and 52. There was no consent for the extraction of 17.

   There are no notes about the wrong tooth being removed in error.

   The lack of detail in the clinical notes are a mild departure from appropriate standard of care.

   My peers would disapprove of the notes.

   In future the notes need to include the reason for the visit, history of the complaint, options given to the patient and any cut and paste notes need to be modified for appropriateness. The consent needs to be accurately recorded. The incorrect extraction needed to be documented and the resulting discussion and plan with the patient.

6. The adequacy of changes made to [Dr B's] practice as a result of the care provided to [Mr A]. Communication is the basis of providing clinical dentistry accurately and with care.

A polite welcome and introduction is essential in any health professional contact.

A through history taking then follows. It is not adequate to ask the patient where the concern is but the history of the problem must also be questioned and recorded. The patient may not always be able to identify the tooth causing the problem. In this case the tooth was loose and causing trouble therefore it was easy for the patient to identify it. If a patient can't identify the tooth more extensive investigations are required to find the cause of their problem.

In principle [Dr B's] remedial steps are correct. However the clinical notes need to be improved in accuracy and completeness as has been covered. Any cut and paste notes need to be modified to be pertinent to each case.

The history taking and clinical notes all help with the correct diagnosis, treatment plan and then the correct tooth is dealt with.

The changes would be viewed well by my peers given that it is such an important part of dentistry.

7. Other matters. It is important to never assume anything and jump to conclusions when treating a patient. The patient may have wanted to keep tooth 17 and may have managed to afford the treatment required. They must be given that choice.

   [Dr B] describes his learning around the Māori culture. These are however values for any culture and all people should be treated this way with face to face greeting and value placed on their health.

   [Mr A] says the dental assistant asked him 'which tooth' as she was getting him from the waiting room. It is appropriate the assistant gets the patient. But it is inappropriate to have that conversation prior to the privacy of the clinical space. There could have been other people around to hear the conversation. If walking somewhere they are not face to face so if the patient happened to indicate a tooth with his hand it may not be seen correctly. It is also inappropriate for the assistant to ask the patient where the problem is or what the problem is. He/she is an assistant and not the professional. This question is part of the history taking which leads to the treatment plan. It could lead to confusion, poor history taking, incorrect diagnosis and incorrect treatment provided if the dentist relies on her description or if the dentist relies on his/her overhearing the conversation indirectly.

   There is no advantage in the assistant asking this question as it would not provide her with any information to prepare equipment more than would already be readily available. The assistant has enough time to get further instruments required while the local anaesthetic is being placed and allowed to work.

   I realise she was a temporary nurse and doing what she thought was best. However I think this should be an area of discussion at [the DHB] in order to provide privacy

to the patient and communications one on one with the dentist only. This could help to provide a better outcome all around.

Conclusion

The care provided for [Mr A] by [Dr B] was unreasonable. This was due to a lack of communication with the patient perhaps relying heavily on an overheard conversation with the patient and assistant and reaching a clinical verdict based only on a look at the existing x-ray.

[Dr B] then failed to be thorough in his discussion with the patient and his clinical investigations. When the incorrect tooth was extracted [Dr B] did not appear to be remorseful.

The clinical notes covering the details of the appointment are inaccurate and not comprehensive. They do not mention that tooth 17 was removed in error.

Overall there is a moderate departure from accepted practice which would be viewed poorly by my peers."

Appendix B: DHB Informed Consent

When is consent required?

Informed consent must be obtained where a patient is competent for each treatment or procedure proposed (eg anaesthesia and surgery are separate procedures). There are, however, situations when a group of procedures or treatments are closely linked and consent for each individual treatment or procedure would be inappropriate (see composite procedures).

Where a series of similar treatments are to be undertaken (eg dialysis, counselling), provided that a full explanation/discussion is held prior to, or at commencement of care provision then on subsequent visits/appointments, agreement to proceed need only be confirmed and any new questions/issues covered. If the plan previously agreed changes significantly, a new consent process must be undertaken (include new written consent if applicable).

Appendix C: Dental Council Te Kaunihera Tiaki Niho — Informed consent practice standard

1. Informed consent is a process requiring effective communication between the practitioner and the patient, provision of all necessary information to the patient, and the patient's freely given and competent consent. It is an interactive process between a practitioner and a patient where the patient:[1]

   a) Gains an understanding of their condition.

   b) Receives an explanation of the possible options for care, including an assessment of the potential risks and side effects, benefits and costs of each option.

   c) Has the opportunity to ask questions and discuss the information given to them.

2. The Dental Council of New Zealand sets out the relevant practice standard for informed consent for all registered oral health practitioners. The relevant excerpts relating to the standards of care provided by Dr B are as follows:

   "Standards with guidance

   1. You must provide an environment that enables open, honest and effective communication.

   2. You must give patients information in a way they can understand, and confirm their understanding, so they can make informed choices about their oral health.

      …

      - Listen to your patients and treat them as individuals. Take their specific communication needs and preferences into account, respecting cultural values and differences.
      - Recognise communication barriers …
      - Encourage your patients to ask questions and give them the opportunity to discuss with you the various options for care, and their preference and concerns.
      - Check whether your patient needs any additional support to understand information, communicate their wishes, or to make a choice; and assist in arranging this, as needed.

      …

   3. You must ensure patients are fully informed during the informed consent process; and give honest and accurate answers to questions relating to their care.

      …

[1] Dental Council of New Zealand. (14 May 2018). 'Informed consent practice standard'. < https://www.dcnz.org.nz/assets/Uploads/Consultations/2017/Informed-consent-practice-standard-consultation/Informed-consent-practice-standard-May18.pdf>.

- Do not make assumptions about the information the patient might want or need — encourage questions and engage in discussion with your patients to ensure they have all of the information they feel they need to make an informed decision.
- Be sure to explain all of the possible options for care; do not make assumptions about how the patient might view the affordability or the value of particular options.

…

4. You must obtain the informed consent of the patient before providing care, unless there is some other clear authority to treat.

5. You must ensure informed consent remains valid throughout the period of care.

…

- Be sure that at all times, the care you obtained consent for is the care that you provide. If care is wrongly provided that has not been consented to, the informed consent that was obtained is not considered 'valid'.
- In the event that a change of practitioner is necessary during a period of care, obtain the patient's consent for this change and confirm their consent for the planned care before proceeding."