Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00656)

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1. 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. It concerns a complaint from Ms A about the care provided to her daughter, Miss A, by Dr B, a dentist.[1]

2. Ms A complained that Dr B undertook inappropriate orthodontic treatment when he fitted Miss A with braces in 2014. Ms A said that the treatment was unsuitable as the roots of her daughter's teeth are short, resulting in the braces causing damage that required further orthodontic treatment and jaw surgery.

3. The following issue was identified for investigation:

   - *Whether Dr B provided Miss A with an appropriate standard of care between 2014 and 2016 (inclusive).*

4. This report sets out the Deputy Commissioner's opinion on the adequacy of the care Dr B provided to Miss A.

[1] Dr B is registered with the Dental Council of New Zealand.

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

5. Independent advice about Miss A's care was obtained from Dr Angela McKeefry, a dentist (Appendix A).

6. Having carefully considered all relevant information, the Deputy Commissioner found that Dr B breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to refer Miss A to a specialist, and undertaking treatment that he was not trained or sufficiently experienced to provide. Dr B also breached Right 4(2)[3] of the Code by failing to keep full, accurate patient records that complied with relevant professional and ethical standards.

7. The Deputy Commissioner further found that Dr B breached Right 6(1)[4] of the Code by failing to provide Miss A and her mother with key information they could have expected to receive before commencing treatment. In doing so, Dr B breached Right 7(1)[5] of the Code, as by failing to give Miss A and her mother key information, they were unable to make an informed choice about Miss A's orthodontic treatment. The Deputy Commissioner was also critical of Dr B's diagnosis and treatment plan in Miss A's case.

8. The Deputy Commissioner recommended that Dr B provide an apology to Miss A and undertake a self-audit of his records of 20 patients and have that audit peer-reviewed by a professional body.

Key events

Initial consultation

9. On 30 January 2014, Miss A (aged 12 years at the time) and her mother attended an appointment with Dr B at a dental service (the clinic).[6] Dr B said that Ms A wished to improve the appearance of Miss A's teeth, and he undertook CBCT (cone-beam computed tomography) X-ray imaging[7] to assess Miss A's teeth and underlying structures. Four X-rays are contained in Miss A's notes, in addition to six photographs of her teeth and a side-profile photograph of her jaw. Dr B said that treatment options were discussed, including the option of Miss A having treatment with a specialist.

10. Dr B acknowledged that he did not document having offered a specialist referral to Miss A and her mother. Ms A told HDC that a specialist referral was not offered, however, and she believes Miss A should have been referred at the outset. Ms A said that Dr B told her that he was an orthodontist, or possibly led her to believe that, and she would not have taken

[2] Right 4(1) stipulates: 'Every consumer has the right to have services provided with reasonable care and skill.'
[3] Right 4(2) stipulates: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'
[4] Right 6(1) stipulates: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — an explanation of the options available … including an assessment of the expected risks, side effects, benefits, and costs of each option.'
[5] Right 7(1) stipulates: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent.'
[6] Dr B was previously a director and shareholder of the clinic. He no longer practises there, having started a new dental clinic.
[7] An advanced imaging technique that provides detailed three-dimensional images of the teeth.

Miss A to him for such a large amount of dental work had she known he was not an orthodontist.

11. Dr B said he informed Ms A that he was a 'general dentist doing orthodontic work'. He said he had never told patients that he was an orthodontist or a specialist; rather, Dr B said he is trained to provide braces,[8] aligners,[9] and removable appliances,[10] and has always offered a referral to an orthodontist.

12. The only notes from the initial appointment state 'X3D 3D Cone' in reference to the CBCT imaging. Dr B told HDC that he accepts that the quality of his record-keeping throughout Miss A's treatment was 'below standard'.

Consent given and braces fitted

13. On 14 February 2014, Miss A and her mother attended another appointment with Dr B, at which time he fitted Miss A with upper and lower braces.

14. Prior to Miss A's orthodontic treatment, Ms A signed a payment plan in relation to it. The payment plan was the second page of a two-page document, with the first page said to comprise the written consent form for Miss A's braces. This page cannot be located. Dr B said that the consent form for Miss A's braces is missing because a flaw in the clinic's scanning system meant that it did not capture every page in every patient document. Dr B's notes of the appointment on 14 February state, in part:

> '[P]atient was given all the treatment options and was informed what was the best possible treatment. Risks and outcomes explained. Verbal consent given by patient to go ahead with treatment … [A]dvice given on maintenance and cleaning kit given.'

Follow-up reviews

15. On 28 March 2014, Miss A and her mother saw Dr B for a follow-up review. Dr B documented that he had given 'advice to improve oral hygiene and regular brushing' and advised Miss A that 'if the hygiene doesn't improve in the next two visit[s he] will remove the braces'. Dr B told HDC that oral hygiene instructions were given throughout Miss A's treatment, as her oral hygiene was consistently poor.

16. In July 2014, Miss A and her mother saw Dr B again, at which time he documented: '[O]h very bad all the gums are inflamed.' As a result, Miss A was booked to see the clinic's hygienist the following week for a clean. The hygienist found that Miss A had generalised gum inflammation and moderate plaque around the brackets of her braces. The plaque was

[8] Brackets and wires that attach to the teeth to straighten them and/or correct issues such as crookedness, crowding, gaps and malocclusion (misalignment of the upper and lower teeth when the mouth is closed).
[9] A series of plastic moulds that fit over a patient's teeth and are each worn for several weeks to gradually shift the teeth into the desired positions.
[10] Dr B told HDC that a unit on orthodontics was part of his Bachelor of Dental Surgery degree, and he had completed eight orthodontic courses since his registration.

removed, and Miss A and her mother were given advice about the deposits being left on Miss A's teeth and how to prevent them.

17. On three occasions in November and December 2014, Dr B documented having seen Miss A and provided advice about improving her oral hygiene in response to her bleeding or inflamed gums.

18. At an appointment on 10 February 2015, Dr B documented that Miss A's oral hygiene was poor and he had discussed her 'non-compliance' and possible options with Ms A. Dr B noted that Miss A and her mother agreed with having Miss A's braces removed. His plan was for Miss A to use retainers[11] until her oral hygiene improved, at which time she would finish her treatment using aligners. Ms A said she did not ask for Miss A's braces to be removed and did not agree that Miss A was non-compliant with her hygiene instructions.

Braces removed and retainers provided

19. Miss A's braces were removed on 27 February 2015. Dr B noted that Miss A and her mother both supported their removal so that Miss A's oral hygiene could be improved. Ms A signed a retainer consent form, agreeing to follow the instructions on the form about the use and care of Miss A's retainers. An impression was taken from Miss A's teeth to make upper and lower retainers.

20. Dr B told HDC that Miss A's braces would not have needed removal, and her treatment could have continued, if she had complied with her oral hygiene instructions. Dr B stated:

> '[I]n hindsight, I should have terminated treatment as soon as [Miss A's] poor oral hygiene became an apparent problem. I should have realised that she had poor commitment to her braces treatment and was … a non-compliant patient.'

21. On 2 March 2015, Miss A received her retainers. Dr B's notes state that she was shown how to wear them and advised that she needed to do so 'all the time'.

Aligners provided

22. Dr B reviewed Miss A on 18 September 2015 and was satisfied that her oral hygiene had improved. He provided Miss A with a set of aligners and documented that she had been instructed to wear each set for 22 hours a day, for a minimum of two weeks.

23. On 26 November 2015, Dr B reviewed Miss A with her aligners and concluded that they were 'trac[k]ing well'.[12] However, at her next review on 29 December 2015, Dr B documented that Miss A had attended without her lower aligner and could not remember how long it had been since she had worn it. Dr B noted that he told Miss A's father, who accompanied her to the appointment, that Miss A's teeth would not move, and it would cost extra to finish her treatment if she did not wear her aligner.

[11] A custom-made device that is used to keep teeth in their current/achieved positions.
[12] Refers to how well the aligners fit the teeth and are helping the teeth to move into the desired positions.

Treatment completed

24. On 9 February 2016, Miss A and her mother saw Dr B for a further review. Dr B considered that Miss A's teeth had moved into the desired positions, and she could start to use retainers. Miss A and her mother signed a consent form for Miss A's second set of retainers, which Dr B provided the following day. He documented that Miss A was given further advice about wearing the retainers. Dr B told HDC that Miss A's treatment was complete at this point.[13] He stated that none of Miss A's teeth were mobile, and her malocclusion[14] showed an improved aesthetic appearance in her post-treatment photographs.

Subsequent events

25. In February 2019, Miss A and her mother attended an appointment with a specialist orthodontist. The orthodontist said that Ms A expressed unhappiness with the results of Miss A's previous orthodontic treatment (by Dr B). The orthodontist found, in part, that Miss A had two teeth that were 'severely compromised' by mobility and short roots. The orthodontist also identified 'severe root resorption'[15] to eight of Miss A's teeth. She recommended that Miss A have upper and lower braces, in addition to mandibular advancement surgery[16] with an oral and maxillofacial surgeon.

26. Following the orthodontist's review of Miss A, Ms A concluded that Dr B should have identified Miss A's short roots and jaw problem in the X-rays he took in 2014. Ms A believes the treatment Dr B provided to Miss A was 'negligent and unprofessional'.

Additional information

27. The Dental Council of New Zealand (DCNZ) told HDC that Dr B was asked to take part in a competence review in 2014.[17] The review identified deficiencies in Dr B's competence in terms of 'scientific dental knowledge; obtaining and analysing patient information; planning an oral health care programme; oral health care and referral processes; and knowing when to refer'.

28. Dr B was required to complete an individual tertiary education programme which comprised theoretical and clinical components in eight areas of dentistry. In September 2018, the DCNZ resolved that Dr B had completed the programme satisfactorily.

29. To assist in the assessment of the standard of care provided and relevant to Dr B's practice as a dentist, HDC sought the opinion of an independent advisor, dentist Dr Angela McKeefry. Dr McKeefry's report is attached in full as Appendix 1, and specific aspects of her report are referred to below.

[13] Dr B subsequently provided Miss A with new retainers twice in 2016, to replace those broken or lost.
[14] Misalignment of the upper and lower teeth when the mouth is closed.
[15] Root resorption occurs when the root of a tooth deteriorates and dissolves gradually. It can be caused by injuries to the mouth and teeth that cause swelling and the loss of bone on and around a tooth.
[16] Surgery that moves the lower jaw forward to bring it into alignment with the upper jaw.
[17] A competence review assesses a dentist's competence and, if a deficiency is found, puts in place appropriate training, education, and safeguards to assist the dentist to meet the required standards and ensure the dentist is safe to practise.

Responses to provisional opinion

30. A copy of the 'Key events' section of the provisional opinion was sent to Ms A, and she was invited to provide comments on it. Ms A confirmed that Dr B did not discuss a treatment plan for Miss A, or a specialist referral, or any problem with Miss A's jaw. Ms A said that Miss A followed Dr B's instructions and her teeth 'protruded out again' after his treatment. Ms A stated that Dr B should never have attempted to treat Miss A.

31. A copy of the provisional opinion was also provided to Dr B for his comments. Dr B responded that he would be happy to carry out the proposed recommendations and would await the final report.

Opinion: Dr B — breach

32. Having undertaken a thorough assessment of the information gathered and guided by the independent clinical advice I received from Dr McKeefry, I am critical of several aspects of Dr B's care and treatment of Miss A. I have set out my decision on these matters below.

Specialist referral — breach

33. It is evident that Miss A had several significant dental problems when she first saw Dr B in January 2014, including extremely shortened upper incisor roots, extreme malocclusion, a retrusive (set back) lower jaw, and severely swollen (hypoplastic) gums due to poor oral hygiene. Dr McKeefry advised that it was clear that Miss A was therefore a complex patient. Miss A was unsuitable for orthodontic treatment by a non-specialist and should have been referred to an appropriately qualified clinician.

34. I cannot reconcile Dr B's and Ms A's different recollections about whether Dr B referred to himself as an orthodontist in their initial conversations. Dr B stated that he refers to himself as a 'general dentist doing orthodontic work'. The DCNZ defines the scope of practice for general dentists as follows:[18]

> 'General dental practice encompasses the practice of dentistry in the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures in accordance with a dentist's approved education, training, experience and competence.'

35. Dr McKeefry advised that Dr B's orthodontic training at the time of Miss A's treatment was 'nowhere near enough … to undertake her treatment to a proficient level' and that Dr B should have referred Miss A to a more appropriately trained clinician. The DCNZ's professional standards (in effect from 2015) are clear that practitioners must practise within

[18] DCNZ, Scope of practice for general dental practice, October 2021: https://dcnz.org.nz/assets/Uploads/Scopes-of-Practice/Scope-of-practice-for-general-dental-practice-8Oct21.pdf

their professional knowledge, skills and competence, or refer to another health practitioner.[19]

36. There is no indication that Dr B complied with this standard by considering whether his training, expertise, and scope of practice were sufficient for him to carry out Miss A's orthodontic work himself. While Dr B told HDC that he should eventually have stopped treating Miss A, his rationale was not that he was not an appropriate clinician to undertake her orthodontic work, but rather that Miss A was not committed to her braces treatment or improving her oral hygiene. It is concerning that Dr B has not acknowledged that Miss A's case was complex and should have been managed by a specialist from the outset.

37. Dr McKeefry said that most dentists would consider that it was 'extremely ill-advised' not to refer a patient with very shortened roots to a specialist before any orthodontic work was carried out. She stated that ideally Dr B would have 'strongly advised' Miss A and her mother that specialist care was preferable, although ultimately Miss A should 'have been referred after the initial records were taken, if not before'. Dr B told HDC that he did discuss a specialist referral with Miss A and her mother, but there is no evidence of this in his records. In addition, one of Ms A's key concerns is that such a referral was not offered. She maintains that if a specialist referral had been offered and she had realised that Dr B was not an orthodontist, she would have taken Miss A elsewhere for the large amount of work she needed. On balance, I consider it more likely than not that Dr B did not offer a specialist referral to Miss A or her mother.

38. Dr McKeefry advised that Dr B's failure to refer Miss A to a specialist for her orthodontic treatment was a severe departure from the accepted standard of care, especially as Dr B lacked any records of Miss A's initial assessment (I discuss documentation separately below). I also note that Dr B has not explained why he did not refer Miss A to a specialist. I therefore accept Dr McKeefry's advice, and I am critical that Dr B failed to practise within his scope.

39. In my view, Dr B did not recognise the complexity of Miss A's case and that specialist input was required from the outset. As a result, Dr B failed to refer Miss A to a specialist and undertook treatment that he was not trained or sufficiently experienced to provide. Accordingly, I find that Dr B breached Right 4(1) of the Code.

Record-keeping — breach

40. Good patient records help practitioners to provide safe, effective, and complete patient care and collaborate effectively with colleagues and other health practitioners. Setting aside the fact that Miss A's treatment should not have been carried out by Dr B, his documentation of her treatment fell far below the accepted standard.

41. The DCNZ's practice standard on record-keeping states that oral health practitioners 'must create and maintain patient records that are comprehensive, time-bound and up to date;

[19] DCNZ, Standard 8 of Standards Framework for Oral Health Practitioners (August 2015): https://dcnz.org.nz/assets/Uploads/Practice-standards/Standards-Framework-for-Oral-Health-Practitioners.pdf

and that represent an accurate and complete record of the care … provided'.[20] Dr McKeefry advised that Miss A's patient notes do not meet the practice standard as several key pieces of information are missing, including:

- What Dr B discussed with Miss A and her mother at many of the appointments, particularly the initial appointment;
- What Miss A was diagnosed with;
- The options that were discussed and the option/s chosen;
- Orthodontic measurements;
- Signed informed consent for the fitting of Miss A's braces;
- Periodontal pocket measurements;
- Progress orthodontic measurements noted throughout treatment;
- Progress or finish X-rays to check on the roots of Miss A's teeth; and
- A full series of finish photos at the completion of treatment in 2016.

42. Dr McKeefry considered that Dr B's omissions in Miss A's patient notes represented a severe departure from accepted practice. I agree. Dr B's poor quality notes do not provide a clear understanding of Miss A's treatment as they should. The absence of clear, well documented clinical records hindered my investigation into the clinical aspects of Ms A's complaint. In addition, more fulsome, detailed clinical records would have assisted the dental practitioners who subsequently treated Miss A to better discern her clinical history. I commend Dr B for acknowledging this issue.

43. Accordingly, I find that Dr B breached Right 4(2) of the Code by failing to keep full, accurate patient records that complied with the relevant professional and ethical standards.

Informed consent for braces — breach

44. I am concerned by the informed consent process undertaken by Dr B regarding Miss A's braces, for two reasons. First, Dr B's documentation of the informed consent process is lacking or missing. The New Zealand Dental Association (NZDA) Code of Practice on informed consent states:

> 'It is essential that clear, accurate contemporaneous written records are made of informed consent discussions. Records should include information regarding the problem(s), the treatment option(s), the risks, the costs, and the option to which the patient has consented. In the presence of written patient records of the informed consent process it is not necessary to obtain informed consent in writing except in the following circumstances …
>
> - If the patient is to participate in any research,

[20] DCNZ, Patient records and privacy of health information practice standard (December 2020): https://dcnz.org.nz/assets/Uploads/Practice-standards/Patient-records-and-privacy-of-health-information-practice-standard-1Dec20.pdf

- If the procedure is experimental,
- If the patient will be under general anaesthetic, or
- If there is significant risk of adverse effects on the consumer.'

45. In my view, Dr B's notes of the informed consent discussion on 14 February 2014 are generic and insufficiently detailed. They do not include any information specific to Miss A or her mother, the treatment being considered for Miss A, the risks it entailed, or the discussions that should have taken place in these respects. Although Dr B documented that Miss A provided verbal consent, he did not state what she had consented to, and the written consent she is said to have given cannot be located.

46. Most concerning is that there is no indication that Dr B advised Miss A and her mother that Miss A was likely to lose her front teeth and that orthodontic treatment would only speed up that loss. Dr McKeefry said that root resorption is a known risk of orthodontic treatment, particularly when the roots are already very short before treatment starts, as were Miss A's. Dr McKeefry advised that 'the longer the teeth are subjected to orthodontic forces, the greater the chance of resorption and tooth loss'. It is possible that Dr B did not communicate the risk of tooth loss to Miss A and her mother because he was not adequately qualified to recognise it. However, having set out to offer orthodontic treatment to Miss A, Dr B had a responsibility to accurately inform her about the treatment, including the risks it involved. In my view, the risk of tooth loss was significant information that Dr B should have provided to Miss A and her mother. Had they been aware of the high risk of tooth loss with braces, it is reasonable to conclude that they may have made a different decision about Miss A going ahead with that treatment.

47. I am also concerned that the informed consent discussion took place on the day Miss A's braces were fitted. Dr McKeefry advised that such a discussion should 'never' be held solely at an appointment when treatment is about to take place. She said that 'patients need time to think things through, discuss with family and possibly seek a second opinion. This is especially the case when there are complex issues like in [Miss A's] situation.' Dr B should have presented Miss A's options to her and her mother at an initial appointment, to enable them adequate time to consider the options and make an informed choice about Miss A's treatment. Miss A and her mother should then have had another appointment with Dr B to confirm their chosen treatment and/or ask any further questions and formally provide written informed consent.

48. Dr McKeefry considered that Dr B's failures to undertake or document a satisfactory informed consent process represented a severe departure from accepted practice. I agree. There is a lack of evidence to show that Dr B gave Miss A and her mother all the relevant information they should have received about Miss A's treatment options, and appropriate time to consider this information prior to treatment commencing.

49. Accordingly, I find that Dr B breached Right 6(1) of the Code by failing to provide key information that a consumer in Miss A's circumstances (and those of her mother) would expect to receive before commencing treatment.

50. It follows that Dr B also breached Right 7(1) of the Code, as by failing to give Miss A and her mother key information about Miss A's treatment options and their risks, Miss A and her mother were not able to make an informed choice about Miss A's orthodontic treatment.

Diagnosis and treatment plan — adverse comment

51. I have found that Dr B should have referred Miss A to a specialist and should not have undertaken her orthodontic treatment himself. Notwithstanding that, having treated Miss A, I am concerned that Dr B did not diagnose her dental problems adequately. As discussed above, Dr B's clinical records are scant and do not confirm that he identified Miss A's extremely shortened roots, malocclusion, and set back lower jaw, as would be expected. Dr B's responses to HDC do not assist in clarifying this. While Dr B did recognise Miss A's poor oral hygiene at the outset, he did not attempt to improve it before treatment was started. Dr McKeefry advised that poor oral hygiene around teeth with shortened roots is known to exacerbate further root shortening, and patients should be dentally fit prior to any elective treatment. Dr McKeefry considered that 'far more emphasis … on the gum health and oral hygiene … would have reduced the likelihood of having to remove [Miss A's] braces partway through treatment'.

52. While Dr B's key failing was undertaking Miss A's treatment himself instead of referring her to a specialist, I consider it relevant to highlight the issues in the treatment itself, which also had an impact on Miss A.

Changes made since events

53. Dr B told HDC that since completion of the DCNZ education programme in 2018 he is more selective about which patients he treats, and immediately refers patients who require specialist treatment. He also stated that he does not see patients who are not 'wholly committed to all aspects of their treatment plan' and will refer these patients to a specialist. Dr B said that he has also significantly improved the way he records his patient notes, treatment plans, and consents, to include:

- X-rays and a full oral examination of the patient before commencement of treatment;
- Intraoral and extraoral patient photos;
- Consent forms and treatment plans that are emailed to the patient or guardian; and
- Consent forms at the retainer delivery stage.

54. In addition, aligner patients are sent a document with the projected outcome of treatment and the number of aligners required. The patient must review this and consent to it before the aligners are fabricated. Patients who require braces are sent an extensive diagnosis and treatment plan before the start of treatment. The plan must be reviewed and signed before treatment starts.

Recommendations

55. Taking into account the detailed DCNZ education programme that Dr B completed, I recommend that he:

a) Provide a written apology to Miss A that reflects on the deficiencies identified in this report. The apology should be sent to HDC, for forwarding to Miss A, within three weeks of the date of this report.

b) Report on the effectiveness of the changes he reported having made to his record-keeping via an audit of the notes of 20 patients treated within the previous three months. If the audit shows that the record-keeping did not meet the accepted standard in every case, Dr B's report should outline why, and the steps taken to ensure future compliance.

c) Arrange for his audit report to be peer-reviewed by a relevant professional body, such as the NZDA, and a plan established to address any necessary improvements. Dr B's audit report and the peer review should be provided to HDC by the professional body within three months of the date of this report.

Follow-up actions

56. A copy of this report with details identifying the parties removed, except the independent advisor on this case, will be sent to the Dental Council of New Zealand, and it will be advised of Dr B's name in the covering letter.

57. A copy of this report with details identifying the parties removed, except the independent advisor 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 independent advice was obtained from Dr Angela McKeefry, a dentist:

'I have been asked to provide an opinion to the Commissioner on case number C21HDC00656 and have read and agree to follow the Commissioner's Guidelines for Independent Advisors, and that I am not aware of any conflicts of interest.

Complainant: [Miss A] (and Mum [Ms A])

Dentist: [Dr B]

Date: 27 August 2022

Independent Advisor: Dr Angela McKeefry (BDS)

My Qualifications and Training

- Bachelor of Dental Surgery (Otago) 1993
- Fellow of the International College of Continuing Dental Education (In Orthodontics)
- Certified Invisalign provider
- Certified Inman Aligner provider
- Certified "6 Months Braces" provider
- Graduated from the Progressive Orthodontic Seminars (POS) 2-year course with Highest Honours (having started over 50 cases during the course)
- Graduated from the Advanced POS Series — orthognathic surgical, skeletal anchorage and growth cases
- Completed one year of a two-year Masters in Specialised Orthodontics (Germany)
- Have been a general dentist doing a wide scope of dental procedures in the same practice since January 1994
- Have served on several dental committees over my career including running the Wellington branch of the recent graduate program for several years.

Instructions from the Commissioner

Thank you for agreeing to provide expert advice to the Health and Disability Commissioner (the Commissioner). The Commissioner is seeking your opinion on the care provided by [Dr B] to [Miss A] in 2014.

Advice Requested

Please review the enclosed documentation and advise whether you consider the care provided to [Miss A] by [Dr B] was reasonable in the circumstances, and why.

In particular, please comment on:

1. Whether the care provided was reasonable based on [Dr B's] experience and qualifications;

2. Whether the management and advice provided by [Dr B] was consistent with accepted practice;
3. Whether there was any indication during treatment to advise referral to a specialist colleague;
4. The informed consent process;
5. The standard of clinical documentation; and
6. Any other matters in this case that you consider warrant comment

For each question, please advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

If you note that there are different versions of events in the information provided, please provide your advice in the alternative. For example, whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

Information Reviewed

1. Letter of complaint dated 23 March 2021.
2. Phone call from complainant dated 18 May 2021.
3. [Dr B] response dated 30 September 2021.
4. Clinical records from [the clinic] covering the period 30 January 2014 to 29 May 2019. Including the Retainer Consent Form

Summary of the Facts

30/01/14
[Ms A] and [Miss A] present at [the clinic] unhappy with the appearance of [Miss A's] teeth. The only thing noted in the clinical records for this appointment is "3D Cone $130".

14/02/14
[Miss A] gets upper and lower braces fixed to her teeth.

27/02/15
Braces are removed due to continued poor oral hygiene.

18/09/15
First set of aligners delivered to [Miss A].

29/12/15
[Miss A] presents without aligners and admits to not wearing the lower aligner for a period of time. Father told lack of compliance will result in the teeth not moving.

10/02/16
Teeth have moved into position and [Miss A] is given retainers.

29/05/19
[Ms A] complains to [the clinic] about [Miss A's] treatment by [Dr B] as an orthodontist had told her [Miss A] had very short roots on some teeth.

18/05/21
[Ms A] again complains in a phone call to [the clinic] about [Miss A's] treatment by [Dr B]. [Miss A] has been seeing an orthodontist for two years at this stage and has been told she needs braces and mandibular advancement jaw surgery.

HDC Questions

Please review the enclosed documentation and advise whether you consider the care provided to [Miss A] by [Dr B] was reasonable in the circumstances, and why.

I think [Dr B] should have recognized the complexity of this case and referred [Miss A] before undertaking any treatment.

1. **Whether the care provided was reasonable based on [Dr B's] experience and qualifications**

I do not know what [Dr B's] experience and qualifications are, other than he must have a Dental Degree. I don't know what if any extra training in orthodontics he has done. This being the case, it is hard to comment.

- **What is the standard of care/accepted practice?**

  If a case is outside your expertise and scope of practice, you should refer the patient to a more appropriately trained clinician. In this case, I don't think it is appropriate that a non-specialist undertook orthodontic treatment. The extremely shortened roots of the upper incisors, coupled with the extreme overjet ("buck teeth"), retrusive lower jaw and hyperplastic gums (severely swollen with poor oral hygiene) make this a complex case which I don't think is suitable for a non-specialist to treat.

- **If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

  This is a severe departure from accepted practice. Had there been excellent records including measurements, diagnosis and detailed discussion about the risks of treatment with shortened roots, the advisability of jaw surgery, an offer to refer to a specialist and the patient declining after convincing the dentist they fully understood the risks/benefits then this would only be a mild departure (but there are no such records).

- **How would it be viewed by your peers?**

  Most dentists would think a case with very shortened roots prior to orthodontics should be referred and that it wasn't, to be extremely ill-advised (especially with the lack of documentation).

- **Recommendations for improvement that may help to prevent a similar occurrence in future.**

  Firstly, it is not clear if [Dr B] noticed the roots were shortened as there is no comment about them in his clinical notes or in any discussions with the patient. Is he able to diagnose adequately and name challenging conditions? Perhaps he needs more guidance around what may or may not be appropriate for a non-specialist to treat. [Dr B] needs to improve his clinical notes as there is really no way to know what he discussed with the patient and if he recognised she had extremely shortened roots, hypoplastic gums and an extreme overjet with skeletal issues. Certainly, a clinical record keeping course and informed consent course would be beneficial.

2. Whether the management and advice provided by [Dr B] was consistent with accepted practice

It is impossible to know what advice [Dr B] provided as there is nothing in the clinical notes, other than to say a discussion was held about options and risks, at the appointment the braces were placed. That seems very unwise as the patient should be allowed time to think things through (especially in a complex case such as this). Surely if the dentist said, "if I put braces on these front teeth, they may be lost in the short to medium term", the patient is going to want at least time to think things through and discuss with family or even get a second opinion.

There is no record of any orthodontic measurements or diagnosis. There is no record of how short the roots are, how mobile the teeth are and no follow up x-rays to at least monitor the roots to see if they are deteriorating. There is no mention of a goal for treatment or of the patient's chief complaint.

[Miss A] clearly had poor oral hygiene prior to starting treatment, yet no attempt was made to rectify this prior to commencing treatment. Poor oral hygiene around teeth with shortened roots is known to exacerbate further root shortening, as is orthodontic treatment.

- **What is the standard of care/accepted practice?**

  There should be clear start/progress/end records with orthodontic measurements, patient's chief complaints, a diagnosis and a goal for treatment.

  There should be a clearly outlined discussion about specific risks and benefits from treatment. The notes should clearly state that the patient understands they are likely to lose the front teeth and that any orthodontic treatment will speed this up. A strong recommendation for a referral to a specialist should be noted and signed by the patient and in fact, the patient should just have been referred after the initial records were taken, if not before.

Far more emphasis should have been placed on the gum health and oral hygiene. This would have reduced the likelihood of having to remove the braces partway through treatment due to lack of home care.

The roots of the at-risk teeth should be x-rayed every 2–3 months throughout treatment to check they are not getting worse. There should also be x-rays of the other teeth to check their roots every 6–9 months.

- **If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

  This is a severe departure from the accepted standard of care.

- **How would it be viewed by your peers?**

  This would be viewed very poorly by fellow dentists.

- **Recommendations for improvement that may help to prevent a similar occurrence in future.**

  More orthodontic training. A greater understanding of the need to be dentally fit prior to starting any elective treatment. Clinical record and informed consent courses.

3. Whether there was any indication during treatment to advise referral to a specialist colleague

The only mention in the documents I have viewed about referral to a specialist, is in the email from [Dr B] in response to the complaint dated 30/09/21. There is no mention of this prior to treatment commencing and he only says the patient has the option of getting treatment done by a specialist. He does not claim to have offered to refer, or better yet, strongly advise that she should be getting specialist care.

- **What is the standard of care/accepted practice?**

  Specialist referral should always be offered as it is clearly one of the treatment options.

- **If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

  This is a severe departure from accepted practice.

- **How would it be viewed by your peers?**

  This would be viewed poorly.

- **Recommendations for improvement that may help to prevent a similar occurrence in future.**

  Perhaps attendance at a clinical record keeping course and an informed consent course.

4. The informed consent process

The clinical notes only state (on the day the braces were placed) "Patient was given all the treatment options and was informed what was the best possible treatment. Risks and outcomes explained. Verbal consent given to go ahead with treatment." That is simply a generic statement with nothing specific to the patient.

- **What is the standard of care/accepted practice?**

  The informed consent discussion should never be held solely at the actual braces start appointment. Patients need time to think things through, discuss with family and possibly seek a second opinion. This is especially the case when there are complex issues like in this situation. There should also be clear documentation of what was discussed and the patient's decision.

  Here is what the New Zealand Dental Association states in their Code of Practice on Informed consent:

  > *It is essential that clear, accurate contemporaneous written records are made of informed consent discussions. Records should include information regarding the problem(s), the treatment option(s), the risks, the costs, and the option to which the patient has consented. In the presence of written patient records of the informed consent process it is not necessary to obtain informed consent in writing except in the following circumstances.*
  >
  > *Written consent required:*
  >
  > *If the patient is to participate in any research,*
  >
  > *If the procedure is experimental*
  >
  > *If the patient will be under general anaesthetic, or*
  >
  > *<u>If there is significant risk of adverse effects on the consumer.</u>*
  >
  > *Dental practitioners may consider obtaining written consent and providing a patient with a copy of this in situations where the treatment is complex, protracted, costly and/or as a reminder of the expectations and obligations of both parties. Written consent can be a useful adjunct to the clinical record notes should issues regarding the treatment be raised in the future. Written consent requires the signature of the patient or authorized person.*

- **If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

  This is a severe departure from accepted practice.

- **How would it be viewed by your peers?**

  This would be viewed poorly.

- **Recommendations for improvement that may help to prevent a similar occurrence in future.**

  Perhaps attendance at a clinical record keeping course and an informed consent course.

5. The standard of clinical documentation

The clinical documentation is very poor. There is no mention of the patient's chief complaints, what was discussed, what was diagnosed and what options were given or chosen. There are no orthodontic measurements noted. I have not seen any signed informed consent. There are no periodontal pocket measurements noted. There are no progress orthodontic measurements noted throughout treatment. There are no progress or finish radiographs taken to check on the roots. The finish photos (not even a full series) were only taken over three years after treatment was completed (when [Ms A] initially complained).

- **What is the standard of care/accepted practice?**

  All the items mentioned above should be noted/undertaken.

- **If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

  This is a severe departure from accepted practice.

- **How would it be viewed by your peers?**

  Among the dental profession it is accepted that a diagnosis, documented issues/ measurements all be recorded. Treatment options, risks and costs must be documented and discussed. Failure to do these things would be viewed very poorly by our peers.

- **Recommendations for improvement that may help to prevent a similar occurrence in future.**

  Perhaps attendance at a clinical record keeping course and an informed consent course.

6. Any other matters in this case that you consider warrant comment

Reading the notes made about the phone call from [Ms A] on 18/05/21, it seems she thinks [Dr B's] treatment has led to [Miss A's] teeth no longer being straight and the need for jaw realignment. This is not the case. [Miss A] had crooked teeth and a skeletal jaw discrepancy before any treatment was started by [Dr B].

Root resorption is a known risk of orthodontic treatment and is of particular concern when the roots are already very short before treatment starts. The longer the teeth are subjected to orthodontic forces, the greater the chance of resorption and tooth loss. Unfortunately, the patient is having to have two rounds of orthodontic treatment because she was not referred by [Dr B] at the outset.

Further independent advice — Dr Angela McKeefry

On 11 December 2023, HDC wrote to Dr McKeefry as follows:

> 'In August 2022, you provided expert advice to HDC concerning the care [Dr B] provided to [Miss A]. HDC has since received [Dr B's] comments regarding your advice. He raised several points, including that:
>
> - he studied orthodontics as a unit of his dental degree and completed a number of orthodontic courses since his registration. He is able to undertake some orthodontic treatments, including the provision of braces, aligner and removable appliances.
> - he was only able to describe the actions he took, or would have taken, in relation to assessment, treatment, specialist referral, periodontal health and oral hygiene, and informed consent as [Miss A's] full records are not available to him.
> - between the start of [Miss A's] orthodontic treatment in 2014 and the fitting of her retainers in 2016, he "managed to achieve a significantly improved aesthetic appearance of her teeth".
> - he should have terminated [Miss A's] treatment as soon as her poor oral hygiene became "an apparent problem"; and
> - his record keeping was "below standard" at the time of [Miss A's] treatment, but he has since completed a Dental Council competency review and made "significant" improvements to his documentation.
>
> Further expert advice requested:
>
> Please review the documents listed above, in addition to the notes previously provided, and provide further advice that addresses the comments made by [Dr B], including:
>
> - whether his comments change any aspect of your original advice. If so, please explain your rationale for the change and confirm the significance of any departure from the accepted standard of care (mild, moderate, or severe); and
> - whether his actions and improvements in terms of record keeping appear adequate.'

On 18 December 2023, Dr McKeefry responded as follows:

> 'I have reviewed the previous documentation, my report ([Miss A]/[Dr B] C21HDC00656 dated 18 December 2022) and [Dr B's] latest comments.
>
> [Dr B's] comments do not change any of my report findings.
>
> I am concerned by [Dr B's] comment: "In hindsight, I should have terminated treatment as soon as [Miss A's] poor oral hygiene became an apparent problem."

A much more important thing he should be realising "in hindsight" is that he failed to adequately diagnose [Miss A's] orthodontic issues and that they were far beyond his scope of training. This leads me to assume, given the chance again, he would take this case on so long as she was brushing her teeth well.

At the point [Dr B] started [Miss A's] case, according to his letter dated 29 March 2023, he had basic undergraduate orthodontic training and undertaken a single Invisalign Education and Training Workshop. This is nowhere near enough training. I would say that even with the training he has undertaken since [Miss A's] case, his training is still extremely insufficient to undertake her treatment to a proficient level.

With regards his actions and improvements in terms of record keeping:

1. What he says he does, sounds good.
2. Without seeing a selection of randomly chosen patient records entered since his up-skilling, I cannot say for sure.'