Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC00620)

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Introduction

1. On 8 March 2022 the Dental Council of New Zealand contacted the Office of the Health and Disability Commissioner (HDC) about a complaint the Council had received from Ms A. The complaint was referred to HDC under section 64(1) of the Health Practitioners Competence Assurance Act 2003.

2. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. The report concerns the identification of the correct tooth for dental treatment. The tooth was to be crowned following a root canal undertaken previously at another dental practice. The tooth that was crowned was situated next to the tooth intended for treatment.

4. The following issue was identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care in 2020.*

5. The parties directly involved in the investigation were:

Ms A	Complainant/consumer
Dr B	Dentist

6. Further information was received from dentist Dr C.

7. Independent clinical advice was obtained from Dr Brett Hawkins (Appendix A).

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.

Events leading up to complaint

8. In September of 2019 Ms A underwent root canal treatment[1] at her usual dental practice, on a tooth identified in the clinical records as tooth 15. The treatment was completed on 25 September 2019 and Ms A was advised by her dentist that tooth 15 should be crowned[2] in approximately six months' time.

9. Ms A told HDC that she had been given a quote for $1,850 for her dentist to crown the tooth, and this was a lot of money for her. She said that she went past Dr B's dental practice on her way home one day and noticed a sign advertising crowns. She went into Dr B's practice and booked an appointment for her tooth to be crowned.

10. Dr B denied advertising using a sign outside his practice. However, he did confirm that at the time of these events he was performing crowns for a reduced price, and this information was available on his website.

11. The clinical record shows that Ms A attended four appointments with Dr B in 2020. Ms A told HDC that she had an initial consultation, and the crown was completed in two parts. The additional appointment occurred between treatments and was because Ms A was experiencing severe pain, which Dr B put down to infection and prescribed antibiotics.

12. Although the record of these four appointments is handwritten and difficult to read, the number 16 (referring to tooth 16) is recorded clearly at two of the appointments. There is no reference to tooth 15 in Dr B's dental records.

13. In April 2021 Ms A returned to her usual dentist who had performed the root canal treatment to tooth 15 in 2019. Dental records from this appointment confirm that a crown had been placed on tooth 16, but not tooth 15.

First treatment

14. Dr B's clinical record notes that the first crown treatment procedure occurred in 2020. Ms A stated that at this appointment she was alarmed as Dr B was not sure which tooth was to be crowned and asked her to indicate the tooth, which she pointed to. She said that she was reassured when Dr B went to the computer as she thought he was checking her previous clinical records to clarify which tooth required treatment.

15. Dr B provided HDC with an outline of his usual practice when consumers who are not regular patients attend appointments for a crown procedure. Dr B stated that usually he would explain the procedure of making a crown and review clinical notes and radiographs prior to proceeding. Dr B said that his usual process for identifying the correct tooth to be treated is as follows:

[1] The inflamed or infected pulp and nerve of the root of the tooth is removed and the canal is cleaned, shaped, and filled to seal the space.

[2] A cap or covering on an existing tooth to improve the look and strength of the tooth.

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> 'Check the patient's card identifying the tooth to be treated and confirm with a review of the x-ray and discussion with the patient to ensure that the patient is aware of what the procedure is and what the treatment is entailing for that appointment.'

16. Ms A told HDC that she requested a copy of her past clinical record from her usual dental practice and provided this to Dr B. However, previous dental provider notes were not part of the dental record provided by Dr B to HDC, and there is no evidence to confirm Ms A's request or to indicate that any information was passed on to Dr B.

17. Ms A does not recall any X-ray images being taken by Dr B prior to the crown procedure commencing. Dr B told HDC that he does not recall Ms A, or the treatment provided, in any detail. He provided a copy of notes he recorded at the time and advised that there were no X-ray images, as 'they appear to be lost'.

18. The notes provided by Dr B consist of one page of handwritten notes. There is no card identifying the tooth that required treatment, nor is there any documentation of a discussion with Ms A, nor of an X-ray being taken.

19. Dr B outlined his usual consent process for a crown, which is verbal consent including a discussion on the options for the situation the patient has presented with and advantages and disadvantages of the requested treatment. He said that in this situation the discussion would include the following:

> '[T]he possibility of the tooth becoming nonvital requiring root therapy or extraction, what alternative treatments are available and suitable, the possibility of porcelain fracture, what types of material we [he] may use in that situation and also, possible referral to a specialist for treatment.'

20. Ms A told HDC that following the first treatment she was in a great deal of pain and at the time thought that 'this [was not] right'. She went back to see Dr B due to the pain, which she described as so severe that she was crying and finding it hard to cope several days after the procedure. Ms A stated that Dr B 'was not fazed' and said that the pain would settle. He prescribed antibiotics as he thought her pain was due to an infection. The clinical record notes that a prescription for antibiotics was provided.

21. Two weeks later, Ms A went back to Dr B for the crown cap to be completed. This was the last appointment she had with Dr B. In her complaint to the Dental Council (passed on to HDC), Ms A said that she was still in 'terrible pain and yet [Dr B] proceeded to complete the crown treatment without hesitation, noting that it would fix the pain'.

Identification of error and subsequent events

22. It was not until Ms A went back to her usual dentist on 12 April 2021, for treatment on other teeth, that the error was discovered. Ms A said that she realised that a mistake had been made when, after having an X-ray, her usual dentist asked why there was a crown on tooth 16. The clinical record notes:

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'Clinically 16 is now crowned. [Patient] said she had it crowned last year and it is the one that had the [root canal]. Advised [patient] that the [root canal] one is the 15 not the 16 and the crowned the one behind the [root canal] one. Clinically 16 slight [tender to percussion], air sensitive B ++ others not.'

23. When the error was identified, Ms A sought advice from Citizens Advice Bureau, who recommended that she contact her general practitioner for assistance with filing a treatment injury claim with ACC. The claim was filed and approved by ACC, allowing any treatment resulting from the crown to tooth 16 to be covered. Ms A went on to require a root canal on tooth 16 on 9 March 2022.

24. Ms A said that tooth 16 had been a 'perfectly healthy tooth' prior to being crowned. There was no indication in the clinical record that prior to the crown being placed, tooth 16 was showing concerning features that would require treatment in the immediate future.

25. Dr B has accepted that he made a mistake and expressed that he was 'truly sorry that this situation [had] arisen' and that he felt very sorry for the position Ms A had been put in. He expressed his willingness to apologise but said that he has been unable to do so, as he has had no direct contact with Ms A since these events.

Relevant standards

26. The Dental Council of New Zealand's informed consent practice standard (2018)[3] states that dentists 'must ensure patients are fully informed during the informed consent process' and 'give honest and accurate answers to questions relating to their care'.

27. Guidance under this section of the standards includes the following:

'…

- Provide the information the patient requests or needs to make an informed choice, including:
  - — an explanation of their condition and the purpose of care.
  - — an explanation of the possible options for care, including their likelihood of achieving the purpose of care; the associated risks, side effects, and benefits — and their likelihood; and the costs of each option.
- 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.

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

[3] https://dcnz.org.nz/assets/Uploads/Consultations/2017/Informed-consent-practice-standard-consultation/Informed-consent-practice-standard-May18.pdf

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

   - 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.
   - Recognise that for informed consent to be valid throughout the period of care, an ongoing process of communication is required between yourself and your patient that keeps them fully informed regarding their condition and the progress of care. This provides them with multiple opportunities to review and re-assess their choice, and to affirm or withdraw their consent for care. This is particularly relevant for treatment with long timeframes, such as orthodontic care.
   - Respect the patient's right to decide about the return or disposal of any body parts or bodily substances removed or obtained during care; offer to return a patient's extracted teeth to them.
   - Keep an accurate and contemporaneous written record of the discussions held in the informed consent process; and document the patient's oral consent when this is given.'

28. The Dental Council of New Zealand's Patient records and privacy of health information practice standard includes the following:[4]

   '1. 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.'

29. This section of the standards includes the following guidance:

   '• Write clearly and only use standard abbreviations and acronyms, so the information can be easily understood by the patient or authorised third parties who may access the record.

   - Record the following information in the patient record:

     …

     — Reason for attendance, including details of any presenting complaint.

     — Relevant history, clinical observations and findings, and diagnosis.

     — Treatment options given, information given to the patient on associated benefits, likely outcomes of care, and potential risks, and final care plan for which consent is obtained'

[4] Patient records and privacy of health information practice standard (1 February 2018).

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Responses to provisional decision

Ms A

30. Ms A was given an opportunity to comment on the 'information gathered' section of my provisional report and advised HDC that she had no further comments.

Dr B

31. Dr B was given an opportunity to comment on my provisional report. His comments have been incorporated into this report where relevant.

Opinion: Dr B — breach

32. To assist with determining whether the care provided to Ms A was appropriate, I sought independent clinical advice from dentist Dr Brett Hawkins.

Assessment, history-taking, planning of treatment

33. Dr Hawkins outlined the accepted process for identifying a tooth that requires treatment. This includes taking a history from the patient, including questioning when the root canal was done, a clinical examination, X-ray imaging, diagnosis, and a discussion on the options available. Dr Hawkins advised that the clinician providing treatment needs to establish their own clinical justification for treatment and not rely on another clinician's assessment and treatment plan.

34. Although Dr B provided HDC with a detailed description of his usual practice, there is no evidence in the clinical record to support that Dr B assessed Ms A appropriately prior to proceeding with treatment, and Dr B does not actually recall having treated Ms A. Ms A indicated that the tooth she wanted to be crowned and the reason for this was that previously it had had a root canal. Adequate history-taking and clinical assessment would have assisted with identification. Of particular relevance is the absence of any X-ray image, as Dr Hawkins advised that this would have identified the tooth that had been root filled.

35. Dr B stated that his usual process is to review an X-ray, but no images were available to HDC, there is no indication in the clinical record that an X-ray was taken, and Ms A does not recall an X-ray having been taken. On balance, I find it more likely than not that Dr B did not take or review an X-ray prior to proceeding with the crown on tooth 16. Dr Hawkins advised that it appears that the expected process was not followed in Ms A's case and, had it been followed, treatment on the wrong tooth could have been avoided. I agree, and I consider it is more likely than not that Dr B did not assess Ms A adequately or obtain an adequate history prior to treating her.

36. I accept Dr Hawkins' advice that the treating clinician has a responsibility to establish their own clinical justification for treatment (in this case proceeding with a crown to tooth 16), and I can find no evidence to support that this occurred or was discussed with Ms A.

37. I note Dr Hawkins' advice that it is not uncommon for a dentist to treat patients without the benefit of having their previous clinical record, and I am therefore not critical that Dr B did not ensure that he had Ms A's previous records from her other dentist. However, even

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without the historical clinical records, the process of assessment, history-taking, planning, and consent to treatment is expected. In addition, prior to any treatment occurring, the clinical justification for that treatment needs to be established by the treating clinician.

38. Dr Hawkins advised that the NZ Dental Association and the Dental Council have codes of practice and standards that were in place at the time of these events, and that failure to follow these standards in this case is a severe departure in relation to assessment, history-taking, and planning of treatment. I accept this advice.

Consent to treatment

39. Ms A specifically made an appointment with Dr B for the purpose of having a crown on a tooth that had previously had a root canal. I appreciate that a crown was recommended by Ms A's usual dentist and that this may have been the only option available for her tooth. I have given some weight to the information Dr B has provided on his usual practice for obtaining consent for a procedure. However, there is no clinical documentation to support that a consent discussion occurred outlining the options, risks, and benefits. I acknowledge Dr Hawkins' opinion that Dr B's consent process was a severe departure from the acceptable standard of care. However, due to the lack of documentation, I am unable to determine whether the consent process was completed appropriately, although the lack of record of any discussions with Ms A at all is very concerning.

Documentation

40. Dr B's clinical notes are brief, difficult to read, and include no information on history-taking, assessment, planning, or consent discussion that took place, which I consider reflects poor documentation practices as well as an inadequate assessment.

41. Dr Hawkins advised that the quality of Dr B's documentation is inadequate and represents a severe departure from the expected standard. There is no detailed information in the clinical record to indicate that the expected process outlined by Dr Hawkins occurred. Similarly, the documentation does not include any patient card or notes to support that Dr B undertook his usual process as he described to HDC.

42. Overall, it is clear that Dr B's documentation does not meet the expected standard for his profession as outlined in the Dental Council's Patient records and privacy of health information practice standard, and I accept Dr Hawkins' advice that this represents a severe departure from accepted practice.

Conclusion

43. The care provided by Dr B to Ms A fell well below the standard expected of a competent dentist. Dr B did not obtain Ms A's history adequately or conduct an appropriate clinical examination, including taking or reviewing X-ray imaging. Consequently, he failed to identify the correct tooth to be crowned. Accordingly, I consider that Dr B did not provide dental

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services to Ms A with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[5]

44. Dr B also failed to maintain adequate 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.[6]

Changes made since events

45. Dr B is no longer practising as a dentist. He retired and sold his dental practice to another provider. Dr B has not held a practising certificate with the Dental Council since 2021.

Recommendations

46. Recommendations are designed to improve practice and systems with the aim of preventing similar situations occurring to other people. Although this investigation has identified areas for improvement, Dr B's retirement from clinical practice makes recommendations targeted at quality and practice improvement impractical.

47. I recommend that:

a) Dr B provide a formal written apology to Ms A for the deficiencies identified within this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Should Dr B return to practice, the Dental Council of New Zealand consider whether a review of his competence is necessary.

Follow-up actions

48. 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.

49. 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.

[5] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[6] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Brett Hawkins:

'**Complaint:** [Ms A]/[Dr B]
Our Ref: 22HDC00620
Independent advisor: Dr Brett Hawkins

I have been asked to provide clinical advice to HDC on case number 22HDC00620. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualification: Bachelor of Dental Surgery, University of Otago, New Zealand, 1992. General dentist providing crown treatments for 30 years.

Documents provided by HDC

1. Letter of complaint dated 8 March 2022
2. Summary of further information gathered via phone call with [Ms A] on 3 October 2023
3. [Dr B's] response email dated 10 June 2022
4. Clinical records from [Dr B] covering the period [in] 2020.
5. Clinical records (including x-rays) from [a dental service] (non-subject provider) covering the period 15 September 2019 to 12 August 2022

Referral instructions from HDC

1. The accepted process for a dentist to identify whether a new patient requires a dental crown, including whether an x-ray is required;
2. The quality of [Dr B's] clinical documentation;
3. Whether review of [Ms A's] previous dental record would be necessary prior to proceeding with a crown;
4. The appropriate identification and consent process for each of the following scenarios:
    a) If the clinical record of past treatment was available
    b) If the clinical record of past treatment was not available
5. Any other comments you feel are relevant.

Brief Summary

THE PATIENT'S COMPLAINT

The patient [Ms A] had root canal treatment completed on tooth 15 by another dentist, [Dr C]. She had been advised by [Dr C] that this root filled tooth required a dental crown. [Ms A] went to [Dr B] for this crown treatment, because the cost of this treatment was

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less than quoted by [Dr C]. [Dr B] performed a crown treatment on tooth 16 not 15 which is the reason for this complaint.

[Ms A] stated in her phone call 3/10/23 to the Health & Disability Commissioner that at the crown preparation appointment, [Dr B] asked her to point to the area that needed the crown. [Ms A] was alarmed that [Dr B] was not sure which tooth needed treatment. [Ms A] recalls that [Dr B] sat by his computer and looked at some records.

[Ms A] states that she was given a copy of her clinical notes from [Dr C] and that she forwarded them to [Dr B]. She also states that she does not remember any x-rays having been taken.

There was nothing in [Dr B's] records indicating that he had received the previous dentist's clinical notes.

After the crown preparation appointment, [Ms A] needed to return to [Dr B] 5 to 7 days later because she was in severe pain. She was given antibiotics by [Dr B] and reassured that the tooth would settle.

[Ms A's] complaint is that the wrong tooth has been crowned which resulted in

1. Extra financial cost as tooth 15 still needs a crown
2. The unnecessary treatment of tooth 16 has severely compromised the integrity of a healthy tooth for the rest of her life.
3. Significant pain during the treatment of tooth 16
4. Root canal treatment now being required for tooth 16 which may not have been required prior to crowning

She states that ACC has accepted this as a treatment injury claim and is covering the cost of the root canal treatment for tooth 16.

No ACC documentation was provided to support this in the information I have been given; however, I see in [Dr C's] clinical notes that an ACC claim was charged for tooth 16 root canal treatment.

[Ms A] states her reason for making this complaint is: "I am reporting this incident in the hope that [Dr B] will be held personally liable for this malpractice and it is recorded against his name."

DR B'S RESPONSE

[Dr B] provided two documents

On 10/6/22 an email to HDC stating "I have retired from dental practice and am unable to recollect the patient or the treatment provided in any detail."

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He provided a copy of the clinical notes. He stated there are no radiographs as they appear to be lost. There are no notes from the new owners of [Dr B's] practice, …, so I cannot determine if extra records are available or not.

[Dr B's] handwritten notes are difficult to read. I have interpreted his notes as best as I can.

I believe the sequence of events are as follows:

11/8/20 [Ms A] had a consultation with [Dr B] regarding crowning a tooth. He has recorded tooth 16 as needing crown treatment.

There appears to be no notes indicating why a crown was needed on this tooth and if an x-ray was taken.

[Appointment 1] [Dr B] does a crown preparation on tooth 16
[Appointment 2] [Ms A] presents with pain and is given a prescription for antibiotics
[Appointment 3] tooth 16 crown is cemented

[Dr B's] email, his clinical notes give no clinical reasons why tooth 16 needed a crown.

<table>
<tr><td colspan="2">Question 1: The accepted process for a dentist to identify whether a new patient requires a dental crown, including whether an x-ray is required.</td></tr>
<tr><td>List any sources reviewed other than documents provided by HDC:</td><td>Dentist Peers
Lectures & webinars over many years
NZ Dental Association Code of Practice: Informed consent 25 March 2017
NZ Dental Council Informed consent practice standard</td></tr>
<tr><td>Advisor's opinion:</td><td>The process of assessment and treatment planning is the same for any dental treatment including crowns.
This process is taught by the New Zealand Dental School as standard practice.
The basic steps are
1. Establish the patient's reason for their visit
2. Questions about dental history
3. Clinical examination
4. X-rays
5. Special test
6. Diagnosis
7. Develop a treatment plan, consider other options, identify benefits, risks and limitations
8. Patient informed consent
9. Deliver treatment

The steps to identify if a tooth needs a crown are as follows:</td></tr>
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	1. Why has the patient come to see me. In this case [Ms A] came to have a crown on a root filled tooth 15 2. Question the patient about any problems they are experiencing such as symptoms from the tooth. 3. Questions about history of this tooth. In [Ms A's] case I would want to know when the root filling was done. If the root canal treatment was difficult or complex often there is pause before crowning to ensure the infection fully resolves 4. Refer to previous notes and records if available. The majority of patients present without their previous notes. 5. Perform clinical examination where some of the following things are checked a. If the tooth is restored or not b. Any current restorations and size c. Any dental decay d. Any cracks e. If the tooth is opposed by another tooth 6. Clinical tests a. Percussion test to see if a tooth sensitive to pressure b. Cold test to see if tooth is still vital 7. Radiographs are taken to check for any problems around the root or top of tooth. For new patients I would always take a radiograph 8. Diagnosis a. Based on the dental findings above a diagnosis is made if the tooth needs a crown or not b. A crown is commonly recommended for these situations i. To protect a tooth that has become weakened (for example by decay) or cracked, by holding it together and preventing it from breaking ii. To cover and support a tooth that has a large filling if there isn't much natural tooth structure left. A common criterion is if the filling is greater than 1/3rd the width of the tooth then a crown is indicated. Some clinicians use a percentage of the tooth that is restored as a criteria

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	iii. To restore strength to any tooth that has undergone root canal therapy iv. To restore length on worn down teeth (for example from grinding) v. To restore a tooth that has already broken. 9. Create Treatment plan with options 10. Present treatment plan to the patient discussing any treatment options with benefits, risks and limitations and costs of each 11. Get patient's informed consent to proceed 12. Deliver the crown treatment
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard process of assessment, treatment planning and consent as described above was normal practice when this complaint occurred
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from the accepted practice. If the standard assessment process was followed then the wrong tooth being treated may have been avoided. At the interview stage [Ms A] may have mentioned about root canal treatment having been done on the tooth she wanted crowned. Taking x-rays would also have shown which tooth was root filled and guided [Dr B] in offering treatment for this tooth.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I consulted with four dentist peers.
Please outline any factors that may limit your assessment of the events.	Having access to the ACC investigation and report would have been helpful but not critical in making this report
Recommendations for improvement that may help to prevent a similar occurrence in future.	None. [Dr B] has retired so there will be no similar occurrences in the future

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Question 2: The quality of [Dr B's] clinical documentation.	
List any sources of information reviewed other than the documents provided by HDC:	Dentist Peers Lectures & webinars over many years NZ Dental Association Code of Practice: Informed consent 25 March 2017 NZ Dental Council Informed consent practice standard

Advisor's opinion:	The handwritten clinical notes done by [Dr B] are difficult to read and minimal. The clinical notes are meant to record the process described above. [Dr B's] notes are missing a lot of this information. Based on this I believe [Dr B's] clinical documentation was inadequate.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The NZDA and Dental Council have standards and codes of practice for this that were in place at the time of this complaint. The clinical notes are meant to record the process described above.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	A severe departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers also viewed this as a severe departure from accepted practice.
Please outline any factors that may limit your assessment of the events.	none
Recommendations for improvement that may help to prevent a similar occurrence in future.	None. [Dr B] has retired so there will be no similar occurrences in the future.

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Question 3: Whether review of [Ms A's] previous dental record would be necessary prior to proceeding with a crown.	
List any sources of information reviewed other than the documents provided by HDC:	Dentist Peers Lectures & webinars over many years NZ Dental Association Code of Practice: Informed consent 25 March 2017 NZ Dental Council Informed consent practice standard
Advisor's opinion:	The majority of new patients present without previous clinical notes and records. A review of [Ms A's] previous dental record would be helpful prior to proceeding with a crown but not compulsory. With or without previous records I would follow the standard assessment & treatment planning steps. When interviewing [Ms A] before starting treatment if I found out that the tooth requiring crowning had recently been root filled, I would try and contact the previous dentist to confirm that that treatment had gone well. If I couldn't make contact then I would rely on my own assessment to determine if the tooth was suitable for crowning.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	I don't believe accessing previous clinical records is a standard.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Accessing the previous clinical records is not a departure.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peer dentist also saw this as not a departure.

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Please outline any factors that may limit your assessment of the events.	none
Recommendations for improvement that may help to prevent a similar occurrence in future.	None. [Dr B] has retired so there will be no similar occurrences in the future.
Question 4: The appropriate identification and consent process for each of the following scenarios: a. If the clinical record of past treatment was available b. If the clinical record of past treatment was not available	
List any sources of information reviewed other than the documents provided by HDC:	Dentist Peers Lectures & webinars over many years NZ Dental Association Code of Practice: Informed consent 25 March 2017 NZ Dental Council Informed consent practice standard
Advisor's opinion:	The identification process is the same for both scenarios. A clinician before providing any treatment needs to assess and establish the clinical justification for that treatment. If the previous records had an x-ray taken recently then this could be used instead of taking another one. But as stated the vast majority of new patients present with no records. The consent process should be the same for both scenarios. As the clinician providing the treatment you need to establish your own clinical justification for any treatment. I will never rely solely on another clinician's assessment and treatment plan because 1. Their assessment may be inadequate or incorrect 2. Their clinical criteria for justifying the treatment may be different to mine 3. I may be able to provide different treatment options with better outcomes 4. Time will have elapsed since they assessed the patient and the tooth condition may have changed After assessing I may determine that this case is not within my scope based on my training and experience

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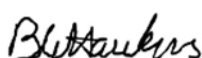
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The NZ Dental Association have codes of practice and Dental Council have standards that were in place at the time of this complaint. The clinical notes are meant to record the process described above. NZDA Code of Practice: Informed consent 25 March 2017 NZDC Informed consent practice standard
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure	There was a severe departure from acceptable standard of care in relation to 1. Identification 2. consent
• How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	2. My peers also viewed this as a severe departure from accepted practice.
Please outline any factors that may limit your assessment of the events.	none
Recommendations for improvement that may help to prevent a similar occurrence in future.	None. [Dr B] has retired so there will be no similar occurrences in the future
Question 5: Any other comments you feel are relevant	

Dr Brett Hawkins



23 January 2024’

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.