New Zealand Health Practitioners Disciplinary Tribunal

Suite 317, 3rd Floor, Harbour City Tower
PO Box 10-781, Wellington, New Zealand
Telephone: 64 4 499 0431 Facsimile: 64 4 499 0662
Email: dathlaw@paradise.net.nz
Website: www.hpdt.org.nz

DECISION NO: 19/Den05/05D

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 91(1)(a) of the Health Practitioners Competence Assurance Act 2003 against **DR D**, Registered Dentist of [ ]

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chairperson)

Dr C Lloyd, Dr H Trengrove, Dr W Hawke and Ms W Davis, (Members)

Executive Officer: Ms S D'Ath (Executive Officer)

Stenographer: Ms H Hoffman

HEARING: Held at Auckland on 5, 6 and 7 September 2005

APPEARANCES: Ms L Curtis for the Director of Proceedings .

Mr H Waalkens QC and Ms A Credin for Dr D.

Introduction

1 Dr D is a registered dentist. At the time of the matters giving rise to the charge Dr D practised from premises in [two North Island centres]. He now practises solely from a clinic in [ ]

2 On 23 December 2003 the Director of Proceedings laid a disciplinary charge against Dr D The charge underwent revision. The amended charge, considered by the Tribunal, is explained in paragraph 7 of this decision.

3 The Tribunal convened in Auckland on 5, 6 and 7 September 2005 to hear the charge. The Tribunal, after considering the evidence and submissions from counsel concluded two particulars of the charge have been established to the requisite standard.

4 In this decision the Tribunal explains its reasons for reaching its conclusions. The Director of Proceedings is invited to make any submissions she may wish to make concerning penalty within 7 days of the date of this decision. Dr Dshould respond to those submissions within 14 days of the date of this decision. If Dr D wishes to pursue an application for permanent name suppression he should do so within the same 14 day period. Any response from the Director of Proceedings in relation to any application for permanent name suppression should be filed within 21 days of the date of this decision.

The Charge

5 The charge focuses upon the treatment Dr D provided to Mrs A of [ ].The period of time covered by the charge was 10 May 2002 to 14 February 2003.

6 Prior to and during the hearing the Director of Proceedings sought approval to amend a particular of the charge, and withdraw other particulars. In the following paragraph

the Tribunal explains the charge in its final version, that being the charge which the Tribunal has considered when reaching its decisions.

7 By the time the Tribunal considered the charge it was reduced to four main particulars, namely:

> "1 An allegation that Dr D '*failed to carry out appropriate planning for the placement of implants in [his] patient, in that [he] failed to perform a comprehensive analysis of [his] patient, including an evaluation of mounted models and appropriate radiographs to determine the relationship of the jaws and available bone volume and form';*
>
> 2 An allegation that Dr D *'failed to advise [his] patient of the risks of the proposed treatment plan and thereby failed to obtain her informed consent to the procedure'*. The particulars of this allegation were:
>
> *(a) [He] failed to advise [his] patient of the risks of using three unsplinted implants with ball attachments to support a permanent removable implant over denture, in the maxilla, when opposing a natural or restored mandibular dentition.*
>
> *(b) [He] failed to advise of the other risks associated with implant surgery including incorrect placement of implants, and/or failure of implants to integrate.*
>
> …
>
> 4A *[He] embarked upon implant surgery for which he was not adequately experienced and/or qualified instead of referring to or sharing the care with a prosthodontist and/or oral maxilliofacial surgeon;*
>
> *4B Upon discovering that one of the implants had failed, and that a third operation was necessary [Dr D] failed to refer Mrs A to an oral and maxilliofacial surgeon;*
>
> …
>
> *5 [Dr D] failed to keep adequate records of the history of and/or treatment of and/or contacts with [his] patient. In particular he:*

(a) 'failed to make clinical records relating to history and/or examination; and/or

(b) failed to record adequate details of surgery performed; and/or

(c) failed to make any record at all for some visits;

(d) failed to make adequate records of medication prescriptions.' "

8 The charge alleged that each particular when viewed either separately or cumulatively with other particulars constituted professional misconduct within the meaning of s.100(1)(a) or (b) of the Health Practitioners Competence Assurance Act 2003 ("the Act").

Legal Principles

Onus and standard of proof

9 The Director of Proceedings accepted that she carried the onus of proof. She also submitted that the degree of proof required was based upon the civil standard of proof, qualified by the requirement that serious allegations required a high level of proof.

10 Mr Waalkens QC challenged the proposition that the standard of proof in disciplinary hearings was based upon the civil standard of proof. He submitted that the standard of proof should be the criminal standard of proof, or at least *"…a high degree of proof …"*.[1] Mr Waalkens' submission was substantially based upon the following observations of William Young J in *F v MPDT*[2]:

> *"[Discipline] is an important issue. The standard of proof required in disciplinary proceedings is high. Indeed, in my view (and I recognise that this is not the practice of the Tribunal) proof beyond reasonable doubt is required. In this respect I adopt the approach taken by the Privy Council in Campbell v Hamblet*[3]

11 When Mr Waalkens made his submissions he had not had the opportunity to consider the Tribunal's decisions in *Aladdin*[4] in which the Tribunal explained its understanding

---

1 Transcript p.193 l.14
2 Unreported, CA 213/04, 4 May 2005
3 [2005] UKPC 19
4 12/Den05/04D; 13/Den04/02D

of the standard of proof required in disciplinary hearings in light of the observations of William Young J in *F v MPDT*.

12 The Tribunal uses as its starting point the judgment of Jeffries J in *Ongley v Medical Council of New Zealand*[5] where His Honour adopted the following passage from *Re Evitt; ex parte New South Wales Bar Association*[6]:

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probability: Rejfek v McElroy*[7]*. Reference in the authorities to the clarity of proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

13 The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[8] where it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". A similar observation was reiterated by another full bench of the High Court in *Brake v Preliminary Proceedings Committee*[9]. The Court said:

> *"The standard of proof is not the criminal standard. The Preliminary Proceedings Committee is required to prove the charge to the civil onus, that is, proof on the balance of probabilities. But the authorities have recognised that the degree of satisfaction for which the civil standard of proof calls, will vary according to the gravity of the facts to be proved: Ongley v Medical Council of New Zealand*[10]*. The charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

14 Numerous other cases have reiterated the test articulated by Jeffries J in *Ongley*. It suffices for present purposes to refer briefly to:

14.1 *M v Medical Council of New Zealand*[11]*:*

> *"The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal*

---

5 (1984) 4 NZAR 369

6 (1967) 1NSWLR 609

7 [1966] ALR 270

8 [1989] 1 NZLR 139 at 163

9 [1997] 1 NZLR 71

10 [1984] 4 NZAR 364, 375-376

11 (No 2) unreported HC Wellington, M239/87, 11 October 1990 Greig J.

> *standard, but measured by and reflecting the seriousness of the charge."*

14.2 *Cullen v Medical Council of New Zealand*[12]*:*

> *"The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge."*
>
> *The MPDC's legal assessor, Mr Gendall, correctly described … the [standard of proof required in medical disciplinary proceedings]*
>
> > *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."*

15 Three Judges sat in the Court of Appeal in *F v MPDT*. William Young J was the only Judge who suggested that disciplinary proceedings should be governed by the standard of proof applicable in criminal proceedings. As noted in paragraph 10 above, His Honour approved a recent decision of the Privy Council in which Their Lordships held that disciplinary proceedings should be decided on the basis of proof beyond reasonable doubt.

16 As Justice William Young's observations were not endorsed by the other member of the Court of Appeal, the Tribunal considers it appropriate to follow the directions of New Zealand Courts which have universally applied the standard of proof test articulated by Jeffries J in *Ongley* for the past two decades. The Tribunal believes that New Zealand case law currently requires the Tribunal to assess culpability on the basis of the civil standard of proof, bearing in mind that serious allegations require a high standard of proof.

17 There may in reality be little difference between the stance taken by Mr Waalkens (at least in relation to his submission that disciplinary hearings require a "high degree of proof") and the submissions of the Director of Proceedings. This Tribunal has consistently held that when allegations are serious there must be compelling evidence

before an adverse finding can be made against a health practitioner.

18 In this particular case, while the disciplinary charge was viewed very seriously by Dr B, in reality the charge he faced contained allegations at the lower end of the spectrum of charges normally considered by this Tribunal. In this case, where the Tribunal has made adverse findings against Dr B it has done so because it is very satisfied that the charge has been established.

Professional Misconduct

19 Professional misconduct is defined in sections 100(1)(a) and (b) of the Act. These subsections of the Act refer to a practitioner being guilty of professional misconduct in two circumstances, namely:

> *"(a) … because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or*
>
> *(b) … because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the practitioner practised at the time that the conduct occurred …"*

20 The definition of professional misconduct in the Act is modelled on the definition of professional misconduct found in the Nurses Act 1977.

21 Those who drafted s100(1)(a) of the Act intended to draw a distinction between malpractice and negligence. Whilst there are differences between malpractice and negligence, it is quite conceivable for acts and omissions to constitute both malpractice and negligence.

22 Malpractice is defined in the Collins English dictionary[13] as meaning:

> *"The immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct"*

The same term is defined in the New Shorter Oxford English Dictionary[14] as meaning:

---

[12] unreported HC Auckland, 68/95, 20 March 1996, Blanchard J
[13] 2nd Edition

> *"Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer …a criminal or illegal action: wrong doing, misconduct".*

Negligence

23 The term negligence has a specific meaning in law. Before a plaintiff could successfully sue a health practitioner for negligence they would need to prove four matters, namely:

23.1 That the practitioner owed the plaintiff a duty of care;

23.2 That the practitioner breached the duty of care they owed the plaintiff;

23.3 That the plaintiff suffered compensatible damage;

23.4 That the damage suffered by the plaintiff was caused by the practitioner's breach of the duty of care they owed the plaintiff.

24 It is highly unlikely the drafters of s100(1)(a) of the Act envisaged those prosecuting health practitioners would need to prove all the criteria required by the common law to establish negligence on the part of a health practitioner. In the Tribunal's view, the term "negligence", as used in s100(1)(a) of the Act focuses on a practitioner's breach of their duty in a professional setting. The test as to what constitutes negligence in s100(1)(a) of the Act requires, as a first step in the analysis, a determination of whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal. Whether or not there has been a breach of the appropriate standards is measured against the standards of a responsible body of the practitioner's peers.[15]

25 The approach set out in paragraph 24 of this decision avoids the need for prosecuting authorities to prove damage. Thus for example, a practitioner who fails to make appropriate notes of a consultation may not cause damage to their patient, but may nevertheless be guilty of negligence within the meaning of s100(1)(a) HPCA Act.

Discredit to the Profession

---

[14] 1993 Edition

26 The term to "bring discredit to the profession" was considered by Gendall J in *Collie v Nursing Council of New Zealand*[16] when considering an appeal brought under the Nurses Act 1977. His Honour noted:

> *"To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the nursing profession was lowered by the behaviour of the nurse concerned."*

Background Jurisprudence

27 In New Zealand, most discussions about the meaning of professional misconduct in a health setting commence with a reference to the judgment of Jeffries J in *Ongley v Medical Council of New Zealand*[17]. In that case His Honour formulated the test as to what constitutes professional misconduct as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

28 Under the Dental Act 1988, the test as to what constituted professional misconduct became distilled to two questions. Those two questions were very similar to the tests applied in medical disciplinary proceedings, namely:

28.1 The first portion of the test involved an objective evaluation of the evidence and answer to the following question:

> *Had the practitioner so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the practitioner's colleagues and representatives of the community as constituting professional misconduct?*

28.2 Secondly, if the established conduct fell below the standards expected of a

---

15 See for example, *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 (HL).
16 HC Wellington, AP 300/99, 5 September 2000
17 supra

practitioner:

> *Was the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the practitioner?*[18]

Professional Misconduct under the Act

29 In its decisions in *Nuttall*[19] and *Aladdin*[20] the Tribunal explained that in its view that much of the jurisprudence concerning the meaning of professional misconduct under earlier legislative regimes continues to be relevant under the HPCA Act. In particular, the Tribunal believes that the test as to what constitutes professional misconduct continues to involve a two step process:

29.1 The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can be reasonably regarded by the Tribunal as constituting:

malpractice; or

negligence; or

Otherwise meets the standard of having brought, or was likely to bring discredit to the practitioner's profession.

29.2 The second step of the process requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

30 In his submissions to the Tribunal Mr Waalkens questioned the way the Tribunal had explained in *Nuttall* its understanding of the test as to what constitutes professional misconduct under the Act. In *Nuttall* the Tribunal explained as clearly as it could that the analysis of professional misconduct involves the two step process set out in paragraph 29 above. Mr Waalkens submitted that the test set out in *Nuttall* and

---

[18] Refer *G v Dental Council of New Zealand* (unreported, HC Auckland CP58/95, 4 March 1996, Morris J.); *A V Dentists Disciplinary Tribunal* (unreported, HC Wellington, AP12/95, 11 February 1997, Neazor J.)

[19] 8/Med03/04P

[20] 12/Den05/04D, 13/Den04/02D

reiterated in paragraph 29 of this decision may not embrace *"clearly and distinctly"* the *"threshold"* before a practitioner could be found guilty of a disciplinary offence.[21]

31 Lest others be left in any doubt the Tribunal repeats that it rigorously applies the two step process set out in paragraph 29 of this decision when determining whether or not a practitioner is guilty of professional misconduct. Before a practitioner is found guilty of professional misconduct the Tribunal must be satisfied that the practitioner's acts or omissions were serious enough to justify a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

32 The Tribunal has assessed Dr D's conduct in this case by addressing the tests explained in paragraph 29 in relation to each of the particularised allegations in the notice of charge. The Tribunal has borne in mind that the acts and omissions in question focused on the way Dr D discharged his clinical and professional responsibilities, and are therefore not readily embraced by the concept of "bringing discredit to the profession" as that term is used in s.100(1)(b) of the Act. Nor do Dr D's alleged acts and omissions fit comfortably with the term "malpractice" as used in s.100(1)(a) of the Act. In this case the Tribunal believes Dr D's alleged short comings are more appropriately examined as incidents of alleged "negligence" as that term is used in s.100(1)(a) of the Act.

Informed Consent

33 The allegations in the second particular of the charge involve a claim that Dr D did not obtain Mrs A's informed consent to the procedure he carried out on her. It is accordingly necessary to examine the duties which Dr D had to obtain his patient's informed consent.

The Code

34 Section 2 of the Health and Disability Commissioner Act 1994 refers to informed consent in the following way:

> *"Informed consent means consent to that [healthcare] procedure where that consent –*

---

[21] Refer Transcript p.210

(a) Is freely given, by the health consumer … and

(b) Is obtained in accordance with such requirements as are prescribed by the Code."

35 The Code is the Health and Disability Services Consumers Rights Regulations 1996. It describes in detail the duties of health professionals to inform patients and obtain informed consent to medical procedures where required. The provisions of the Code relevant to the case before the Tribunal are:

35.1 Right 5(2) which provides:

> *"Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly and effectively".*

35.2 Right 6(1) which provides:

> *"Every consumer has the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"*

35.3 Right 6(2) which provides:

> *"Before making a choice or giving consent, every consumer has a right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."*

35.4 Right 7(1) which provides:

> *"Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or common law, or any other provision of this Code provides otherwise".*

NZDA Code of Practice

36 The New Zealand Dental Association has endeavoured to educate New Zealand dentists about their duties and responsibilities to obtain their patient's informed consent to proposed procedures.

37 In a "*Code of Practice*" for "*Informed Consent*" issued by the New Zealand Dental Association in April 1995, and amended in 1996 and September 2001 the NZDA reminded dentists that they have:

> *"… an ethical responsibility to inform his/her patient on treatment options, to help the patient arrive at the most appropriate treatment plan and thus gain their consent"*

The same Code lists six criteria for informed consent, namely:

> *"1 Information on which to make a decision;*
>
> *2 Comprehension of the information;*
>
> *3 Competence to make a decision;*
>
> *4 Clear recommendations and advice by the dentist;*
>
> *5 Absence of pressure or coercion;*
>
> *6 Patient's decision …"*

Under the heading of *"Information to be given"* the Code reminds dentists of their duty to explain to patients:

> *"1 The nature, status (whether it is orthodox or developmental) and purpose of the treatment or procedure, including its expected benefits.*
>
> *2 The likelihood of achieving that purpose: the prognosis.*
>
> *3 The possible emotional, mental, functional and social outcomes of the proposed treatment.*
>
> *4 All significant known risks, including general risks associated with the procedures such as anaesthesia, the degree of that risk and the possibility of its occurrence.*
>
> *5 Possible complications or side effects of treatment.*
>
> *6 Probable consequences of not receiving the treatment.*
>
> *7 All relevant management options/alternatives with their possible effects and outcomes.*
>
> *8 The nature and status of the person who will carry out the procedure.*
>
> *9 Other information requested by the person to receive the proposed treatment."*

The Code also records under the heading of *"Specialist Referral"*:

> *"When appropriate, patients should be given the option of referral to specialist(s). When referral to a specialist is considered the best option and this is declined, it should be noted on the patient's records."*

Common Law

38 The leading New Zealand case on informed consent is *B v Medical Council of New Zealand*[22] an unreported but nevertheless important judgment delivered by the current Chief Justice when she was on the High Court Bench. That case concerned a charge of conduct unbecoming a medical practitioner brought under the Medical Practitioners Act 1968. The case concerned several allegations including a claim that a doctor failed to properly inform his patient about the risks associated with not excising a lump found in the patient's breast. In *B v Medical Council of New Zealand* Elias J adopted the reasoning of the High Court of Australia in *Rogers v Whittaker*[23] and stressed the importance of assessing the adequacy of information conveyed by a doctor to a patient was to be viewed from the standpoint of the patient, rather than the doctor. Poignantly Her Honour said:

> *"In my view, the provision of inadequate information in a situation where the patient needs this information for his or her decisions affecting treatment or investigation, will almost always be professional misconduct or conduct unbecoming".*

The Evidence

Procedure Performed on Mrs A

39 Before examining the evidence it is helpful to briefly explain the procedure which Dr D carried out on Mrs A.

40 When Mrs A consulted Dr D in May 2002 she had experienced difficulties with retaining her upper denture. The upper jaw is referred to as the maxilla. Mrs A had her natural, albeit restored teeth in her lower jaw (mandibular). Doctor D endeavoured to address the problems Mrs A had experienced by inserting three implants in her maxilla, towards the front of her mouth. The implants had ball attachments which were designed to clip into an over-denture. It is important to appreciate that in this case the three implants inserted by Dr D were not braced or splinted to each other.

---

22 supra
23 (1992) CLR 175

Evidence from witnesses called by the Director of Proceedings

41 The Tribunal received and considered an agreed bundle of documents which included Dr D's clinical records relating to his treatment of Mrs A. Those records included copies of digital and panorex x-rays taken by Dr B, operation reports prepared by Dr D and a consent form signed by Mrs A.

42 The Director of Proceedings presented evidence from the following witnesses:

42.1 Mrs A.

42.2 Mr A.

42.3 Mr Clarke, an oral and maxilliofacial surgeon who saw Mrs A on 13 February 2003 and subsequently undertook restorative treatment on Mrs A together with Dr Aitken.

42.4 Dr Aitken, a general dentist practicing in Hamilton who has restricted his practice to implants, crown and bridge work. Doctor Aitken became involved in Mrs A's care on 3 April 2003 when he was asked to assist Mr Clarke.

42.5 Doctor Neilson, a general dentist in Thames who had fitted Mrs A's upper denture in June 2001. Doctor Neilson saw Mrs A on occasions when she was under the care of Dr D.

42.6 Doctor Cautley, a consultant prosthodontist who in May 2004 was asked by ACC to provide an opinion on aspects of Dr D's management of Mrs A. Doctor Cautley subsequently provided an expert opinion for the Director of Proceedings.

42.7 Doctor Payne, a specialist prosthodontist and senior member of the Faculty in the School of Dentistry at the University of Otago.

42.8 Ms Vonlanthen, an employee of the Health and Disability Commissioner who produced a number of letters and documents obtained by the Commissioner and Director of Proceedings.

43 The Director of Proceedings had intended to call evidence from Dr Thyne an oral and maxilliofacial surgeon in Wellington. Doctor Thyne's brief of evidence was made

available to the Tribunal before the hearing. Regrettably Dr Thyne's wife passed away approximately a week before the hearing. Understandably Dr Thyne was not able to appear before the Tribunal. Accordingly the Director of Proceedings withdrew his brief of evidence and it has been disregarded by the Tribunal.

44 Mr Clarke, Dr Neilson and Dr Aitken were not required for cross examination. Their briefs of evidence were tendered on the basis that their evidence was not challenged. The Tribunal notes however that in his evidence Dr Aitken refers to conversations he had with Dr Stolz and Dr Viljven. The Tribunal has not taken account of the comments attributed to those dentists.

Ms Vonlanthen's evidence was tendered without her being required for cross examination.

45 Mr Waalkens QC challenged the accuracy of Mr and Mrs A's recall of certain events. Having carefully observed both Mr and Mrs A, and in particular their demeanour when cross examined the Tribunal concluded both were honest witnesses. In some aspects their memory of events has become distorted with the passage of time. However the most essential elements of Mrs A's evidence have been accepted by the Tribunal.

<u>Mrs A</u>

46 Mrs A explained that she consulted Dr D in early May 2002 because she had experienced difficulties in retaining a number of upper dentures that had been made the previous year by Dr Neilson and a dental technician, Mr Larsen. It was Mr Larsen who recommended Mrs A contact Dr D at his clinic in [ ]. Mrs A saw Dr D for the first occasion on 10 May 2002.

47 At the first consultation Dr D explained to Mrs A a process whereby implants could be inserted into her maxilla to support an over-denture. It appears to be common ground that Dr D explained that the over-denture would be more secure with five implants.

48 It was Mrs A's evidence that at the consultation on 10 May Dr D explained to her and Mr A that an upper over-denture could be secured with three implants "*… close to the*

front of [her] mouth".[24] Mrs A told the Tribunal that she asked Dr D if she needed five implants. Her evidence was that *"He said that three would be sufficient, but that because of where the three implants were going to be placed there would be space for two further implants to be inserted if I wanted them later".*[25]

49 Mrs A told the Tribunal that Dr D proposed modifying her existing denture so that it could be clipped onto the implants. She also said that the estimate of the cost of the total procedure was approximately $7,000. Mrs A also recalled that Dr D told her that the cost of the procedure if five implants were inserted would be about $10,000.

50 Mrs A made it clear that cost was an important consideration for her and MrA.[26] She also however made it very clear that she was strongly influenced in her decision to agree to three implants because Dr D had lead her to believe three implants would succeed. Her answer to a question from Mr Waalkens QC on this point was:

> *"There was no compromise. We discussed three and then he said that five would be better and I said I really can't afford five, will three be workable?. He said three will be workable. He explained that they [the denture] would tilt, having the three wouldn't tilt. Personally I thought they still probably would but he said they wouldn't, so why would I want to pay $10,000 for five when three are going to work".*[27]

During cross examination Mrs A reasserted that Dr D told her three implants *"would be workable"* and she disagreed with Mr Waalkens proposition that Dr D told her five implants would be preferable.[28]

51 Mrs A was also adamant Dr D did not discuss with her the question of splinting or having the implants with bars. In cross examination she said:

> *"There was no mention of bars. The $10,000 was just to put in five implants … there was no mention of bars".*[29]

52 In her evidence Mrs A told the Tribunal that during the first consultation Dr D reassured her by saying that he had done 400 implants. She told the Tribunal:

---

[24] S E Hamilton evidence in chief paragraph 7
[25] S E Hamilton evidence in chief paragraph 8
[26] Transcript p.24 l.8
[27] Transcript p.25 l.7
[28] Transcript p.25 l.14-21
[29] Transcript p.24 l.31-32

> *"Doctor D said that in 400 cases he had done, he had only one failure and that was because the patient had had poor hygiene and not because of any failure with the implants themselves. Although he did mention there was a slight risk of infection he said this was only a problem where the patient's dental hygiene was poor. He did not mention anything about the risk of implants being inserted crookedly or becoming loose".*[30]

53 Mrs A was certain Dr D told her that her implants would be guaranteed for ten years.

54 After the consultation on 10 May 2002 Dr D sent Mrs A a letter (dated 10 May 2002) in which he said, *inter alia*:

54.1 He had gone over the whole treatment plan in detail and would revisit it once he had obtained a panorex x-ray. The panorex x-ray would give Dr B greater information about the amount and quality of tissue in the proposed implant site.

54.2 Doctor D would take moulds of the upper jaw and plate.

54.3 Doctor D wrote *"Having seen you today I feel that there is more than enough tissue to place all three implants, and this is far from the normal situation, therefore I am content to plan this"*.

54.4 The full cost of the treatment would be $6,637 but Dr D offered a 10% discount, reducing the cost to $5,973.

54.5 Doctor D said *"We have been placing implants for 12 years now and have had one failure. Generally these are very stable and long lived items and by placing three now you allow for the placement of two more at a later date."*

55 The second consultation occurred on 23 May 2002. It was at this consultation that Mrs A signed a "*Implant and Periodontal Treatment Information and Consent Form*". The form records that Mrs A understood that her dental treatment would comprise *"three implants with button heads to secure the upper denture"*. The form records that Mrs A understood the treatment she was to undergo had two advantages over alternative treatment methods, namely "*stability and security"*. The form signed by Mrs A recorded she was aware there is a risk that implant surgery may fail. The form

---

[30] S E Hamilton evidence in chief paragraph 12

states *"ster-oss implants have provisional acceptable by the American [Dental] Association and have 6 year results with single teeth with an overall success rate of 97.7%"*. The Tribunal notes this information was not relevant to the procedure Mrs A was to undergo.

The consent form recorded that if an implant should fail within 5 years it would be replaced.

56 At the consultation on 23 May 2002 Dr D took digital x-rays and made mouldings. It is likely Dr D also created a template from Mrs A's denture at this time. Also at this consultation Dr D obtained a detailed medical history from Mrs A.

57 Doctor D provided Mrs A with three pamphlets headed:

57.1 "Post-surgical instructions for implant patients"

57.2 "Implant care"

57.3 "Implant instructions"

58 The Tribunal cannot be certain exactly when these pamphlets were provided to Mrs A. A handwritten drawing on "Implant instructions" showing the sites of the proposed implants and the shape of an implant suggests this pamphlet was probably given to Mrs A at one of the pre-operative consultations, probably on 23 May 2002.

59 The Tribunal notes that the pamphlet "Implant care" states: *"Your implant is guaranteed for 10 years"*.

60 Arrangements were made for Mrs A to go to Dr D's practice in [ ] For the placing of the implants on 7 June 2002. Before Dr D undertook this procedure on 7 June he took a Panorex x-ray.

61 Doctor D placed the implants in Mrs A's maxillary teeth sites 13, 23 and 21. After placing the three implants it became apparent to Dr D that there was a deficiency with the way the implant at site 21 had been placed. Mrs A was certain that Dr D offered to re-fix the implant at site 21 on 7 June 2002. The Tribunal suspects Mrs A may be confused about this point because Dr D's records (such as they are) suggests that the implant at site 21 was re-positioned in [ ] on 14 June 2002.

62 The next step involved the uncovering of the implants. The Tribunal cannot determine with any certainty exactly when this occurred. There is an indication in Dr dB's records it may have occurred on 8 August 2002. Mrs A told the Tribunal:

> *"In approximately August I had my implants I had my implants uncovered whereby Dr D took out the packing over the implants so that they were now visible. My denture which Dr D had had modified for me was then clipped onto the implants. I remember feeling it click into place the first time however a few hours later one of the rings the implant was supposed to click into fell out and another of the rings fell out a few days later."*[31]

63 Mrs A explained that because of the failure of the denture rings she held her denture in place with dental adhesive.

64 Mrs A told the Tribunal that she had an appointment with Dr D in September. She said that at that consultation Dr D expressed concern about an implant. Mrs A said:

> *"…At another check up he decided that the implant was indeed crooked and needed to be re-done. Although I am not entirely certain of the date when it was re-done I believe it was just after my friend Janice went to Scotland (she left 5 September 2002). I remember that I talked to her about it as she rang to ask me how I was feeling.*
>
> *I think it was during this operation Dr D took the implant out and put it back in the same hole. However it may be that he inserted it directly next to its prior position. On this I am not entirely sure".*[32]

The Tribunal cannot determine from Dr D's records exactly when this procedure was carried out.

65 Mrs A told the Tribunal that as with the earlier operation in June she suffered extreme pain following the replacement of the implant in September 2002. On this occasion she believes Dr D prescribed her antibiotics and codeine for pain relief. Mrs A said that her pain was so serious that Dr D came to see her and prescribed pain relief which had the desired effect.

66 Mrs A told the Tribunal that her implants "*… never did what they were supposed to (ie hold my denture in place and stop my plate from tilting)"*[33]. Mrs A said that because she was continuing to have problems with the implants she returned to Dr D *"in or*

---

[31] S E Hamilton evidence in chief paragraph 22

[32] S E Hamilton evidence in chief pgs 23,24,25

[33] S E Hamilton evidence in chief paragraph 29

about November 2002". At about this time Dr D agreed that the implant at site 13 was loose. He suggested further surgery.

67 The third operation was undertaken at Dr B's [ ] clinic on 10 February 2003. A new longer and wider implant was inserted into site 13 on this occasion by Dr D.

68 Mrs A explained that by 12 February 2003 she was starting to feel extremely unwell. She was suffering pain, had a temperature and was feeling nauseous. Mrs A said she telephoned Dr D who told her that her symptoms were:

> *"…quite normal and attributed the pain to the inflammation that naturally follows surgery."*[34]

Mrs A saw her general practitioner. By that evening Mrs A was feeling worse. She again telephoned Dr D's practice but could not speak to anyone. Mrs A then telephoned the emergency dentist in [ ] who in turn contacted Mr Clarke, an oral and maxilliofacial surgeon in [ ].

69 Mrs A saw Mr Clarke on 13 February 2003. Mrs A asked Mr Clarke if he would be willing to take over her treatment. Mr Clarke suggested Mrs A talk to Dr D about who should continue with her treatment.

70 Mrs A returned to Dr D on or about 14 February 2003. She explained that she no longer had confidence in him and said she wished to transfer to Mr Clarke. Mrs A said she subsequently felt guilty about telling Dr D this so in mid March 2003 she telephoned Dr D's practice to see if he wished to continue to treat her. Doctor D declined this invitation. Shortly after Mrs A returned to Mr Clarke who, in consultation with Dr Aitken embarked on a new treatment plan. On 23 April 2003 Mr Clarke removed the failed implant at site 13. On 17 July Mr Clarke inserted four new implants. Mrs A was then treated by Dr Aitken who completed the new treatment plan by inserting a bridge.

71 Mrs A told the Tribunal that the new treatment undertaken by Mr Clarke and Dr Aitken has been successful.

---

[34] S E Hamilton evidence in chief paragraph 33

72 After observing Mrs A give her evidence, and after taking into account the submissions of counsel, the Tribunal concluded:

72.1 Mrs A underwent the procedure performed by Dr D because she believed, on his advice, that three implants were "workable".

72.2 Mrs A was influenced in her decision to undergo the procedure performed by Dr D because it was less expensive than other options he raised.

72.3 Mrs A was not aware of the risks of failure of the procedure undertaken by Dr D. In particular she was not properly told about the risks of:

- Inserting three implants, as opposed to four or possibly five implants;
- Not bracing or splinting the implants;
- The inherent potential weaknesses of the treatment plan because her mandibular comprised her natural (albeit restored) teeth.

72.4 Mrs A was influenced by Dr D's reassurances that he had performed 400 implants with only one failure, and that failure was due to poor dental hygiene.

72.5 Mrs A was also influenced by a reassuring statement such as:

- The reported 97.7% success rate of steri-oss implants;
- That the implants would have either a five or ten year guarantee.

MrA

73 The Tribunal heard from MrA who, in general terms, confirmed Mrs A's recall of the chronology of events.

Dr Neilsen

74 The Tribunal received and considered Dr Neilsen's unchallenged evidence which explained:

74.1 Doctor Neilsen made and fitted an upper denture for Mrs A on 5 June 2001;

74.2 On 11 June 2002 (4 days after the first surgery performed by Dr B) Mrs A saw Dr Neilsen regarding tooth ache in tooth 46;

74.3 On 16 June 2002 Dr Neilsen received an emergency call out to Mrs A because of pain associated with her tooth 46;

74.4 On 22 July 2002 Dr Neilsen shaped and cleaned the root canals of tooth 46;

74.5 In early September 2002 Dr Neilsen received a call from Mrs A who was distressed because she had just received notice that Dr D was closing his [ ] practice.

Mr Clarke

75 Mr Clarke, an oral and maxilliofacial surgeon, practices in[ ]. He became involved in Mrs A's care when he was contacted by the emergency on-call dentist in [ ] on the evening of 12 February 2003. Mr Clarke arranged to see Mrs A the following day. When Mr Clarke examined Mrs A he observed inflammation and infection where the implant at site 13 had been inserted. Mr Clarke discussed with Mrs A the treatment which had been carried out by Dr D. Mr Clarke told Mrs A that he did not like Dr D's treatment plan because it involved unsplinted implants being placed in the maxilla. Mr Clarke said his:

> *"…reason for saying that is that the potential for failure is considerably higher than with a bar over-denture (ie, interlinking the implants to give them proper support). In the maxilla, implants should be linked across the midline as the maxilla flexes across the midline. This is particularly so when the patient still has her bottom teeth in that this increases bite/chewing forces as compared to a patient with a lower denture".*[35]

76 Mr Clarke received a letter of referral from Dr D on or about 13 March 2003. That letter related to Mrs A. Mr Clarke agreed to treat Mrs A, which he did in conjunction with Dr Aitken. Mr Clarke took radiographs on 2 April 2003 which showed that the implant at site 13 had suffered bone loss around it. This indicated the site was still infected and not likely to integrate. The sites of the other two implants were not infected. Mr Clarke's treatment plan comprised:

76.1 Removing the implant at site 13 on 23 April 2003

76.2 Placing 4 new implants in 17 July 2003.

77 Mr Clarke was not required for cross examination. His evidence was accepted on the basis that it was not challenged by Dr D.

Dr Aitken

78 Doctor Aitken is registered as a general dentist. He practices in [ ]. Although Dr Aitken does not have specialist registration he has, since 2001, restricted his practice to "implants, crown and bridge work".

79 Doctor Aitken became involved in Mrs A's care on 3 April 2003 following a referral from Mr Clarke. When Dr Aitken saw Mrs A he observed she was wearing an upper denture that was held in place with dental adhesive. Doctor Aitken observed implants at sites 11 and 23, as well as the implant at site 13 which he said "*showed evidence of infection and was accordingly unlikely to ever integrate*".[36]

80 Doctor Aitken told the Tribunal that the treatment undertaken by Dr D was *"…never going to be an appropriate solution for Mrs A …"*. Doctor Aitken told the Tribunal:

> *"The prognosis for one of the three existing implants in the upper jaw was hopeless as it was infected and the prognosis of the remaining two implants extremely poor if they alone were used to retain an over-denture especially in an 'unsplinted' manner ie not joined together. The bone of the upper jaw is often lacking in density so although two implants could satisfactorily be used to restore a lower jaw over-denture case where the bone is normally very dense, in the upper jaw the poor quality and often quantity of bone make this treatment modality extremely risky unless implants are 'splinted' together".*

Doctor Aitken said he told Mrs A the treatment option followed by Dr D *"…would be like placing implants in sand"*.

Doctor Aitken explained his:

> *"…reason for saying this was that [he] was aware from research that unsplinted implants connected to ball attachments to retain a full upper denture against natural teeth has a very high risk of individual failure. This is particularly true when the treatment – as with the case with Mrs A – does not go according to plan and fewer implants remain than were*

---

[35] P J Clarke evidence in chief p.6
[36] R F Aitken evidence in chief p.2

ideally required to maintain support of the prosthesis."[37]

81 Doctor Aitken supported his comments about the inadequacy of the treatment plan followed by Dr D by referring to a Journal article[38] which apparently referred to two cases similar to Mrs A's in which all implants were lost within a two year period. Doctor Aitken also referred the Tribunal to a further study[39] which apparently *"highlights the disastrous failure rates of implants (72%) where planned treatment cannot be carried out and fewer implants are used to support the prosthesis in the maxilla than were originally planned*".[40]

82 Doctor Aitken unequivocally stated that in his opinion:

> *"…if implants are to be used for over-denture support in the maxilla then all the implants must be splinted together".*[41]

83 In Dr Aitken's view the best treatment option for Mrs A was a fixed prosthesis or bridge in her upper jaw. The cost of this treatment was considerably more than Mrs A had paid Dr D. Doctor Aitken and Mr Clarke discounted their fees for this work. Nevertheless the procedures they performed cost $15,090. Mrs A accepted the proposals put forward by Dr Aitken in conjunction with Mr Clarke. Over the ensuing months Mr Clarke and Dr Aitken undertook their treatment plan without any major issues arising.

84 As with Mr Clarke, Dr D chose not to cross examine Dr Aitken. The Tribunal has accordingly accepted Dr Aitken's admissible evidence on the basis that it was accepted by Dr D.[42]

Dr Cautley

85 Doctor Cautley is a Prosthodontist. He practices in Nelson. He became familiar with Mrs A's case in May 2004 when he was asked to provide an opinion to ACC's medical misadventure unit. He was subsequently contacted by the Director of Proceedings to provide expert opinion in the case brought before the Tribunal.

---

37 R F Aitken evidence in chief p 5 and 6
38 Implant – Supported Overdentures: a Longitudinal Prospective Study Int J Oral Maxillofac Implants 1998, 13(2): 753-62 by Bergindall and Engquist
39 Implant – Supported Maxillary Overdentures: Outcome in planned and emergency cases, Int J Oral Maxillofac Implants 1994, 9, 184-190 by Palmqvist, Sondell and Swartrz
40 R F Aitken evidence in chief p 7
41 R F Aitken evidence in chief p 8

86 The Tribunal has no hesitation in concluding Dr Cautley has the requisite qualifications to provide expert opinion evidence in this case. He has held academic and practicing positions as a prosthodontist and published widely in the area of prosthodontics. Doctor Cautley's evidence was based on his 15 years experience of providing implant treatment and his understanding of the principles of implant based treatments.

87 In forming his opinion Dr Cautley acknowledged that he encountered considerable difficulty in working out what Dr B had done on occasions in this case because of the absence of proper records.

88 Doctor Cautley was able to confirm however that the records showed Dr D did take:

88.1 Digital x-rays on 23 May 2002

88.2 Panorex radiographs on 7 June 1002.

89 Doctor Cautley also pointed out there was evidence Dr D had prepared a model and clear stent pre-operatively.

90 Doctor Cautley noted that Dr D appeared to place implants at sites 13, 23 and 21 on 7 June 2002, but that he was not satisfied with the positioning of the implant at site 21. He also drew attention to the re-positioning of the implant at site 21 into site 11 on 14 June 2002.

91 Doctor Cautley told the Tribunal that the next entry in Dr D's records was for 17 June 2002 which suggested Mrs A required significant pain relief.

92 Doctor Cautley's analysis of the evidence recorded that there were no further meaningful entries in Dr D's records although his report to ACC Medical Misadventure Unit[43] suggests he saw Mrs A again on 8 August 2002. This report suggested that on 8 August 2002 Dr B took an x-ray and gave her a *"full upper and lower denture"*.

93 The Tribunal notes that the records submitted in the agreed bundle of documents also suggests Dr D placed full upper and lower dentures in Mrs A on 8 August 2002. In

---

[42] The Tribunal has disregarded Dr Aitken's hearsay comments in paragraph 9 of his evidence in chief.

the bundle of documents can be found the following:

p.20 "08/08/02 Full upper and lower plate"

p.21 "08/08/02 Full upper and lower plate"

p.22 "08/08/02 Full upper and lower plate"

p.29 "08/08/02 Dent-F/, Full upper lower plate $760"

94 The Tribunal agrees with Dr Cautley that it was highly unlikely that Mrs A ever received a lower denture. Mrs A, Mr Clarke and Dr Aitken would have commented on this significant event if it had occurred.

95 Doctor Cautley understood the next event, set out in Dr D's report to ACC, was that he uncovered the implants. One of the implants was found to have soft tissue around it and was replaced with a longer and wider implant. Doctor Cautley noted that it was not clear from Dr D's records when the implants were uncovered.

96 Doctor Cautley's evidence then proceeded to the events of 12 February 2003 when Mrs A telephoned the on-call emergency dentist in Thames and subsequently saw Mr Clarke and Dr Aitken who instigated a different treatment plan.

97 Doctor Cautley expressed several concerns about the treatment provided to Mrs A by Dr D. Doctor Cautley's concerns can be summarized in the following way.

Treatment Plan

98 Doctor Cautley thought the treatment plan by Dr D was inappropriate. He said that placing implants in the maxilla can be challenging because of a number of reasons including the:

> *"frequent finding that residual bone levels are less than ideal, Maxillary bone is less dense and softer than mandibular bone, and failure rates of implants in the maxilla are known to be higher than in the mandible".*[44]

Doctor Cautley explained:

---

[43] Annexed to Ms Vonlanthen's evidence

[44] A Cautley evidence in chief p.31

> *"It has been the accepted clinical view that at least four implants are required for full arch reconstruction, and these should always be splinted, that is, using a bar attachment rather than ball attachments. Experienced researchers and clinicians would concur that the use of fewer unsplinted implants allows for greater leverage on the implants and a higher rate of failure; it is recognized that the main reason for implant failure post integration is over loading. Texts written by these clinicians propound this view."*[45]

Doctor Cautley said:

> *"The current standard where a patient has lower teeth, is four to six implants splinted on a bar. I accept that if a patient had no lower teeth and never wore a denture in the mandible then this plan may have worked, however it was unlikely to work in this situation."*[46]

Planning

99 Doctor Cautley was critical of the level of planning undertaken by Dr D in this case. He suggested the steps taken by Dr D would not meet the standard of care expected of a dentist undertaking this category of treatment.

Informed Consent

100 Doctor Cautley advised the Tribunal that it is considered standard practice to splint together implants in the maxilla to support an over-denture. He said that in the absence of supporting evidence, the decision to proceed with unsplinted implants in this case could *"…only be considered experimental..."*.[47]. Doctor Cautley thought Dr D was obliged to explain to Mrs A the experimental nature of the treatment he was proposing.

Failure to Refer

101 Doctor Cautley acknowledged that there was a division of opinion within the dentistry profession over whether or not general dentists should undertake implant work. Doctor Cautley said that in his opinion Dr D should never have attempted the surgery he carried out on Mrs A. Doctor Cautley suggested Dr D could have undertaken the treatment plan with an experienced surgeon.

---

45 A Cautley evidence in chief p.32
46 A Cautley evidence in chief p.35
47 A Cautley evidence in chief p.38

Record Keeping

102 Doctor Cautley was very critical of Dr B's records which he described as "poor" and that "*where there are records, most of these are of poor quality, containing only scant details of discussions and treatment*".[48]. Doctor Cautley's concerns about Dr D's records can be summarized in the following way:

102.1 An absence of any record of Dr D discussing the option of a fixed denture;

102.2 An absence of details of the operation performed on 7 June 2002, and in particular the absence of details of:

- Pre-operative medication drugs and dosages;
- Local anaesthetic administered;
- Details of the surgery performed;
- The tightness of the implants;
- The types and sizes of the implants;
- Whether sutures were placed;
- Post operative medication including pain relief and antibiotics

102.3 The absence of records for consultations which Dr D subsequently confirmed in his report to ACC had occurred on:

- 23 May 2002
- 21 June 2002
- 4 July 2002
- 16 August 2002
- 26 September 2002
- 25 November 2002
- 14 March 2003

102.4 The apparent confusion of other patients records with Mrs A's;

102.5 The failure to adequately record prescriptions;

102.6 The failure to record medications administered during and after the third operation.

103 In cross examination it was put to Dr Cautley that Dr D should be judged as a general dentist, not as a specialist. Doctor Cautley responded by insisting that there were not two standards of care. He acknowledged that there are general dentists who can provide the same standard of care as a specialist in some circumstances. He insisted that if a general dentist wants to embark upon a more complex case then they need to be able to do so to the same standard as a specialist.[49]

104 When questioned by Mr Waalkens QC Dr Cautley acknowledged he had not produced any text books *"… that say thou shalt not adopt a free standing implant treatment plan with an over-denture to anterior maxillary treatments like Mrs A had."*[50] Doctor Cautley also acknowledged that the absence of a clear direction in text books not to embark on the treatment Dr D carried out might explain why Dr D unwittingly ended up treating Mrs A the way he did.[51].

105 Doctor Cautley reconfirmed in cross examination that Dr D took three periapical x-rays of the sites where the implants were to go, as well as a Panorex radiograph on 7 June 2002. Doctor Cautley also noted that there was information Dr B had prepared models and a stent which Dr Cautley described as *"… probably quite reasonable"*[52] conduct on the part of Dr D.

106 It was put to Dr Cautley that the computer programme used by Dr D generated references to lower and upper dentures in relation to the entries on 8 Augsut 2002. Doctor Cautley said that if the references in Mrs A's notes to a lower denture were a "typo" or computer programme problem then he would not "have a problem with that".[53]

---

[48] A Cautley evidence in chief p.44
[49] Transcript p.82 l.1-11
[50] Transcript p.86 l.28-34
[51] Transcript p.87 l.22-27
[52] Transcript p.93 l.24-27
[53] Transcript p.99 l. 12-19

Dr Payne

107 The second expert called to give evidence by the Director of Proceedings was Dr Payne, a specialist prosthodontist and senior lecturer in the School of Dentistry at the University of Otago. Doctor Payne's academic and practical experience as a prosthodontist made him eminently qualified to provide the Tribunal with expert testimony on the management of Mrs A's case.

108 Doctor Payne's knowledge of the facts was based primarily upon:

108.1 Doctor D's incomplete records;

108.2 Doctor D's explanation to ACC.

108.3 Mrs A's evidence.

Doctor Payne's understanding of the facts was very similar to that of Dr Cautley and need not be reiterated in this decision.

109 When commenting on the appropriateness of Dr D carrying out the work he performed on Mrs A, Dr Payne told the Tribunal:

109.1 Doctor D had been registered as a general dentist since 1972, and had attended several implant courses;

109.2 He was concerned that the courses attended by Dr D were likely to be short. By contrast, Dr Payne referred to Dr Aitken who he said had attended *"countless international training courses and conferences"* and despite his experience, Dr Aitken does not undertake implant surgery;

109.3 "The current standard of care is the placement of a minimum of four implants in the endentulous maxilla to support a maxillary over-denture. There is not clear consensus on this as some authors say 4-6 implants whilst other keynote text books do actually say 3-6 implants. However, although there is controversy in the minimum standard of care for the endentulous maxilla, there is however agreement that the implants must be splinted with a gold bar. Some authors and researchers even recommend as many as 8 implants. However, this consensus or agreement is always subject to change with the

publication of new research".[54]

109.4 The degree of surgical difficulties associated with "the endentulous maxilla as a surgical site is high". For this reason Dr Payne suggested patients such as Mrs A should be sent to an oral and maxilliofacial surgeon for surgery of the kind carried out.[55]

109.5 If Dr D confirmed to Mrs A that 3 implants would be satisfactory then that "was of concern" to Dr Payne, as this "is not the standard of care" in a patient such as Mrs A.[56]

109.6 In planning treatment in a patient such as Mrs A the dentist should prepare and take:

- study models
- photographs
- radiographs, and if possible
- cephalonetic views
- computerized tomography scans
- 3D computer reconstructions

109.7 A fixed bridge was not the only appropriate treatment for Mrs A. A maxillary over-denture on "four or more splinted implants would also have met the [appropriate] standard of care".[57]

109.8 Doctor D failed to give Mrs A appropriate information before undertaking surgery when:

- He said in his letter of 10 May 2002 that 3 implants could be placed, allowing for the placing of 2 more at a later date;

---

[54] AGT Payne evidence in chief p.43
[55] AGT Payne evidence in chief p.44
[56] AGT Payne evidence in chief p.45
[57] AGT Payne evidence in chief p.48

- Mrs A consented to "3 upper implants with button heads to secure the upper denture";

- The consent form refers to the sterioss implant system which has not been marketed since 1998.

109.9 Mrs A needed to be informed that the proposed treatment option of 3 unsplinted implants supporting an over-denture opposing a natural mandibula dentition had not been tested in "clinical research trials".[58]

109.10 Doctor D's records were poor. In this regard Dr Payne's criticisms of Dr D mirrored the concerns conveyed by Dr Cautley about the substandard quality of Dr D's records. Doctor Payne said:

> *"The standard of record keeping for all surgical and prosthodontic procedures was poor. Details of the implant surgery performed by Dr D are minimal, and would fall well short of an expected standard for record keeping of both implant surgery and prosthodontics of this type."*[59]

110 Interestingly, Dr Payne provided the Tribunal with information about research being undertaken at the University of Otago which suggests that patients with a mandibular over-denture may be successfully treated with a 3 implant maxilla over-denture. It is important to stress however that the research being undertaken by Dr Payne and his colleagues concerns a different category of case to Mrs A who had a natural mandibular.

111 When cross examined by Mr Waalkens QC Dr Payne's attention was drawn to a widely used text book "Prosthodontic Treatment for Endentulous Patients".[60] At page 502 of that text can be found a sentence which reads:

> *"Maxillary over-dentures require the placement of a minimum of three to four implants, which are usually joined with a connecting bar".*

Mr Waalkens put to Dr Payne that the reference to "usually" in this sentence undermined Dr Payne's evidence that implants in the maxillary must be splinted with a bar. Despite rigorous questioning on this point Dr Payne maintained his position

---

58 AGT Payne evidence in chief p.60
59 AGT Payne evidence in chief page 33
60 12th Ed 2004 Mosbe, Inc

that clinical evidence could not support the course of treatment followed by Dr B. In particular, Dr Payne drew attention to another respected text "Implant Overdentures: the Standard of Care for Endentulous Patients"[61] which concludes with the following sentences at pages 96 and 97:

> *"Maxillary overdentures have become better documented in the last few years, and prosthetic concepts and treatment protocols have been established. There is still a great need for long term surveys to analyse treatment outcomes with planned cases. As long as comparative data of planned maxillary overdentures are lacking, a minimum of four implants with a rigidly splinting bar must be recommended as the standard of care".*

Similarly, when questioned about passages in Prosthodontic Treatment for Endentulous Patients found at pages 504 and 506 of that text, Dr Payne was certain that the references relied upon by Mr Waalkens QC did not lend support for the treatment regime followed by Dr B in this case. Doctor Payne did acknowledge however that this text did not state a dentist must use splints or bars to brace implants in the maxillary to support an overdenture.[62]

112 When cross examined about Dr D's planning for the treatment Dr Payne conceded:

112.1 Photographs were not mandatory;

112.2 He had read it suggested Dr D did make study models;

112.3 Doctor D took panoramic and opex x-rays;

112.4 Computerised topographical scans and 3D computer reconstructions were not mandatory;

112.5 That Dr D appeared to conform to appropriate standards when planning Mrs A's treatment.[63]

113 Doctor Payne also drew attention to the possibility that Dr D may have tried to refer Mrs A to a specialist on 21 January 2003. At page 171 lines 23-33 of the transcript Dr Payne referred to an entry in the clinical records made probably by a practice nurse about a telephone conversation Dr D had with Mr Clarke.

---

[61] Edited by Feine and Carlsen, Quintessence Publishing Co 2003

114 The final topic of cross examination concerned the quality of Dr D's records. Doctor Payne agreed with Mr Waalkens that poor record keeping did happen, in busy practices, and that such short comings were regrettable.

The Case for Dr B

115 Throughout the Director of Proceedings' case Mr Waalkens QC made it clear that it was highly likely Dr D would be giving evidence. For example:

115.1 At page 54 line 7 of the transcript Mr Waalkens is recorded as saying that it was 99.9% certain Dr BDwould give evidence;

115.2 At page 110 lines 15-17 of the transcript Mr Waalkens said no election had been made but then said *"he [Dr D] will be giving evidence …"*.

Appropriately, Mr Waalkens QC provided the Director of Proceedings and the Tribunal with Dr D's proposed brief of evidence before the hearing. He also made available briefs of evidence from Dr Worthington and of Mrs D. When cross examining witnesses Mr Waalkens put propositions contained in Dr D's brief of evidence on the basis Dr D would be called to give evidence.[64]

116 It was a source of surprise to the Tribunal that Dr D elected not to give evidence or call Dr Worthington whose evidence in chief may well have assisted the Tribunal. In light of the decision not to call either Dr D or Dr Worthington the Tribunal has been required to disregard their briefs of evidence.

117 When Mr Waalkens QC announced at the end of his opening statement that Dr D would not be giving evidence the Tribunal invited Ms Curtis to consider whether or not she wished the Tribunal to call Dr D to give evidence so as to assist the Tribunal in determining the charge. The Tribunal's invitation to Ms Curtis should not be construed as a suggestion that the Tribunal necessarily believes it can and/or should compel a health practitioner who is the subject of a charge to give evidence.[65] As it transpired Ms Curtis did not make an application to have the Tribunal call Dr D, and the issue as to whether or not the Tribunal could or should follow that course of action

---

62 Transcript p.158 l.30; p.159 l.22
63 Transcript p.166 l.21
64 See for example Transcript p.160 l.28-30, p.162 l.11
65 Refer *ADLS v Leary* HC Auckland M1471/84, 12 November 1985, Hardie-Boys J.

will have to be determined on another occasion.

118 Doctor D asked his wife to give evidence. She explained that she has been her husband's practice manager for approximately 11 years. Mrs D told the Tribunal that:

118.1 Implant work comprises about 5-10% of her husband's practice;

118.2 Doctor D had worked on approximately 400 implant cases;

118.3 Doctor D made models in connection with his treatment of Mrs A;

118.4 Doctor D made a stent for Mrs A;

118.5 The reference in the records for 8 August 2002 to a lower denture was a computer error;

118.6 Doctor D had only one failure with an implant prior to Mrs A's case.

119 In both his opening and closing submissions Mr Waalkens stressed the following points by way of general submissions:

119.1 The Director of Proceedings had not proven the charge to the requisite standard;

119.2 Even if the Tribunal was satisfied Dr D had not adhered to appropriate standards, his shortcomings did not justify a disciplinary finding. For example, Mr Waalkens acknowledged Dr D's records *"were not up to standard"*. Mr Waalkens submitted this omission did not justify the Tribunal finding Dr D guilty of professional misconduct.

119.3 Doctor D was registered as a general dentist. He was not a specialist prosthodontist or oral and maxilliofacial surgeon. It is therefore only appropriate for Dr D to be judged by the standards of those who practice in the same "scope of practice" as him.[66] In particular, Mr Waalkens urged the Tribunal not to judge Dr D against the standards of Dr Payne and Dr Cautley.

119.4 Mr Waalkens QC submitted this was a case in which Dr D unwittingly became involved in implant work that was more complex than initially apparent. Mr

---

[66] Section 100(1)(a) of the Act

Waalkens said a number of factors contributed to this, namely:

- Doctor D's willingness to do the best he could for Mrs A;
- The constraints of Mrs A's financial resources;
- The absence of published research on the procedure he carried out;
- The absence of a clear warning in the literature not to embark on the treatment Dr D undertook;
- An encouragement from manufacturers and suppliers of implants for general dentists to undertake implant treatment;
- An absence of what Mr Waalkens called "professional regulation";
- Changing practices and standards.

120 The Tribunal refers to Mr Waalkens submissions in relation to each particular of the charge when considering its findings in relation to the details of the charge.

Tribunal's Findings in Relation to Each Particularised Allegation of the Charge

Particular 1: Doctor D failed to carry out appropriate planning for the placement of the implants in Mrs A.

121 This particular of the charge alleges Dr D failed to undertake an appropriate evaluation of his patient, and that specifically he failed to prepare mounted models, and appropriate radiographs to determine the relationship of Mrs A's jaws and available bone volume and form.

122 This particular of the charge has not been proven to the requisite standard. The Tribunal agrees with Mr Waalkens' submission that the evidence of Drs Payne and Cautley establish that Dr B did take apical x-rays and a panorex x-ray. The fact the panorex x-ray was taken on 7 June 2002 was not ideal, but nevertheless it was taken and would have allowed Dr D an opportunity to assess the adequacy of the bone density in Mrs A's maxilla. There was also evidence, albeit scant, that Dr D did

prepare models and a stent. In these circumstances the Tribunal is not satisfied that the first particular of the charge has been proven to the requisite standard.

Particular 2: **Doctor D did not obtain his patient's informed consent in that he failed to advise Mrs A of the:**

(a) risks of inserting 3 unsplinted implants into her maxilla;

(b) **other risks associated with implant surgery including incorrect placement of implants, and/or failure of implants to integrate.**

Particular 2(a)

123 The Tribunal has found the first part of Particular 2 proven. That is to say the Tribunal is satisfied to the requisite standard that Dr D did not warn Mrs A of the risks of inserting 3 unsplinted implants into her maxilla to support an overdenture when she had natural teeth in her mandibular. The Tribunal is also satisfied that Dr B's failure to warn Mrs A of these risks was a failure to adhere to the standards expected of a dentist in his position and, that his shortcomings constituted a serious failure on his part. Doctor D's errors justify a disciplinary finding for the purposes of maintaining professional standards and protecting the public.

124 The Tribunal is very satisfied from Mrs D's evidence that Dr B did not explain to her the risks of the 3 unsplinted implants in her maxilla, on the contrary, the Tribunal is very satisfied Dr D told Mrs A that the proposed 3 unsplinted implants would work.

125 During his closing submissions Mr Waalkens acknowledged there was no evidence before the Tribunal that Dr D explained to his patient the risks of inserting 3 unsplinted implants into his patient's maxilla to support an overdenture.[67]

126 The Tribunal understands Dr D's defence to this particular of the charge to be that as a general dentist Dr D could not be expected to know of the risks of relying on 3 unsplinted implants in Mrs A's maxilla to support an overdenture. This submission was based upon the contention that the state of the literature was "poor" and there were inadequate warnings to the profession about the procedure carried out by Dr D.

---

[67] Transcript p.255 l. 1-14

127 The Tribunal does not know what Dr D knew about the relevant literature or what research he had undertaken before embarking upon the treatment he provided Mrs A. The Tribunal is however aware:

127.1 Doctor D led Mrs A to believe that 3 implants in her maxilla would work;

127.2 There have been no trials or published reports which confirm that 3 unsplinted implants in the maxilla will adequately support an overdenture where there are natural teeth in the mandibular;

127.3 There are articles referred to by Dr Aitken which warn of the risks of unsupported implants being placed in the maxilla to support an overdenture;

127.4 Doctor Aitken, a general dentist criticized Dr D's management plan. He knew that unsplinted implants connected to ball attachments to retain a full upper denture against natural teeth have a very high risk of failure, and that if implants are to be used for overdenture support in the maxilla then all implants must be splinted together.

128 The treatment plan put in place by Dr D was based upon his optimistic belief that it would work. That optimism was not well founded. Doctor Cautley described Dr B's treatment of Mrs A as experimental. The Tribunal does not go so far as to say that Dr D was experimenting with Mrs A. The Tribunal states however that Mrs A should have been told that her proposed treatment was not endorsed by any authorities on the topics. Furthermore, the Tribunal believes that any dentist embarking on "leading edge" procedures must familiarize themselves with the risks associated with the proposed procedures. Doctor Aitken was very familiar with the risks of the treatment undertaken by Dr D. It was also emcumbent on Dr D to make himself familiar with those risks and advise his patient of those risks before embarking on the treatment plan in question.

129 For these reasons the Tribunal has concluded:

129.1 Doctor D's failure to warn Mrs A of the risks of the proposed treatment (as set out in Particular 2(a)) in the notice of charge) was a failure to adhere to the standards which the Tribunal would expect from a dentist in Dr B's position.

129.2 Doctor D's failure to warn Mrs A about this issue, was a serious omission

which justifies a disciplinary sanction in order to uphold professional standards and protect the public.

Particular 2(b)

130 The Tribunal has concluded that the Director of Proceedings has not proven to the requisite standard that Dr D failed to warn Mrs A of other risks associated with implant surgery. This part of the charge specifically alleges Dr D failed to warn about incorrect placement of implants or failure of implants to integrate.

131 The consent form signed by Mrs A on 23 May 2002 specifically records her acknowledgement that she was:

> *"… aware that there is a risk that the implant surgery may fail, and that further surgery may be necessary, including removal of the implant."*

132 In these circumstances the Tribunal is not satisfied Dr D failed to warn Mrs A of other risks of the treatment plan as alleged in Particular 2(b) of the notice of charge.

Particular 4(a): Doctor D embarked upon implant surgery for which he was not adequately experienced and/or qualified instead of referring his patient to an appropriate specialist.

(b) Upon discovering that one of the implants had failed Dr D failed to refer Mrs A to an oral maxilliofacial surgeon.

Particular 4(a)

133 The Tribunal has found in Dr D's favour in relation to this particular of the charge, albeit by a narrow margin.

134 The Tribunal believes that the Director of Proceedings has not been able to establish to the requisite standard an evidential basis for this particular of the charge and that it must accordingly be dismissed.

135 In reaching this conclusion the Tribunal agrees with Mr Waalkens' submission that technically speaking, any general dentist can embark on the treatment undertaken by Dr B on this occasion, even though it may not be wise to do so.

136 There was evidence Dr D had undertaking 400 implant cases, and that he may have had a very high success rate.

137 In the absence of clearer professional guidelines on referral to a specialist in cases such as this, and more compelling evidence about Dr D's experience the Tribunal believes it not appropriate to impose an adverse disciplinary finding against Dr D because he elected to provide treatment which should have been provided by specialists.

Particular 4(b)

138 The Tribunal is also not satisfied to the requisite standard that Dr D did not take steps to refer Mrs A to an oral and maxilliofacial surgeon when it became clear that the implant at site 13 had failed.

139 There is evidence, albeit scant, that Dr D may have made contact with Dr Clarke on or about 21 January 2003. There is an entry in Dr D's records for 21 January 2003 which reads:

> *"Phoned and left message for [Mrs A] to call us so that we can inform her that [Dr D] has spoken to Peter Clarke about the option of day stay at[ ] and the cost would be about $2,000. However if we do it here there would not charge as it is a redo."*

140 In addition, the Tribunal notes in the annexures to Ms Vonlanthen's statement there are telephone records from Dr D's practice. Those records suggest seven minutes of telephone calls to Dr Clarke's practice from Dr D's practice on the morning of 21 January 2003.

141 Although it is marginal, the Tribunal believes there is some evidence Dr D may have tried to refer Mrs A to Dr Clarke on or about 21 January 2003, and that in these circumstances particular 4(b) of the charge has not been proven to the requisite standard.

Particular 5: Doctor D failed to keep adequate records of this history of his dealings with Mrs A and the treatment he provided.

142 The Tribunal has found this particular of the charge proven to the requisite standard.

143 The Tribunal has carefully examined Dr D's records. They are grossly inadequate from the period 7 February 2002 to 14 February 2003.

144 The Tribunal agrees with Dr Cautley and Dr Payne criticisms of the adequacy of Dr D's records.

145 The records of the surgery performed by Dr D on 7 June 2002 fell well below the standards expected of a dentist in Dr D's position. His records should have stated:

145.1 What pre-operative drugs were used and their dosages;

145.2 The amount and type of local anaesthetic administered;

145.3 Details of the surgery undertaken;

145.4 The types and size of implants inserted;

145.5 Whether or not sutures were placed;

145.6 What post operative drugs were prescribed and the dosage.

146 There were a number of consultations and contacts between Mrs A and Dr D which were not recorded in Dr D's notes. There was evidence of consultations on:

21 June 2002

4 July 2002

16 August 2002

26 September 2002

25 November 2002

14 March 2003

That were not adequately documented. In some instances they were not documented at all.

147 There appeared to be records of other patients merged with Mrs A's records. For example, at p.29 of the agreed bundle of documents there are references for 14 June 2002 that are highly unlikely to relate to Mrs A. The references refer to implants on

sites 41 and 23, bone grafting and implant posts and cores. Comment has already been made about the entries for 8 August 2002 suggesting the placing of a lower plate in Mrs A. It is clear to the Tribunal Mrs A did not have a lower plate. Even if that error was due to a computer programme the Tribunal believes it is incumbent on Dr D to make sure his records are accurate. The error should have been detected and corrected.

148 The report for the final operation does not state what antibiotics or analgesics were given and in what dosages.

149 The New Zealand Dental Association has issued a Code of Practice dated 12 September 1994 which explains to dentists the reasons why they must maintain accurate and proper records. A key reason why dentists are required to maintain proper records is to ensure that others involved in their patients care can readily understand what treatments have been administered. In this case two very experienced dentists have examined Dr D's records and struggled to understand what treatment and steps he undertook.

150 In this case Dr D's records were so grossly inadequate a disciplinary sanction is required in order to maintain professional standards. It is unusual for a health practitioner to be sanctioned in a disciplinary forum because of the inadequacy of their records. However in this case, Dr B has fallen so far below accepted standards the Tribunal believes it must record a disciplinary finding on Dr B. Part of the reason for taking this step is to reinforce to the profession the need for adequate records to be kept by all dentists.

Cumulative Charge

151 The Tribunal has found two particulars of the charge proven as professional misconduct. It is accordingly not necessary to consider the cumulative charge. The Tribunal records however that if it were required to consider the cumulative charge the Tribunal would have had no hesitation in holding that when viewed cumulatively, the two adverse findings made against Dr D constituted professional misconduct.

152 The Tribunal will now receive and consider submissions on penalty and name suppression. If for any reason the parties are unable to adhere to the timetable for the submissions set out in paragraph 4 of this decision they should notify the Tribunal.

DATED at Wellington this 14th day of October 2005.

.....

D B Collins QC
Chair
Health Practitioners Disciplinary Tribunal