New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: **40/Den/05/21D**

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 Act against **A,** Dentist, of Dunedin **,**

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chairperson)

Dr J Edwards, Dr R East, Dr H Trengrove and Ms W Davis (Members)

Ms S D'Ath (Executive Officer)

Ms G Rogers (Stenographer)

HEARING: Held in Dunedin on 8 and 9 May 2006.

APPEARANCES: Mr J Tamm for the Director of Proceedings.

Mr M McClelland for Dr A.

Introduction

1 Doctor A is a registered dentist. Dr A went to Dunedin in 2002 to pursue training in oral and maxillo-facial surgery. Whilst studying Dr A carried out dental work on a locum basis at the Knox Dental Clinic in Dunedin. Dr A worked at that clinic after hours and on the weekends.

2 On 16 November 2005 the Director of Proceedings laid a charge of professional misconduct against Dr A with the Tribunal.

3 The charge related to the manner in which Dr A treated a patient, Dr Michael Holmes, on 4 October 2003.

4 There were three particulars to the charge, namely:

4.1 An allegation Dr A failed to obtain Dr Holmes' informed consent to the extraction of tooth 26 and that he failed to accurately advise him of other options for management of the tooth prior to extraction.

4.2 An allegation Dr A failed to take a radiograph of tooth 26 prior to extraction.

4.3 An allegation Dr A prescribed medication without care and skill. It was claimed Dr A provided his patient with a prescription pad form containing a pre-printed list of prescriptions without ascertaining the appropriateness of all medications for a patient in Dr Holmes' circumstances.

5 At the commencement of the hearing Mr Tamm sought leave to withdraw the third particular of the charge. That application was granted. The Director of Proceedings alleged that when viewed separately or cumulatively the remaining two particulars of

the charge constituted professional misconduct within the meaning of s.100(1)(a) and (b) of the Health Practitioners Competence Assurance Act 2003 ("the Act").

6 After hearing all evidence and submissions the Tribunal retired and on the afternoon of 9 May advised it did not find the charge proven to the requisite standard. This decision explains the Tribunal's reasons for reaching this conclusion.

Legal Principles

Onus and Standard of Proof

7 The Director of Proceedings accepted that she was required to prove the charge and that at no stage did Dr A carry any onus of proof.

8 New Zealand authorities currently require the Tribunal to assess the culpability of a health practitioner on the basis of the civil standard of proof, bearing in mind that serious allegations require a high level of proof. In *Brake v Preliminary Proceedings Committee*[1] a full Court of the High Court expressed the standard of proof in the following way:

> *"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 … The charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

Professional Misconduct

9 Professional misconduct is defined in sections 100(1)(a) and (b) of the Act. These subsections of the Act refer to a health professional 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*

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1 [1997] 1 NZLR 71

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

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

11 Those who drafted s.100(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.

12 Malpractice is defined in the Collins English dictionary[2] 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[3] as meaning:

> *"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

13 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:

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2 2nd Edition
3 1993 Edition

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

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

13.3 That the plaintiff suffered compensatible damage;

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

14 It is highly unlikely the drafters of s.100(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 s.100(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 s.100(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 fell 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.[4]

15 The approach set out in paragraph 14 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 s.100(1)(a) of the Act.

Discredit to the Profession

16 To bring discredit on the nursing profession is a term that was considered by Gendall J in *Collie v Nursing Council of New Zealand*[5] in which he described the term to bring discredit to the nursing profession in the following way:

> *"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*

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4 See for example, *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 (HL).
5 HC, Wellington Registry, AP300/99, 5 September 2000, Gendall J.

> *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

17 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*[6]. 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."*

18 Legislative changes to the composition and structure of medical disciplinary bodies in 1995 caused the analysis as to what constituted professional misconduct to evolve from the seminal test articulated by Jeffries J in *Ongley*.

19 Under the Nurses Act 1977, the Pharmacy Act 1970, the Dental Act 1988, and the Medical Practitioners Act 1995, the test as to what constituted professional misconduct became distilled to two questions:

19.1 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*

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[6] supra

colleagues and representatives of the community as constituting professional misconduct?"

19.2 Secondly, if the established conduct fell below the standards expected of a health 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?"

The second limb to the test referred to in paragraph 19.2 above recognised the observations in *Pillai v Messiter*[7], *B v Medical Council*[8], *Staite v Psychologists Board*[9] and *Tan v ARIC*[10] that not all acts or omissions which constitute a failure to adhere to the standards expected of a health practitioner would in themselves constitute professional misconduct.

Professional Misconduct under the HPCA Act

20 The Tribunal is of the view that much of the jurisprudence concerning the meaning of professional misconduct under earlier legislative regimes continues to be relevant under the Act. In particular, the Tribunal believes that the test as to what constitutes professional misconduct continues to involve a two step process:

20.1 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.

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7 (1989) 16 NSWLR 197
8 HC Auckland, HC 11/96, 8 July 1996 Elias J
9 (1998) 18 FRNZ 18
10 (1999) NZAR 369

20.2 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.

21 The Tribunal has assessed Dr A's conduct in this case by addressing the tests noted in paragraph 20 in relation to the allegations in the notice of charge. The Tribunal has borne in mind that the acts and omissions in question focused upon the way Dr A discharged his clinical and professional responsibilities and are, therefore, in the circumstances of this case, more appropriately examined as alleged acts of "negligence" as that term is used in s.100(1)(a) of the Act.

The Evidence

22 On the morning of Saturday 4 October 2003 Dr Michael Holmes awoke to discover that his upper left first molar tooth (26) had lost a filling. Dr Holmes could feel sharp edges of the remains of the tooth cutting his tongue and the side of his mouth. When Dr Holmes looked at the tooth he could see that a large part of the filling which had previously been there was missing.

23 Dr Holmes was intending to go out with members of his family that weekend. He decided to obtain dental services to temporarily relieve the discomfort he was suffering. Dr Holmes telephoned his regular dentist, Dr Roger Smith and through a series of telephone message services he was directed to the Knox Dental Centre.

24 Dr Holmes went to the Knox Dental Centre at 5.30pm on 4 October. On arriving at the surgery Dr Holmes filled out a questionnaire relating to the state of his health. In completing that questionnaire Dr Holmes noted:

24.1 He was receiving medical treatment;

24.2 He had been in hospital for abdominal surgery;

24.3 He suffered high blood pressure;

24.4 He had bronchitis/chest ailments;

24.5 He had diabetes;

24.6 He was currently taking the following medications:

- Pentasa
- Loperamide
- Naplin
- Gliclazide
- Metaformin
- Zotab
- Atacand
- Lipex

24.7 He was a smoker (he smoked approximately 15 cigarettes a day);

24.8 He had previously had a reaction to anaesthetic.

25 In addition to completing the health questionnaire Dr Holmes also filled in a patient questionnaire in which he recorded *"Dressing for first upper (L) molar please"*.

26 After completing the questionnaire Dr Holmes spoke with Dr A. Their discussions led to Dr Holmes explaining he had experienced liver and kidney damage which in turn had resulted in the diagnosis of late onset diabetes. Dr Holmes explained how he had undergone repeated abdominal surgery and now had a Hartman's Colostomy, adhesions and incisional hernias.

27 Dr Holmes told Dr A that in addition to the medications listed in the questionnaire he was also on a calcium channel blocker but he could not remember the name of that medication (Nifedipine). Dr Holmes was also taking an antibiotic, Cefaclor, but he did not mention this medication because he did not consider it relevant.

28 Dr A then examined Dr Holmes' mouth. Having done so Dr A told Dr Holmes that tooth 26 was *"totally rotten"*.

29 There is a dispute about what happened thereafter. Dr Holmes' evidence was that Dr A explained to him the tooth needed to be extracted urgently and there was nothing else that could be done for the tooth.

30 Dr A on the other hand told the Tribunal that he fully explained to Dr Holmes options that were available. It was Dr A's evidence that he told Dr Holmes that restoration was an option. Dr A said he informed Dr Holmes this would initially involve a temporary filling, followed by root canal treatment and a crown. Dr A said he told Dr Holmes this option could be pursued with Dr Holmes' regular dentist and would cost somewhere between $1,800 and $2,000. Dr A was also certain he explained the factors for and against extraction, including the complications which might follow if the tooth were removed. Dr A appears to have told Dr Holmes that the cost of extraction would be $250.

31 It is clear Dr A did remove tooth 26 from Dr Holmes' mouth that night and that he did not take a radiograph of the tooth before it was extracted.

32 Following the extraction Dr A provided Dr Holmes with a pre-stamped prescription sheet on which was printed the following list of medications:

32.1 Amoxycillin 500mg tds 10 days

32.2 Metronidazole 400mg tds 10 days

32.3 Savacol mouthwash – 5 times / day

32.4 Voltaren 50mg tds 5 days

32.5 Metachlopropamide 10mg PRN tds 5 days

32.6 Codeine 30mg 1-2 tabs tds 5 days

32.7 Panadol.

33 After raising concerns in respect of the appropriateness of several of the medications listed on the prescription Dr Holmes explained that he accepted the prescription on the

basis that he would only be taking Metronidazole for 5 days in conjunction with Savacol mouthwash.

34 On Monday 7 October Dr Holmes visited his own dentist, Dr Smith who examined Dr Holmes and x-rayed the site of the extracted tooth. Dr Smith removed two stitches and told Dr Holmes about various treatment options.

35 In addition to the evidence of Dr Holmes the Director of Proceedings adduced evidence from Dr Smith and Dr Goodhew an independent expert.

36 Dr Smith explained that Dr Holmes had been a patient since June 1992 and that for most of that time he had provided treatment on demand. Dr Holmes had a history of financial and medical difficulties which meant Dr Holmes had minimal contact with Dr Smith.

37 Dr Smith explained that Dr Holmes attended his clinic on 7 October 2003 in a distressed state. Dr Holmes conveyed to Dr Smith that he was upset because, upon reflection, he had lost a tooth unnecessarily, its removal was traumatic, post operatively there was discomfort and he felt Dr A had not taken into account Dr Holmes' medical history when prescribing antibiotics and pain relief.

38 Dr Smith said he would have expected a pre-operative x-ray to have been taken of tooth 26. Dr Smith also explained that had the tooth been retained it might have been possible to restore it with a root filling and crown. This treatment would have cost $2,200. Instead Dr Holmes was faced with doing nothing or the expensive options of a three unit dental bridge (at the cost of approximately $3,500) or an implant support crown (at a cost of around $5,000 to $6,000). Dr Smith was clearly concerned that Dr A had removed his patient's tooth 26 without first referring Dr Holmes back to Dr Smith.

39 Dr Goodhew is a general dental practitioner in Timaru. He is a very experienced and well respected dentist who assisted the Tribunal with his well considered and impartial expert evidence.

40 Dr Goodhew thought it was "highly questionable" to extract tooth 26 on the evening of 4 October given the absence of any serious symptoms. Dr Goodhew explained that it is a generally accepted protocol of dentistry that an emergency care provider will

confine treatment to relief of symptoms and advise the patient to return to their usual dentist for definitive treatment.

41 Dr Goodhew explained to the Tribunal that the options available on the evening of 4 October that should have been pursued were:

41.1 Applying an adhesive cement as a temporary dressing; or

41.2 Smoothing/or reducing the sharp edges of the fractured tooth.

42 When Dr A gave his evidence he explained that he considered that a temporary dressing was not an option because he did not want to interfere with any later restorative treatment that might have been needed to be carried out. He also said he was concerned that the root was soft and that he might cause damage by drilling the root.

43 Dr A also explained that he considered grinding or smoothing the tooth was not an option because it might be painful and require local anaesthetic because a portion of the broken tooth lay below the gum.

44 Dr Roger Goulden also gave evidence as an expert. He was retained by Dr A.

45 Dr Goulden gave his evidence by way of a video link. He practises in Harley Street, London, and has an impressive list of qualifications. In addition to his extensive dental qualifications Dr Goulden holds a Master of Laws degree and devotes a significant portion of his time to his “medico-legal practice”.

46 After carefully analysing the evidence made available to him Dr Goulden reached the following key conclusions:

46.1 It was not practical to provide a temporary dressing to tooth 26 in the circumstances of this case;

46.2 There were compelling clinical indications to extract the tooth;

46.3 The management of the extraction complied with accepted clinical procedures;

46.4 It was not necessary to take an x-ray once it was determined that tooth 26 should be extracted;

46.5 It was appropriate to extract the tooth even in light of Dr Holmes' medical history.

Evaluation of the Evidence

47 The first particular of the charge requires the Tribunal to ascertain if Dr A properly informed Dr Holmes of the treatment options available before extracting tooth 26 on 4 October 2003.

48 There are fundamental differences between Dr A's recollection of what he said to Dr Holmes on 4 October and Dr Holmes' recollection of what he was told about the treatment options.

49 The Tribunal has carefully evaluated the credibility of both Dr A and Dr Holmes and assessed their respective accounts of the events in question. Having undertaken this exercise the Tribunal is satisfied both witnesses gave their evidence honestly and that in some respects both were mistaken and confused.

50 It is clear that Dr Holmes suffers from significant medical conditions and that he failed to accurately remember a number of crucial facts about his visit to Dr A on 4 October 2003. By way of example, Dr Holmes initially thought he had crossed out inappropriate medicines stamped on the prescription pad. It is clear this was done by Dr A. Dr Holmes thought that he had suffered both pre and post operative shock. This would not be surprising and perhaps explains why Dr Holmes was unable to accurately recall a number of matters that occurred during the consultation and treatment on 4 October 2003.

51 By the same token the Tribunal found some of Dr A's explanations confusing and unsatisfactory. While the Tribunal accepts Dr A believed the tooth was unsalvageable, no satisfactory explanation was given for not simply removing the jagged protruding portion of the tooth and referring the patient back to Dr Smith.

52 The Tribunal has borne in mind that the onus of proof rests with the Director of Proceedings. In the final analysis the Tribunal was not satisfied the Director of Proceedings has discharged the onus of proof to the requisite standard. Accordingly the Tribunal has concluded that the factual basis for the allegations in the first particular of the charge have not been proven.

53 The second particular of the charge requires the Tribunal to determine whether or not Dr A's failure to x-ray tooth 26 constituted professional misconduct.

54 After carefully evaluating the conflicting views of Dr Smith/Dr Goodhew on the one hand Dr Goulden on the other, the Tribunal has concluded:

54.1 It would have been highly desirable for Dr A to have x-rayed tooth 26 on the evening of 4 October 2003;

54.2 Having decided that tooth 26 was not salvageable it was not mandatory that tooth 26 be x-rayed before extraction.

55 The Tribunal has concluded that whilst the failure to x-ray tooth 26 was undesirable, it was not an omission that satisfies the test of professional misconduct explained in paragraph 20 of this decision.

56 In the final analysis, the Director of Proceedings has not established the charge, and it accordingly must be dismissed.

Dated at Wellington this 23rd day of May 2006

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D B Collins QC
Chairperson
Health Practitioners Disciplinary Tribunal