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Risk management from Dental Protection

Dental Protection

# RISKWISE

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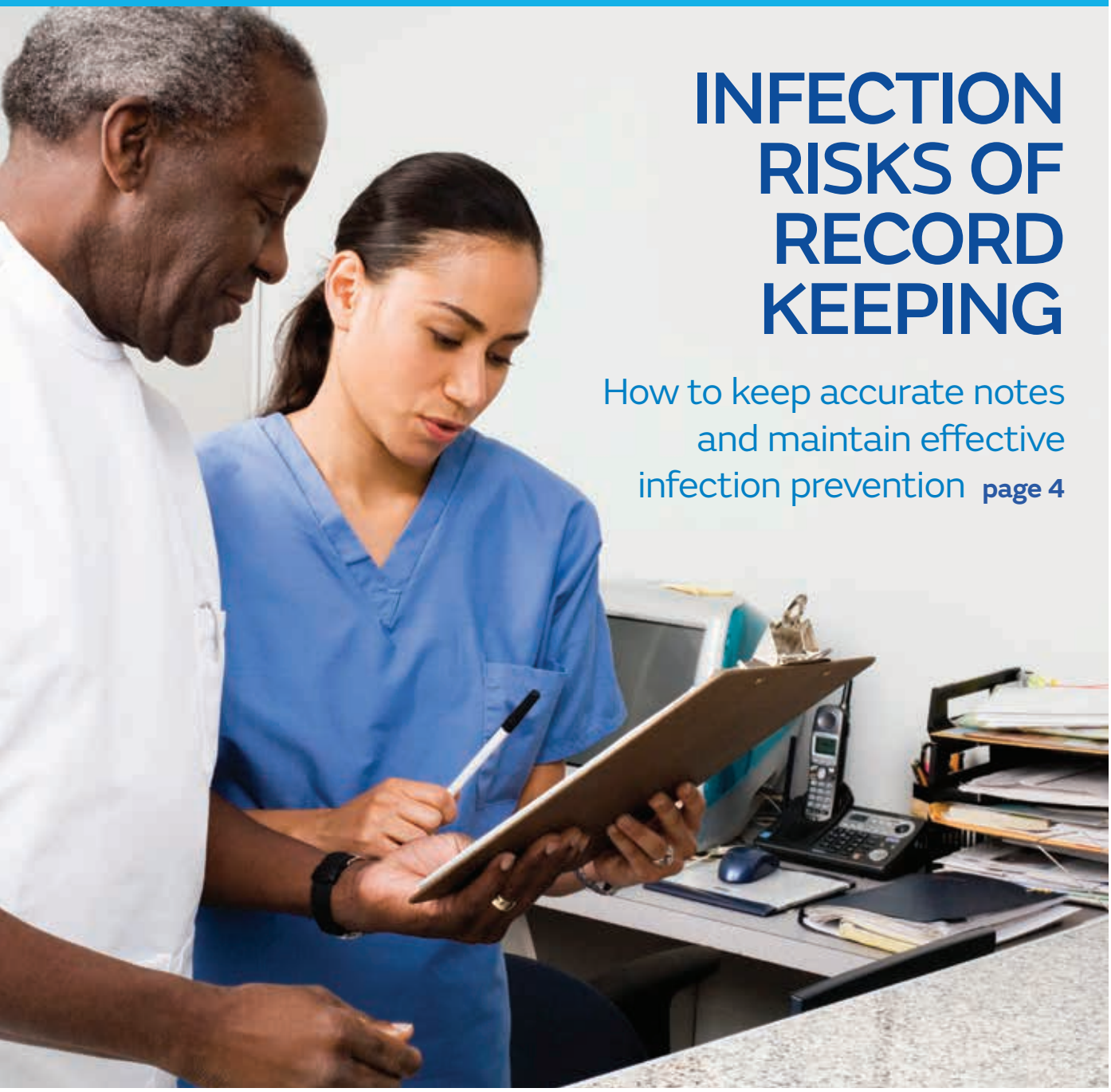

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# EDITORIAL

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Hello and welcome to this edition of *Riskwise*. As Dental Protection's flagship publication, *Riskwise* offers the latest information on dentolegal topics and advice from our dentolegal advisers and professional experts.

## IN THIS ISSUE

In this edition, we provide a comprehensive overview of how to maintain an effective standard of infection prevention and control in your approach to record keeping. This article highlights that in addition to ensuring that dental records are accurate and contemporaneous, the infection control protocol within the clinical setting is also worthy of further consideration.

Meanwhile on page 4, Dr Mark Dinwoodie explains the importance of checking that a patient has fully understood everything you have told them about their treatment. There are many benefits of checking what the patient understands, which includes the reduced likelihood for misunderstandings, the confirmation of future actions, and clarity over costs.

I'd also like to draw your attention to the article on page 8 which was written by Dental Protection's Dental Director Dr Raj Rattan. He has created a detailed and interesting feature on patient interaction and the management of patient expectations. This is a timely feature as patients are now invariably more demanding when it comes to making decisions about their treatment.

## CASE STUDIES

We're always looking for new ways to support members so, starting in this edition, *Riskwise* will now always feature a selection of case studies. These are practical examples of claims and complaints that have been faced by members, and we offer learning points and guidance for you based on these situations.

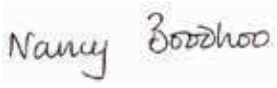
Not only can members turn to us to request professional indemnity and world-class legal representation in times of trouble, but they can also access expert training and medicolegal or dentolegal advice to help them reduce the threat and impact of a complaint, claim or investigation.

If you are concerned about any of the topics that have been discussed in this edition, or you have another query for which you are seeking advice, then please contact one of dentolegal advisers on **+44 207 399 1400** or **enquiries@dentalprotection.org**

I would also encourage you to access and use the education materials which are available on the website through Prism (**dentalprotection.org/prism**).

I hope you find this edition informative and useful. If there are other topics you'd like to see covered, then please get in touch and let us know. We're always happy to hear feedback.

Best wishes,



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# INFECTION RISKS OF RECORD KEEPING

*How does the dental team balance the need for contemporaneous records and, at the same time, maintain an effective standard of infection prevention and control?*

## READ THIS ARTICLE TO :

- ✓ Learn how to achieve a successful standard of infection control in your approach to record keeping
- ✓ Discover where major infection risks can occur

Very few clinicians have the luxury of dedicated secretarial support at the chairside while they are working on patients. Whatever your approach to record keeping, maintaining an effective standard of infection control should be paramount.

## MAINTAINING THE CHAIN OF STERILITY

Have you ever stopped to think what happens when contaminated fingers touch the paper record card or hit the keys of the computer keyboard? There will certainly be a greater risk of disease transmission if the writing instrument or the writer's fingers had been contaminated when the entry was made.

Operator-to-patient contact is one of the main methods of spreading bacteria but patient records handled by the dental team can also be the cause of cross contamination. Hand hygiene is essential if effective zoning is to be achieved. Periodic review by the dental team of adherence to this protocol is one method to ensure compliance.

## PAPER RECORDS

In order to create effective zoning within a clinical area, paper records need to be kept beyond the area of clinical activity. Since barrier protection is applied to the hands whilst treating patients, it means that additions to the record can only be made before gloving up or after they have been removed and the hands washed. If the need arises to add information to the record during the course of the treatment, there are three ways to deal with this:

- Remove and change the gloves after adding to the notes.
- Create a second barrier (such as a loose fitting bag or disposable 'mitt') placing it over your gloved hand before writing.
- Another member of the team who is not gloved up could make the entry

## SILVER PAPER

Superbugs, including MRSA and clostridium difficile pose a growing challenge. Items such as patient records and case note folders can now be impregnated with an additive containing silver ions, which instantly kills microbes on contact. This provides a permanent hygienic solution that is active 24 hours a day throughout the lifetime of the product. Clinical research conducted by one manufacturer showed that 99.9 per cent of bacteria are killed within 24 hours. This approach will possibly become a required standard for the manufacture of record cards in the future, if we do not manage to go paperless.

## COMPUTER RECORDS

In many dental surgeries there has been an attempt to eliminate paper records and to replace them with a computer-based equivalent. From an infection control perspective the use of a computer in the surgery reduces the number of items touched by the clinical team and, with suitable safeguards, it can be utilised within the zone of clinical activity.

The risks arise primarily from direct contact (for example, a contaminated gloved hand/finger) or via aerosols and splatters. The former can be managed by ensuring that there are strict hand hygiene protocols in place, while the latter can be reduced by appropriate surgery design and computer positioning.

Aerosols are inevitably created in the dental surgery when working in the patient's mouth. Aerosols and droplets generated by high-speed dental drills, ultrasonic scalers and air/water syringes are contaminated with blood and bacteria and represent a potential route for transmitting disease. Pathogens can settle onto surfaces anywhere in the clinical environment. Keeping a computer in the surgery means the keyboard, the mouse and the monitor are vulnerable.

## KEY PLAYERS

The average unprotected keyboard is a blackspot for bacteria, each square inch harbouring a staggering 3,295 organisms. One study found potential pathogens cultured from computers included coagulase-negative staphylococci (100% of keyboards), diphtheroids (80%), Micrococcus species (72%), and Bacillus species (64%). Other pathogens cultured included ORSA (4% of keyboards), OSSA (4%), vancomycin-susceptible Enterococcus species (12%), and nonfermentative gram-negative rods (36%). Particular bacteria hotspots are the space bar and vowel keys because they are most often used.

Therefore, computer equipment should be covered with a plastic barrier when contamination is likely. This would apply primarily to the mouse and keyboard.

Like any barrier used during patient care, it should be changed between patients. If a reusable form-fitted barrier is used, it should be cleaned and disinfected between patients. The use of disinfectant wipes has also been advocated, but the potential to damage the plastic keyboard needs to be considered. Infection control keyboards that are capable of being washed are also available.

Strict hand hygiene is also important. Before touching any office equipment wear powder-free gloves or ensure your hands are clean. Computer equipment is an example of a clinical contact surface and the basic principles of cleaning and disinfection used routinely in the dental environment should also apply.

## SCREEN ATTRACTION

The risk posed by the computer screen is slightly different. Bacterial cells possess a negative electrical charge, while the technology used in flat screens generate positively charged static electric fields. Consequently, bacteria dispersed within the aerosols will be attracted to the computer screen. Avoiding contamination of the unit housing the screen is important because it cannot be properly cleaned and disinfected or sterilised. Avoid touching the screen whilst treating patients, be aware of the potential bio-load on the screen and perform hand hygiene if you need to adjust the monitor with ungloved hands.

So in addition to ensuring that your dental records are accurate, complete and contemporaneous, the infection control protocol within the clinical setting is also worthy of further consideration.

The resources listed below are just a few of those used in this article.

RESOURCES


1. Rutala WA, White MS, Gergen MF, Weber DJ; Bacterial contamination of keyboards: efficacy and functional impact of disinfectants.. Infect Control Hosp Epidemiol 2006;27:372–377.
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4. Maureen Schultz, Janet Gill, Sabiha Zubairi, Ruth Huber, Microbial contamination of laptop/ keyboards in dental settings, Anjumn et al International Journal of Public Health Dentistry

# DID THEY UNDERSTAND WHAT YOU SAID?

Dr Mark Dinwoodie explains the importance of checking that the patient has fully understood everything that you have told them about their treatment

### BENEFITS OF CHECKING PATIENT UNDERSTANDING INCLUDE:

- Information has been understood
- Patient decisions are correctly informed relating to outcomes, options, risks and benefits
- Misunderstandings are less likely
- Future actions are accurately confirmed
- Clarity over costs

Have you ordered a takeaway meal recently? Do you remember the last thing the other person did?

In most cases, the person taking your order will run through what you ordered to check that they have understood you correctly and that the correct items are listed, before they calculate the cost and take payment.

## LISTING DETAILS IN A DENTAL SETTING

I wonder how often we check through all the key points when communicating information to others in clinical practice; for example, when important information is passed from the dentist to patient or between members of the dental team.

It's not uncommon to discover a patient, returning after their initial treatment, has not done what was advised because they had misunderstood what was intended. For example, they may have mistakenly stopped their Warfarin before an extraction, against previous advice.

A process of repeat-back/read-back is used by many high reliability organisations to help ensure "message sent is message received".

A common everyday scenario arises when we are given directions by a stranger – we are usually confused after about the fourth instruction. Likewise, the same confusion may arise with the sequence of events required in the assessment and placing of implants, or the timescale to complete a course of orthodontics.

Interestingly, in a recent poll of 2,000 patients who had been to see their medical general practitioner, 31% did not understand what their GP was telling them, leaving them feeling confused, anxious or uneasy. A quarter of these did not ask for clarification, 11% said nothing because of embarrassment, with 10% doing likewise because they didn't want to waste their doctor's time. Three percent gave up altogether and went to see another doctor.[1] There is no reason to think that dental patients would act any differently.

## ELIMINATING MISUNDERSTANDING

A process of repeat-back/read-back is used by many high reliability organisations to help ensure "message sent is message received",[2] so reducing the likelihood of misunderstanding or incorrect transfer of information. The process of repeating back words and phrases seems to help recall.[3] Of course there are other ways of supporting information transfer, such as patient leaflets, photos, models or other written or online material. However, they may not be enough on their own to ensure understanding.

> "A process of repeat-back/read-back is used by many high reliability organisations to help ensure "message sent is message received"

## THE CHALLENGE IS HOW AND WHEN TO DO THIS

The greater the consequences or likelihood of misunderstanding, then the greater the imperative for checking understanding. For example, such as complex or lengthy dental treatment, language or communication difficulties. The consequences of poor communication are increasingly significant when the proposed treatment carries greater risks, such as surgical treatments, when patients are anxious, or treatment is elective, such as cosmetic work, or equally when patients decline treatment.

There is an elevated risk of misunderstanding when patients wish to discontinue treatment, such as requesting the removal of orthodontic appliances before the treatment is completed.[4]

It is important that the patient clearly understands the consequences of:

- proceeding with a proposed treatment
- declining treatment
- discontinuing treatment

## READ THIS ARTICLE TO :

- Understand the consequences of poor communication
- Learn how to eliminate patient misunderstanding
- Discover techniques to ensure patients understand what you say

## REALISTIC EXPECTATIONS

Disappointment about a particular treatment can arise from unmet expectations. Consequently, checking your own understanding of patient expectations can help ensure that they are realistic.

Many healthcare professionals find it difficult to find the right words or phrases to use in these circumstances and feel that the patient may feel patronised. Reassuringly, research suggests that if done sensitively, patients actually welcome it.

Commonly used techniques, as highlighted by Kemp[5], are shown in the box (above right), with the third option being preferred.

The first option may result in a patient saying they think they understand, but they may not or may prefer not to admit they don't understand. In the second option, the patient may feel like they are being subjected to a test. The third option is the best – the key aspect being to not make the patient feel bad if they don't understand, what Kemp describes as a "shame-free space".

This process obviously takes time and it may not be possible or appropriate to check absolutely everything has been understood. Deciding in advance the most important things that you want the patient to understand will focus your efforts on those things which you need to check.

Although this article has focused on interactions between dentists and their patients, checking understanding is just as important when sharing clinical or administrative information with other members of the dental team, for example, when a patient requires an urgent referral, requires further investigation of their medical history, or when new guidelines or protocols have to be introduced to your own practice dental team.

### KEMP'S TECHNIQUES

**1.** "I've given you a lot of information. Is there anything you don't understand?" (Yes-No)

**2.** "It's important that you do this exactly the way I explained. Could you tell me what I've told you?" (Tell Back Directive)

**3.** "I've given you a lot of information. It would be helpful to me to hear your understanding about your condition and its treatment." (Tell Back Collaborative) – preferred


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1. AXA News and Media release. Good communication boosts GP-patient relations: AXA PPP healthcare introduces online glossary to help patients better understand common medical terms. OnePoll for AXA PPP posted in Health August 7th 2014. Accessed 12/11/16
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3. MacLeod C, Gopie N, Hourihan K, et al. The production effect: delineation of a phenomenon. J Exp Psychol 2010;36:671–85
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# GREAT EXPECTATIONS

## Dental Director Dr Raj Rattan discusses the need to manage patient expectations and interactions

### READ THIS ARTICLE TO :

- Learn how to manage patient expectations and interactions
- Discover what the "expectation disconfirmation" theory is
- Learn from a case study

Our lives are enriched by our daily experiences. Our response to these experiences is largely determined by our expectations – a "surprise" is only a surprise because we have no expectation about the event or occurrence. Other responses, such as making a complaint, arise when expectations are not met. The "expectation disconfirmation" theory can help the dental team to understand patient satisfaction in relation to expectations and outcomes.

The concept is best illustrated by the following sequence:

1. When a patient visits a practice or a dentist, they do so with a pre-set level of expectation. In the case of existing patients, prior experience of the service will influence these expectations. In the case of new patients, the experience of friends and family (or whoever else has recommended the service) will play a part. For others, the expectations may be set by words and images that appear on websites and marketing literature.
2. These expectations are the standard against which the dental team and the practice will be judged.
3. When expectations are met, confirmation occurs.
4. Disconfirmation arises when there is a difference between expectation and outcome.
5. If the outcome is better than expected, there is positive disconfirmation and this leads to satisfaction. Negative disconfirmation arises when the outcome is below the pre-set level of expectation and may lead to a complaint. Simple disconfirmation is the term used to describe a situation where the expectation meets the outcome; it is neither better nor worse.

Complimenting and complaining behaviours are determined by this outcome. Clinical practice continues to advance and improvements in techniques and materials allow clinicians to raise the bar when it comes to setting standards. Where there is competition in the market amongst providers of services, advertising and marketing materials are one method of differentiation. It is all too easy to over-promote the benefits of care and influence expectation levels such that they cannot be met.

The adage that "first impressions count" is also relevant here. The practice environment itself contributes to expectation levels. It has been described as the "servicescape" of business. It also impacts on the perceptions of quality, expectations and performance. (Interestingly, cleanliness is cited as the area of the "servicescape" that received the most complaints in the wider business world.)

## CASE STUDY

A patient attended for the removal of lower impacted third molars. After the removal of one tooth, his dentist called him in the evening to make sure he was comfortable and that there were no postoperative issues. The call was not expected and the patient expressed his gratitude for the care he was shown. Two weeks later, the same dentist removed a molar on the other side and, on this occasion, did not call the patient as a local postgraduate meeting had overrun and there was no opportunity to telephone. On his return to the practice some days later for a review appointment, the patient commented that he was surprised not to have received a call on the second occasion.

In a matter of two weeks, the patient's baseline expectations had changed and he had crossed from the positive to the negative side of the disconfirmation continuum. It is a reminder of the importance of setting realistic expectations that can be met consistently. At first glance, the mantra of under-promise and over-deliver offers a solution. But lowering expectations also potentially lowers the appeal of the service or product, especially in a competitive market. It is a matter of striking a balance.

Some leading researchers in the field suggest that there are three types of expectation.

1. The desired service – a level that the patient hopes to receive.

2. Adequate service – this is the minimum tolerable level, because patients will have recognised that the desired service is not always achievable.

3. Predicted service – the level of service a patients thinks they are likely to receive on the basis of probability.

The gap between one and two is the so-called "zone of tolerance" and the predicted service is likely to lie within that zone. It is a zone in which the dental team can perform in comfort. It is only when the experience falls outside the zone of comfort that a patient demonstrates complaint behaviours. The extent of the tolerance is contextual. It varies amongst patients and may vary at different times in the same patient, depending on what else is happening in their life.

# THE POWER OF EXPECTATION

## PATIENT SATISFACTION

Patient satisfaction is a mental state and is a multi-dimensional construct affected by many variables. It influences positive patient behaviours such as loyalty.

Dissatisfaction has the opposite effect. Many studies have shown that patient satisfaction is determined by subjective and objective experiences and their dentist's interpersonal and communication skills, and the "communication of care and attention" has been cited as the most influential in maintaining patient loyalty (Holt and McHugh).

Dentists should focus on and develop effective communication skills before, during and after treatment sessions by involving patients in treatment decisions. For example, according to one study, patients who received more preparatory information and knowledge had superior postoperative pain control and satisfaction after undergoing third-molar extraction than patients who did not.

To avoid complaints, we must focus on the human and psychological aspects of the dentist/patient relationship, and adapt our communications to better manage patient expectations within the expectancy-disconfirmation paradigm. It is also worth paying attention to the "servicescape", as it is the antecedent to the experience itself and can mould patient perceptions.


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Zeithaml V, Bitner M. Services marketing. New York: McGraw-Hill, 1996.


# INAPPROPRIATE PRESCRIBING OF ANTIBIOTICS

A dentist received a complaint from a patient's mother, regarding the inappropriate and incorrect prescribing of antibiotics for her 16-year-old daughter on three separate occasions.

The dentist first saw the patient when she presented as an emergency with a buccal swelling of her lower right first molar (46). The patient was coming to the end of a period of orthodontic treatment and was due to have her fixed appliances removed two weeks later. The tooth had previously undergone root canal treatment. The dentist prescribed amoxicillin 250 mg three times a day for three days. As the patient was going on holiday, the member also gave the patient a separate prescription for amoxicillin 250 mg per day for five days. Both prescriptions were questioned by the pharmacist, and a new prescription was issued requesting the recommended dose of 500mg three times a day for five days.

One month later the patient presented as an emergency and was seen once again by the dentist. He prescribed metronidazole 250 mg three times a day for three days. The pharmacist again questioned the prescription, and the dentist wrote a new prescription with the recommended dose of 200mg three times a day for five days.

The dentist had graduated in a different country and had only been working in the Caribbean for six months. It is imperative that all practising dentists familiarise themselves with appropriate local prescribing standards of the drugs they might prescribe. Good record keeping must include a thorough medical history including allergies and any ongoing or recent medication to avoid inappropriate prescribing, allergic reactions or other drug interactions. In the current climate, the justification of necessity of prescribing antibiotics is being closely monitored. It may be useful for reference to review the local therapeutic guidelines and check your records reflect the justification for the prescription and the ongoing treatment that may be required.



## LEARNING POINTS

- Make sure you are familiar with the standard prescribing guidance wherever you practise.
- There are a variety of online resources that provide access to recognised national guidelines.

# LONGSTANDING PERIODONTAL DISEASE


A patient had attended the same general dental practitioner for more than 20 years, and had undergone regular treatment by a dental hygienist during that time.

The treating dentist retired and a new dentist purchased the practice. He examined the patient and advised her that she had periodontal disease. Full-mouth radiographs were taken, and the patient was given a vigorous course of oral hygiene instruction, scaling and root planing. The new practitioner handed the patient a report that included a charting of the teeth, the radiographs and notes about the bone loss around the roots of the teeth.

The new dentist also recommended a referral to a periodontal specialist because of the advanced state of her periodontal condition. The patient was horrified that this condition had not been discussed with her in the past, and was upset by the cost quoted by the periodontist for ongoing treatment to manage the situation.

A letter of complaint was received by the retired dentist, in which the patient asked about compensation and mentioned legal action. The retired dentist then contacted Dental Protection for assistance.

A dentolegal adviser reviewed a copy of the original notes, which simply recorded the dates of the patient's examination appointment and occasionally noted when scaling and polishing had been performed. There were no radiographs or evidence of any periodontal screening, such as a periodontal pocket charting.

The situation was discussed with the retired dentist. Seemingly, he had persistently advised the patient about her periodontal condition, and sent her to the hygienist for oral hygiene instruction and scaling, but this treatment was not recorded in any detail. The dentist also mentioned that he had frequently spoken to the patient about her periodontal condition over the early years of her treatment. More recently he had not further discussed the matter because the patient seemed disinterested.

The lack of detail demonstrating how the disease had been monitored left the original dentist vulnerable. Fortunately, the matter was settled by reimbursing the fees paid to the new dentist and the periodontal specialist for the patient's recent periodontal treatment.

## LEARNING POINTS

- Keep detailed records of all discussions with patients regarding advice and treatment.
- Ensure that patients clearly understand the significance of periodontal disease and the likely outcomes should treatment advice be ignored.
- Use every appointment as an opportunity to remind patients with periodontal disease of the need to maintain good oral hygiene.
- Keep adequate notes of home care advice given to patients and the importance of flossing, brushing and smoking cessation.

# GUIDELINES ON PRESCRIBING


## LEARNING POINTS

There is a legal and ethical obligation for all practitioners to comply with contemporary standards of care:

- Provide justification in the notes for all treatment undertaken.
- Ensure that the medical history is current and up to date.
- Consider fully the patient's past medical history.
- Follow evidence-based guidelines on prescribing in the jurisdiction in which you practise.

A new patient (Mr T) attended a new practice for an initial examination and an OPG radiograph was taken. The dentist informed Mr T that this x-ray had shown deep decay under a crown 16, and that the prognosis of 46 was also very poor because of considerable decay. Treatment options for both teeth were discussed and well documented in the clinical records, and Mr T decided to have both teeth extracted.

The upper tooth was extracted uneventfully, but unfortunately Mr T returned as an emergency with a dry socket. The socket was irrigated and packed.

Mr T was allergic to penicillin and was already taking a course of metronidazole tablets, which had been prescribed by a medical practitioner whom he had visited a few days earlier. Because Mr T remained in considerable pain, the dentist decided to prescribe a further course of antibiotics, clindamycin.

Unfortunately the patient, who had a long standing history of irritable bowel syndrome, went on to develop pseudomembranous colitis and an overgrowth of clostridium difficile, resulting in severe abdominal pain, nausea and diarrhoea. He was hospitalised and needed to undergo complicated and unpleasant medical treatment.

Six months later, the dentist received a letter from solicitors acting on behalf of Mr T, requesting a copy of the patient records. This was followed by a letter of claim, alleging negligence on the part of the dentist. It was accompanied by an expert report that pointed out that the patient notes were "very sparse" and recorded no clinical reasons why the prescription of the additional antibiotics was necessary.

In addition, the national guidelines for this jurisdiction advised that the antibiotic prescribed was not regarded as being the third choice antibiotic for the treatment of dental infections; the guidelines in that jurisdiction suggested clarithromycin as the alternative antibiotic of choice. The expert concluded that the dentist had failed in his duty of care to the patient. The adverse outcome in this case could have been avoided if current guidelines had been followed.

The allegations were found to be indefensible and the case was settled for a modest amount.

# COMMUNICATION AND CHANGE OF DENTIST

A patient received a letter explaining that he would have to start seeing a new dentist. Later, the practice owner received a complaint from the patient. No concerns had been raised about the clinical care, so the letter came as something of a surprise. However, there had been some concern about the lack of information provided to the patient about the changeover. He later said that he had felt pressured into choosing a new dentist at short notice and this had triggered the complaint.

The patient had no previous knowledge of this change and there was no mention of the name of the new treating practitioner. The letter was generic and had been sent to all the patients previously seen by the associate; however, it did not provide any details, other than a suggestion to call the practice to arrange an examination appointment.

The member requested assistance from Dental Protection and a way forward was suggested. A letter was sent to the patient apologising for his dissatisfaction, with an explanation that the practice felt it was in the best interest of the patient to discuss the change in staff when they attended for their routine check-up. It was explained that whilst most patients had been informed that their dentist was leaving, this was not known at the time of the last check-up with this particular patient.

The new dentist was introduced to the patient, who was reassured that his experience would complement the range of the other services available within the practice.

An apology was offered to the patient for the earlier lack of communication. The practice advised that the concerns would be discussed at a team meeting, to ensure that there was an improvement in communication techniques and skills within the practice.

The patient accepted the letter of apology and subsequently booked an examination appointment with the practice principal.

## LEARNING POINTS

- Always ensure that communication with the patient is clear and understandable.
- Use techniques such as asking the patient to repeat back information to ensure they have understood everything fully.

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# A DIFFICULT PATIENT INTERACTION

A young male patient attended a local dental practice with toothache. The dentist diagnosed the source of the pain as irreversible pulpitis from an extensively carious tooth upper right six (16), which had a large fractured amalgam restoration. The patient did not wish to have an extraction and, as there was sufficient tooth left to restore, the dentist carried out a root canal treatment and placed a gold shell crown.

All was well for many years; tooth 16 remained symptom and pathology free. The dentist subsequently sold the practice. The patient then returned after some years suffering from a periapical abscess on the same tooth and the new owner advised the patient to have a re-treatment of the root, which would cost more than the sum originally paid ten years earlier.

The first dentist received a letter of complaint, alleging negligent care and demanding full reimbursement for the subsequent treatment costs. The patient also alleged that he had been informed, at the time of the original treatment, that it would be 100% successful.

The dentist contacted Dental Protection, feeling aggrieved because the tooth he had treated had remained functional and symptom free for more than ten years.

The root treatment had been carried out using a standard technique, and the radiographs demonstrated a well-obturated root canal filling with sound crown margins.

However, the clinical records could not demonstrate any discussion about the benefits, risks, alternatives, complications and prognosis. If the patient pursued a legal challenge, the clinician would have been vulnerable regarding the consent process, despite the satisfactory standard of clinical treatment.

With Dental Protection's help, the original dentist responded to the patient, explaining that no medical intervention has a 100% guarantee and that the clinical care provided was in line with standard procedure and protocols.

Together with an expression of regret, an offer was made to refund the private root canal treatment fees as a goodwill gesture. The patient did not accept this and demanded a refund for the private crown placed after the root filling, and reimbursement for the difference in treatment costs that had accrued in the meantime.

A further response was provided for the patient with the assistance of a dentolegal adviser, reiterating the position. The additional cost of the crown was included in the goodwill gesture and the issue was resolved.

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## LEARNING POINTS

- Be aware of the unrealistic expectations of some patients and their persistence in pursuing dentists many years after treatment. You can help protect yourself from this by carefully documenting all relevant discussions with the patient.
- Patients should be given advice regarding the long-term prognosis of proposed treatment, and this should be documented in the clinical records.
- Clinical records are vital in detailing discussions about consent.
- Even when the clinical care is satisfactory, if there is a flaw in the consent process dentists are vulnerable.

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## You can contact Dental Protection for assistance dentalprotection.org

### Membership Services

Telephone +44 113 241 0727

### Dentolegal advice

Telephone +44 207 399 1400



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