



Riskwise

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Australia



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Editorial



Dr Raj Rattan
Dental Director

Beginning, middle and end

In the 1970s, Dick Cavett's chat show was compulsory viewing for many American audiences. His casual informal style appealed to many of his guests, amongst them the "master of suspense" Alfred Hitchcock. During one interview, Hitchcock described the three-shot sequence in his film *Rear Window*. The first segment, he explained, showed a close-up of James Stewart, the second a lady tending to a child and the third is again of James Stewart, who is seen smiling. This, says Hitchcock, demonstrates that he is a "nice, benevolent gentleman".

He then explained to Cavett that if the middle segment was replaced with a shot of "a girl in a bikini" and the other segments remained identical, the gentleman would then be, to quote Hitchcock, "a dirty old man". It is a reminder that perception of events and actions – the story – is context-dependent and changing just one aspect leads us to different conclusions.

Context in dentolegal cases

It is the same with dentolegal cases. No two cases are ever the same. Putting the clinical and contextual element aside, the relationship between the dentist may also impact the outcome. For example, we know from our dentolegal case experience that some dentists are only too happy to refund patients even when there is no requirement to do so. For this group, it is the price of preservation of what is often a long-standing relationship, which perhaps also extends to other members of the family, even across generations. Others in a similar scenario would take a different view.

The clinical records, disclosed as part of the assessment of the case, may have entries that open new avenues of investigation, and it may therefore be in the dentist's best interests to resolve the issue without escalation. It was the famous French economic journalist Frédéric Bastiat who wrote about the difference between the "seen" and the "unseen". The seen were the identifiable consequences of an action, whereas the unseen were the less obvious consequences – the unintended consequences.

In one of his essays, he observed: "There is only one difference between a bad economist and a good one: the bad economist confines himself to the visible effect; the good economist takes into account both the effect that can be seen and those effects that must be foreseen." The same can be said of dentolegal scenarios – it is our task to take into account the foreseen when supporting members. It is an example of risk containment.

Dentolegal stories

We like stories. Mankind has been telling stories for millennia. We use dentolegal stories to deliver key risk management messages, partly because our members tell us this is what they want to hear but also because research suggests that we are far more likely to remember facts when they are woven into a story. Our case reports are dentolegal stories, but they are short stories, often condensed to 750 words even though the case file may contain 100 documents or more.

We present them using Aristotle's formula – the story must have a beginning, middle and an end. Sometimes these stories appear on social media where the format and need for brevity distils them down even further. This distillation process often takes out the middle of the story and what is presented is the beginning and the end – often not in that order. Starting with the end attracts attention and draws people in – I think they call it clickbait on the internet.

It is sometimes interesting to review dentolegal postings on social media. I have in previous editorials drawn the distinction between information, misinformation and disinformation. Information is supported by facts that are verifiable statements of truth. Misinformation is false information that is spread with intent to mislead – an individual may share information without realising it is not true. It spreads quickly, often unchecked and without challenge. No wonder Dictionary.com names "misinformation" as their word of the year in 2018.

Disinformation is information that is intentionally misleading or biased. It has been rampant during the COVID-19 outbreak. It prompted Guy Berger at UNESCO to say: "When disinformation is repeated and amplified, including by influential people, the grave danger is that information which is based on truth, ends up having only marginal impact."

The classification has been expanded to include midinformation – an information crisis that occurs because not all the facts are known. The vacuum is then filled by rumour and misconceptions at a time of emerging knowledge.

Truth

We like easy answers to complex questions for no other reason than we are hardwired to take cognitive shortcuts known as heuristics. We rely on the familiar, the reported, selecting facts that support pre-existing views, all of which distort our view of the world. We are not the rational beings we may believe we are and are often guided by emotional and irrational thinking. It can affect how we see our patients, our treatment planning and the way we view the dentolegal landscape.

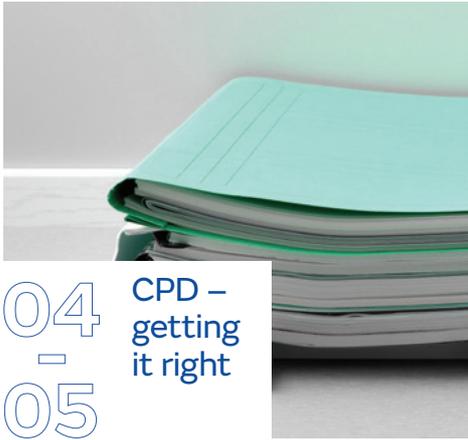
The truth was once the foundation stone of journalism, but it has morphed into something else. To find it, check the credibility of the information source, look for the middle of the story – not just the beginning and the end. As Hitchcock demonstrated during his interview some 50 years ago, context is all, and it is within the context that the truth is hidden.

When you contact us for advice and support and tell us your story, our teams will be equally focused on all three elements and when the middle is a muddle, you may rely on us to make sense of it. And when you share your story, all we ask is that you include the middle bit.

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CPD – getting it right

The Dental Board of Australia mandates that registrants complete a minimum of 60 hours of continuing professional development over a three-year cycle.¹ With the onus on you to only choose courses that are fit for purpose, how do you know which these are? And what happens if you complete CPD that is not? **Dr Annalene Weston**, Dentolegal Consultant at Dental Protection, considers the issue

At first blush, the parameters for selecting appropriate CPD are relatively straightforward – no less than 60 hours over a three-year cycle, with at least 80% of those hours being deemed scientific.² The Dental Board gives reasonably comprehensive guidance on how to choose appropriate CPD activities:

You should choose activities that demonstrate the following characteristics:

- Open disclosure about monetary or special interests the course provider may have with any company whose products are discussed in the course
- The scientific basis of the activity is not distorted by commercial considerations. For example, be aware of embedded advertising and direct commercial links
- The learning objectives, independent learning activities and outcomes
- Articles from peer-reviewed journals and/or be written by a suitably qualified and experienced individual
- Address contemporary clinical and professional issues, reflect accepted dental practice or are based on critical appraisal of scientific literature
- The content of CPD activities must be evidence-based
- Where relevant, select CPD activities where you can enquire, discuss and raise queries to ensure that you have understood the information
- If the CPD activity includes an assessment or feedback activity this

should be designed to go beyond the simple recall of facts and seek to demonstrate learning with an emphasis on integration and use of knowledge in professional practice, and

- an opportunity to provide feedback to the CPD provider from participants on the quality of the CPD activity.

CPD programs alone cannot be used to increase scope of practice. You must be aware that undertaking a single CPD activity may not provide you with sufficient clinical experience to incorporate techniques and procedures into your practice. CPD relied upon to improve or broaden knowledge should provide experience in the technique or procedure. This may be in a simulated environment.³

Many people select CPD in the field of dentistry they work in, or simply because they are interested in the topic. Price and convenience are also considerations. It is extraordinary to think that something so straightforward as CPD can become so contentious in the eyes of the regulator – and yet, at Dental Protection we see this issue arise often.

Are you audited for your CPD?

AHPRA routinely audit whether practitioners have completely the required hours of CPD. More commonly, however, discrepancies or gaps in CPD first become apparent during the course of a complaint, as it is common practice for AHPRA to request a copy of a practitioner's CPD logbook as part of the investigation of the patient's complaint.

An alarming number of practitioners do not have a logbook in the first instance, breaching this basic requirement. When they do then

collate their CPD appropriately, they often uncover a limited amount of CPD that does not satisfy AHPRA as being appropriate in either amount, content or route of administration. There is an expectation that your CPD will cover a broad spectrum of relevant subjects, including infection control, and that some of this CPD would be face-to-face (so not reading articles or watching YouTube videos alone).

The following points are important, should a practitioner be found to have breached the *Standard for Continuing Professional Development*:

- The Board can impose a condition or conditions on your registration or can refuse an application for registration or renewal of registration, if you do not meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)
- A failure to undertake the CPD required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the Board (section 128 of the National Law), and
- Registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for dental practitioners (section 41 of the National Law).⁴

Not fit for purpose

While the guidance regarding the nature and type of courses a practitioner should choose seems in many ways to be self-explanatory, many practitioners find during the course



of a complaint to the regulator that the investment of time and money they have made appears to have been misplaced, and that all that glittered was truly not gold.

Case study

Dr W was interested in orthodontics and undertook several short courses designed for GDPs. They found this somewhat unsatisfactory because they really wanted to learn more, at a deeper level. A company they respected advertised a course featuring an international guest speaker. The description looked good and Dr W's interest was piqued. The course was in-depth and approached orthodontics in a fresh way. Dr W felt the outcomes were outstanding and could quickly see the application for their practice. Mentorship was offered from the speaker and, with this in place, Dr W confidentially moved forwards and prescribed some orthodontic treatment using this approach and the recommended appliances. Everything went well, although the amount of expansion did seem concerning. Reassurance from the mentor led Dr W to push on.

A letter was received from a specialist orthodontist, stating that patient A had been overexpanded: their upper 4-4 were no longer contained within bone, the lateral incisors had resorbed to such a level that they required immediate extraction, the prognosis of the upper 3s and 4s – plus one of the upper centrals – was guarded, and the appliance and rapid expansion had caused this significant harm. Dr W was shattered.

Two more letters arrived in quick succession: one from the regulator and one from a lawyer. Following an investigation, the regulator made a finding of unsatisfactory professional conduct and placed conditions on Dr W that they could not practise orthodontics without

supervision from a specialist orthodontist. The lawyer's letter set out a claim in negligence that had the potential to reach into a six-figure pre-court settlement sum, with the matter needing to stay out of the public arena. The work was ultimately indefensible.

Stretching the boundaries

CPD, such as a course about a new technique or procedure, will help you:

- Maintain, improve and broaden your expertise, experience and competence
- Develop the personal and professional qualities you will need throughout your career.

However, you must choose your CPD based on your division's scope of practice and understand its limits. For example, dental hygienists, dental prosthetists, dental therapists and oral health therapists cannot become dentists through CPD courses.⁵

Case study

Ms D, a registered oral health therapist, had undertaken a unit on orthodontics at dental school. She had enjoyed this course and sought work at a practice that mostly provided orthodontics, including growth appliances and orthopaedic appliances. Ms D attended a clear aligner course with her colleagues, registering herself on the course as an OHT. During the course, she timidly raised her hand to advise she was an OHT and would not be able to provide the appliances to patients – she was just there to learn. The course convener told her this was untrue as she had studied orthodontics at dental school, and consequently this

fell within her scope of practice. With the encouragement of those around her, Ms D began to prescribe aligners for her patients, following the diagnostic formula provided by the course.

Patient Q was unhappy with their care and reported Ms D to AHPRA. On discovery of the treatment provided, AHPRA took immediate action and suspended Ms D.

Dr W and Ms D are not alone. Good, ethical practitioners across Australia have found to their horror that treatment courses they have attended and been mentored in have been found wanting when their training is examined by the regulator. These two practitioners happen to have been affected in the field of orthodontics, but the issue is not limited to this discipline of dentistry.

We encourage all practitioners to critically appraise any CPD they are considering and apply the guidance from AHPRA to their course selection. Also, ask around – there are many more Dr Ws and Ms Ds in the dental community than you may think, and they will gladly share their stories so others do not have to go through all they have suffered.

References

1. Registration Standard: Continuing Professional Development. dentalboard.gov.au/Registration-Standards.aspx
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Body dysmorphic disorder: spotting the warning signs

Dr Mike Rutherford, Senior Dentolegal Consultant at Dental Protection, looks at why dental practitioners should be alert to the risks of treating patients with body dysmorphic disorder



Body dysmorphic disorder is something that is poorly understood but it is important for dental practitioners to have some awareness, in order to effectively identify and manage patients who are affected by the condition.

What is body dysmorphic disorder?

It is a recognised psychological disorder that was first described in the *Diagnostic and Statistical Manual of Mental Disorders*, which is produced by the American Psychiatric Association. The disorder is characterised by a preoccupation with physical and aesthetic defects or imagined defects – often the face, skin and hair. It is equally proportioned in genders, usually begins in late adolescence and often presents in the early 30s. It is generally continuous through life to a lesser or greater extent and rarely has spontaneous remission. It is characterised by:

1. A preoccupation with appearance:¹
 - Men – often it is the genitals, height, hair and body build
 - Women – weight, hips, legs and breasts
 - Usually five to seven body parts over the course of the disorder
2. Obsessive thoughts lasting hours every day²
3. Compulsive behaviours – skin picking, mirror checking, disguising or camouflaging the area of concern³

What impact does it have on the people who suffer from it?

Body dysmorphic disorder leads to distress and impairment of functioning. Many people also have obsessive compulsive disorders and alcohol abuse is a common finding. Body dysmorphic disorder can render some sufferers housebound, and lead to suicidal ideation for many at some or several points of their life. Unfortunately, many members of society – including dental practitioners – think this is a silly pickiness that can be sorted out by a bit of rational explanation: it can't.

Looking at the frequency, many patients are not diagnosed, but a population frequency of 1-3% is accepted, so for the average dental practitioner this will likely mean one patient every week or two. It also means that quite a few practitioners reading this article will statistically be part of this cohort – as a profession we are not exempt.

What does this mean for cosmetic dentistry?

The frequency in differing practices is also skewed: cosmetic or dermatological medicine is demonstrated to attract a disproportionate number of patients with body dysmorphic disorder. It would therefore seem predictable that dental practices that promote themselves as cosmetic will attract more body dysmorphic patients. Advertising of these cosmetic services will naturally attract these patients.

Dentistry has undergone an extraordinary change in direction over the last 30 years. We have moved from being about purely treatment and prevention of disease to also being a provider of cosmetic and aesthetic treatments – with some practices doing this exclusively: the ubiquitous orthodontic treatment, teeth bleaching, Botox and fillers; and cosmetic tooth treatments such as veneering. This has been brought about by affluence, revolutionary products and techniques, and a consumer driven market who know about these treatments, can do their 'research' online and know what they want.

It is estimated that the vast majority of body dysmorphic patients seek cosmetic treatments – liposuction, rhinoplasty, Botox, tooth whitening; and frighteningly many are provided with the requested treatment. This is an alarming statistic because almost all patients with body dysmorphic disorder who undertake treatment report they are disappointed with the outcome. This is simply because they have a psychological disorder and not a physical disorder. Treating the perceived defect will not cure the disorder.

This simple statement and statistic should drive our approach to offering cosmetic procedures to patients we suspect may have unrealistic or unattainable expectations from treatment.

How dental practitioners can avoid risk

We as a profession are not particularly adept at diagnosing or picking patients with body dysmorphic disorder, but we can follow a few basic ground rules that will help us avoid trouble down the road. These ground rules begin on day one. Most patients with body dysmorphic disorder doctor-shop; a patient who presents with a history of disappointment with previous dentists and treatments (not just dental) may just be unlucky but perhaps there is more to the story – be aware. Patients who 'talk you up', telling you how great you must be, or what a great job you did on their friend... take a reality check – most of us are not that great that we deserve praise before we provide treatment.

Warning sign number two: patients who may seem to know as much or more about the treatment than you do – this may be part of the obsession. They have researched this treatment extensively and this can lead to a multitude of problems.

Firstly, the research and the perfect results your patient has seen online may differ from what you intend or what you can do. Their facial shape, facial symmetry or features may dictate that the whole result will not be like the examples on your website. Beware the temptation to agree to a particular treatment, product or process that your patient demands because that is what they want.

Stick instead to what you know and what works best in your hands.

Secondly, this patient research can lead to failures in the consent process; our patient knows so much that we may not enforce the consent process as much as we normally would – the risks and warnings, the advice on likely outcomes – because our patient seems to know all about it already. Conversely our patients may not listen when a practitioner describes risks and warnings, limitations and likely outcomes – why should they? They have researched this thoroughly and know how it should turn out. They may tune out of this discussion because they have already envisioned the outcome and just want to get on with it. This is not a patient problem – it is our problem because it is our professional obligation to ensure the consent process is valid.

Thirdly – and this is the red flag we should not miss – when the defect or deficiency that your patient describes is so minor that in your opinion you can barely detect it, or you don't believe that it is an actual defect. If you can't see it, you can't fix it. You have to be able to say no.

Making sure that your consent process is sound and providing your patients plenty of information, visuals of the outcome, mock-ups, time in temporary veneers or crowns is all very helpful, but sometimes you just need to say no. Patients can be persuasive, they may flatter us, they may tell us how much they trust us, they may try coercion – but if you can't envision how the result is going to look significantly different, you have to say no.

It doesn't matter how good your consent process is, no-one wants to deal with a disappointed and angry patient who believes that you have ruined their teeth, or at best, wasted their time and money.

I wish to acknowledge the influence and ideas of Dr J Timothy Newton, Kings College London, on this article through two of his lectures on the subject presented for MPS and Dental Protection Australia.

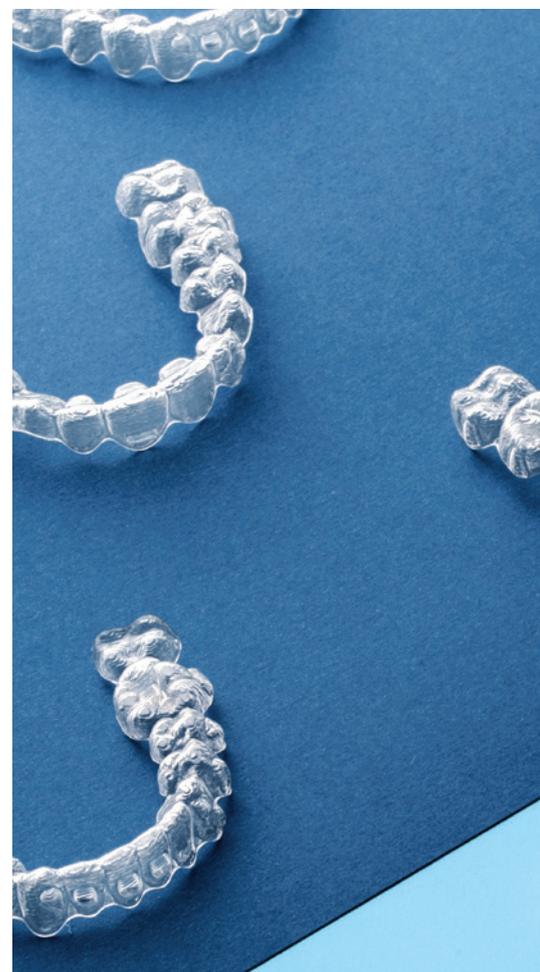
For a more in-depth discussion with Dr Rutherford on this topic, listen to the podcast "The role of body dysmorphia" – available now at dentalprotection.org.au

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Direct-to-consumer orthodontics – understanding the risks

Dr Yvonne Shaw, Dental Underwriting Policy Lead at Dental Protection, and Dr Kiran Keshwara, Dentolegal Consultant, consider some of the risks of patients pursuing direct-to-consumer dental care



The growing popularity of adult orthodontic treatment has seen increased activity from companies offering orthodontics services directly to patients.

A recent survey by the British Orthodontic Society (BOS) identified that 80% of orthodontists had seen an increase in adult patients seeking orthodontic treatment.¹ The restrictions on practice arising from the COVID-19 pandemic, coupled with patients having to engage with remote dental care and advice, may lead to more patients seeing orthodontic treatment through a direct-to-consumer (DTC) approach as an attractive option.

We have considered some of the risks the dental team probably need to consider that may flow from patients pursuing DTC dental care.

Acting in the patient's best interests

Central to the dentolegal questions that members ask about is the risk of harm to a patient. Concerns range from a patient not understanding the implications or limitations of treatment but also the risks relating to the treatment itself, such as:

- Progression of pre-existing dental conditions such as periodontal disease or caries
- Root resorption
- Exacerbation or development of TMJD

- Adverse tooth movement such as creation of anterior or lateral open bites and changes to occlusion.

Of course, all the above risks can equally apply to any course of orthodontic treatment and these types of complications form the basis of some of the claims we deal with. However, the risk of a problem developing, or not being identified at the outset, is likely to be significantly increased if a patient has not had a full clinical examination prior to commencing treatment.

The question we are often asked is what a clinician should do if they become aware a patient is, or is contemplating, undergoing treatment provided through a DTC site. Professionals recommend an initial face-to-face contact at the beginning of the patient consultation and it is therefore appropriate to make patients aware of the potential risks of proceeding with a course of treatment in the absence of this examination taking place. To assist in communicating the risks, members may find it helpful to direct patients to orthodonticsaustralia.org.au and search for “direct to consumer” – this is an Australian Society of Orthodontists page that details some of the risks involved with DTC treatment.

Another consideration is that patients may fail to disclose they are, or have been, undergoing treatment with aligners obtained directly from a DTC site. This could impact

upon the assessment of a dental problem or provision of dental care where tooth position may not be stable. This may be an issue where patients have not attended for care during the COVID-19 pandemic but proceeded with orthodontic treatment in the interim. Dentists may therefore wish to consider asking specific questions to elicit whether a patient has had any form of dental treatment, including any ‘DIY’ approaches, as part of their assessment process.

Access to records

Another question that arises is how to respond to a request from a patient, or DTC orthodontic provider, to supply written confirmation that a patient is fit to proceed with orthodontic treatment. This is in effect asking a dentist to make a decision on whether or not a patient is suitable for treatment that the practitioner themselves will play no part in planning or delivering.

While a patient may have attended recently for dental examinations, this does not equate to a patient being fit to proceed with a specific course of orthodontic treatment. It would not be appropriate for a clinician to comment on whether a patient is fit to proceed where they have no involvement in the clinical assessment, treatment planning or provision of that course of treatment. In this scenario, it would be in the patient's interests to advise that a clinical examination, with an appropriately trained orthodontic clinician,



would be required to ensure all treatment options and specific risks are considered.

However, patients may instead request a copy of their records or provide authority for these to be disclosed to a third party. If the patient has made such a request, and provided a signed form of authority, then the disclosure of information should be dealt with in accordance with data protection legislation. If the records are to be disclosed with a view to dental treatment being provided elsewhere, one approach that could be considered would be to provide a courtesy call to the patient confirming receipt of the request thereby opening a discussion into what treatment the patient is seeking. A clear note of any discussion with the patient regarding what was advised should be recorded in the patient's records.

Adequate and appropriate indemnity

All dental professionals must have appropriate insurance or indemnity in place to make sure that patients can claim compensation to which they are entitled.

Registrants must therefore ensure they have adequate and appropriate indemnity arrangements in place if they are involved in the provision of DTC orthodontic treatment. Dental registrants working in this setting are therefore encouraged to speak to Dental Protection to ensure appropriate protection is in place for themselves and their patients.

Clinicians working for DTC providers need to ensure they are not breaching any regulatory guidance.

What to do if a patient returns

Sometimes a patient may return after having started or completed DTC orthodontic treatment. They may be disappointed with the results and ask the clinician to provide more treatment or 'fix' the unsatisfactory treatment.

As with all patients, the clinician should treat them with 'fresh eyes' and complete their regular, thorough assessment of the patient. An appropriate assessment, diagnosis and detailed discussion with the patient about what they do not currently like about their teeth and what their expectations are will help the clinician in forming a treatment plan that will help overcome the patient's concerns. Naturally, if the patient's expectations are unrealistic or the clinician feels they cannot meet them, the patient can be informed of this and referred to another dentist.

Sometimes patients may present on the advice of the DTC provider, or of their own volition and request that a general dentist provide either fixed or pull down retainers for their completed DTC treatment. This is fraught with potential problems. If there is relapse, then quite likely in the patient's eyes it is due to the inadequacy of your retainers rather than any inherent

instability in the teeth repositioning. After all – they looked fine before you touched them! Unless you have experience and confidence in orthodontic movements and results it is probably more prudent to refer the patient for specialist orthodontic assessment and retention. Your patient may not agree or may complain about the likely expense, but it is best if you do not compromise your own position by providing treatment you are not comfortable with simply because your patient insists.

As with all dental treatment, the patient and clinician should have a discussion around the treatment options, possible treatment outcomes, risks and benefits of each of the options.

Further advice and support

Any members of Dental Protection affected by the issues outlined in this article should contact our dentolegal advice line on **1800 444 542** for further guidance and support.

References

1. bos.org.uk/News-and-Events/News



Case study

Regulating the effects of COVID-19

By Dr Louise Eggleton, Dentolegal Consultant

A sole practitioner was forced to close her dental clinic on two occasions during the COVID-19 pandemic.

On the first occasion, the dentist was unable to source some items of essential personal protective equipment for aerosol generating procedures. This resulted in the suspension of appointments for many types of clinical interventions and the dentist was only able to offer a telephone triage service, during which patients were given clinical advice and prescriptions for antibiotics when appropriate, or referral to another clinic if necessary.

The second unavoidable closure arose after the dentist had contact with a family member who had tested positive for COVID-19. The dentist was forced to self-isolate for the recommended period of time in accordance with government guidelines. Unfortunately, a suitable locum dentist could not be found to cover the treatment appointments at such short notice. Patients were therefore contacted to reschedule or were offered emergency appointments at a nearby dentist who had agreed to provide additional support to the practice.

Most patients were very understanding of the dentist's position. However, one patient, who had also been affected by the first closure of the practice, was unhappy because their follow up appointment had to be rearranged. As the patient was experiencing discomfort, he accepted an alternative emergency appointment at a nearby practice. The patient was advised their tooth was unrestorable and required extraction. The extraction procedure was completed uneventfully, but the patient immediately went to complain to the Dental Council, alleging the six-week delay in treatment by the first dentist had caused the loss of his tooth.

The dentist was understandably shocked and upset when she received notification of the AHPRA complaint. She immediately contacted Dental Protection for advice and guidance and we assisted her in preparing a reply to AHPRA. It was explained that both situations were beyond the dentist's control and could not have been predicted. The response stated that her actions were reasonable and proportionate and that she had acted in a highly responsible and professional manner by observing the local government and Australian Dental Association guidelines during that time.

After consideration, the Dental Council accepted the dentist's explanation and the case was closed with no further action. The dentist, who had been under a considerable amount of stress while trying to manage her single-handed dental clinic and cope with the Dental Council investigation, was unsurprisingly very relieved to have the matter resolved.

Following further discussions with her case manager at Dental Protection, and taking into account the extreme stress and pressure of the situation, the dentist accepted the offer of confidential counselling services. Access to these services was available free of charge as part of the dentist's membership benefits. The dentist went on to receive additional guidance and support following this difficult period.

Learning points

- Patient perceptions of events do not always reflect the true picture. It is important to spend a little time explaining the reasons why their appointments and treatment may be delayed. We suggest that the clinical record includes details of these conversations.
- Dental Protection recognises the significant additional pressures many dentists are facing during the pandemic and how changes to the way we deliver care will have an impact on patient perception. We understand dentists continue to try their best to provide a good level of service to patients during this time, while adhering to the guidance set by State governments and ADA. Unfortunately, it can be very difficult to predict how a patient may react to events that can often be outside the dentist's control.
- Contact Dental Protection at the earliest opportunity to ensure we can help support and guide you through any complaints, claims or regulatory challenges that which may have been triggered by the additional pressure of providing dental care during the COVID-19 pandemic.
- You are not alone – Dental Protection understands the serious pressures dental professionals have faced during this time. We are able to offer confidential counselling services by independent professional providers at no additional cost, as part of your membership benefits. Please contact us for more information.

Case study

Cosmetic procedure leads to complaint

By Dr Richard Hartley, Dentolegal Consultant



A 25-year-old male patient saw his dentist to discuss options to improve the appearance of his upper teeth, as he disliked the shade of them and also felt that the shape could be improved.

Following a discussion of the treatment options, the patient discounted whitening and porcelain veneers, and elected to proceed with composite veneers to improve both the shade and shape of the teeth.

The dentist noted in the records their conversation with the patient: "This treatment is being provided because it is a minimally invasive alternative to porcelain veneers. This means we are adding material to your teeth without any preparation of the teeth. No long-term damage is caused to the teeth and the restorations can be removed in the future."

The patient was also warned that his teeth would feel bulkier and advised that the veneers could be repaired in the future. They could be expected to last five to ten years.

The dentist did not carry out any additional diagnostic adjuncts such as study models, a wax-up or occlusal analysis, and the patient attended the following week to have composite veneers directly bonded to the teeth, which the member did freehand.

After a week the patient returned to the practice to say that he disliked the appearance of the veneers, and also commented that some of the composite material had chipped. He requested that the composite veneers be removed and his teeth returned to their original appearance.

The dentist agreed to this and voluntarily offered the patient a full refund of fees for the placement of the composite veneers. Following their removal, the patient complained that there was a small chip on his upper left lateral incisor that had not

been there before, and also noted that the appearance of the central incisors was not quite the same as before the composite had been placed.

He requested a second opinion and this was provided by a colleague at the practice, who confirmed that there had been enamel removed from the buccal surfaces of both centrals, and that the upper left lateral had been damaged along the incisal edge. The colleague was reluctant to get involved in the remedial treatment, however, as he felt that the patient would be better served by a dentist with more experience in cosmetic work, given that there was evidence of parafunction.

The patient then put in a formal complaint stating that his teeth had been damaged. He said he would never have agreed to the treatment had he been made aware that there was a possibility that there were risks associated with the treatment and therefore it was not entirely reversible, as had been suggested to him.

The dentist contacted Dental Protection for advice. He had reflected on his actions and now realised that he had perhaps been too ambitious in his treatment plan given his inexperience of cosmetic dentistry. His intention had always been to carry out a reversible procedure and he was distraught with the mere thought that he had damaged the patient's teeth. With our assistance he was able to cover the cost of a referral to a local dentist with a special interest in aesthetic dentistry for some remedial treatment, and the matter was resolved to the patient's satisfaction.

The dentist acknowledged that the lack of a thorough initial assessment and planning had compromised the clinical outcome and raised some questions in relation to valid consent. He subsequently enrolled on a practical cosmetic dentistry course to improve his knowledge and skills.

Learning points

Cosmetic cases such as this can often present challenges, both technically and in relation to managing patient expectations, and so the following is essential to bear in mind:

- Take care when managing the patient's expectations, particularly in relation to elective cosmetic procedures.
- While reversible procedures offer a margin of safety and reassurance for both the patient and the dentist, remember to consider the risks associated with the process of reversal and make sure the patient is aware of them.
- Patients will examine the result of elective cosmetic procedures involving teeth in the smile line more than they might when placing a posterior composite, for example, and even the tiniest of defects is likely to prompt a reaction.
- Ensure that the patient has all the relevant information so that they can make an informed decision when it comes to consenting to treatment.

Only carry out a task or type of treatment, or make decisions about a patient's care, if you are sure that you have the necessary skills and are appropriately trained, competent and indemnified.

Case study

Continuity of care

By Dr Simrit Ryatt, Dentolegal Consultant



It is not unusual to find yourself taking over the care of patients from a colleague within the practice you work, as dentists move on to different practices, retire, take annual leave or face sudden illnesses. It can sometimes be a daunting experience if you have to cover for a colleague, especially if it is someone who is very popular with patients or has a personality and persona that is very different to your own.

Successful dentist-patient relationships are rooted in reciprocity – mutual trust and respect. The departure or absence of a dentist from the practice has to be managed with a number of perspectives in mind. It is always a good idea to be as transparent as possible about any changes to your patients' care and to advise them of a clinician's departure, whether this is face-to-face or remotely.

Ideally, a personal introduction offers many benefits – the so called “warm handover”. This is not always possible, especially if a colleague's departure is sudden and unplanned. Other times there may be commercial sensitivities and contractual arrangements may even forbid certain conversations. Communications relating to a colleague's departure may be limited depending on the circumstances. While it may be ethically desirable to be open and transparent about the circumstances, the truth may infringe personal rights of the individual such as confidentiality. Where possible, the incoming and outgoing parties should agree the message and also ensure that the dental team is aware.

This can be a positive if the patient now has a dentist they prefer, but more commonly it

introduces an extra challenge for the new dentist of building trust and respect midway through a course of treatment.

The continuity of clinical care is facilitated by well-organised, clear and comprehensive treatment notes. If there is an opportunity, discuss the handover with the colleague in question. Taking over the care from a predecessor need not be a daunting process and it can be an opportunity to hone your communication skills and build rapport with new patients. Relationship building and effective communication are key to risk mitigation when it comes to the transfer of care from one clinician to another.

Case study 1

When a former colleague has left and there are detailed clear notes

Dr C contacted Dental Protection as she was worried about a situation she was facing at the practice where she worked as a locum associate.

Dr C was aware one of her colleagues had left the practice on bad terms and many of his private patients were only part-way through their treatment plans. The practice owner offered Dr C the opportunity to become a permanent, self-employed associate, and suggested that she take over the departing associate's patient list, and confirmed that she would receive the relevant fees from now on.

The clinical records of the departing associate were very comprehensive, clear and unambiguous. The clinical justification and rationale for the clinical treatment had been recorded and there was evidence that

the patient had consented to what was done and what had been planned.

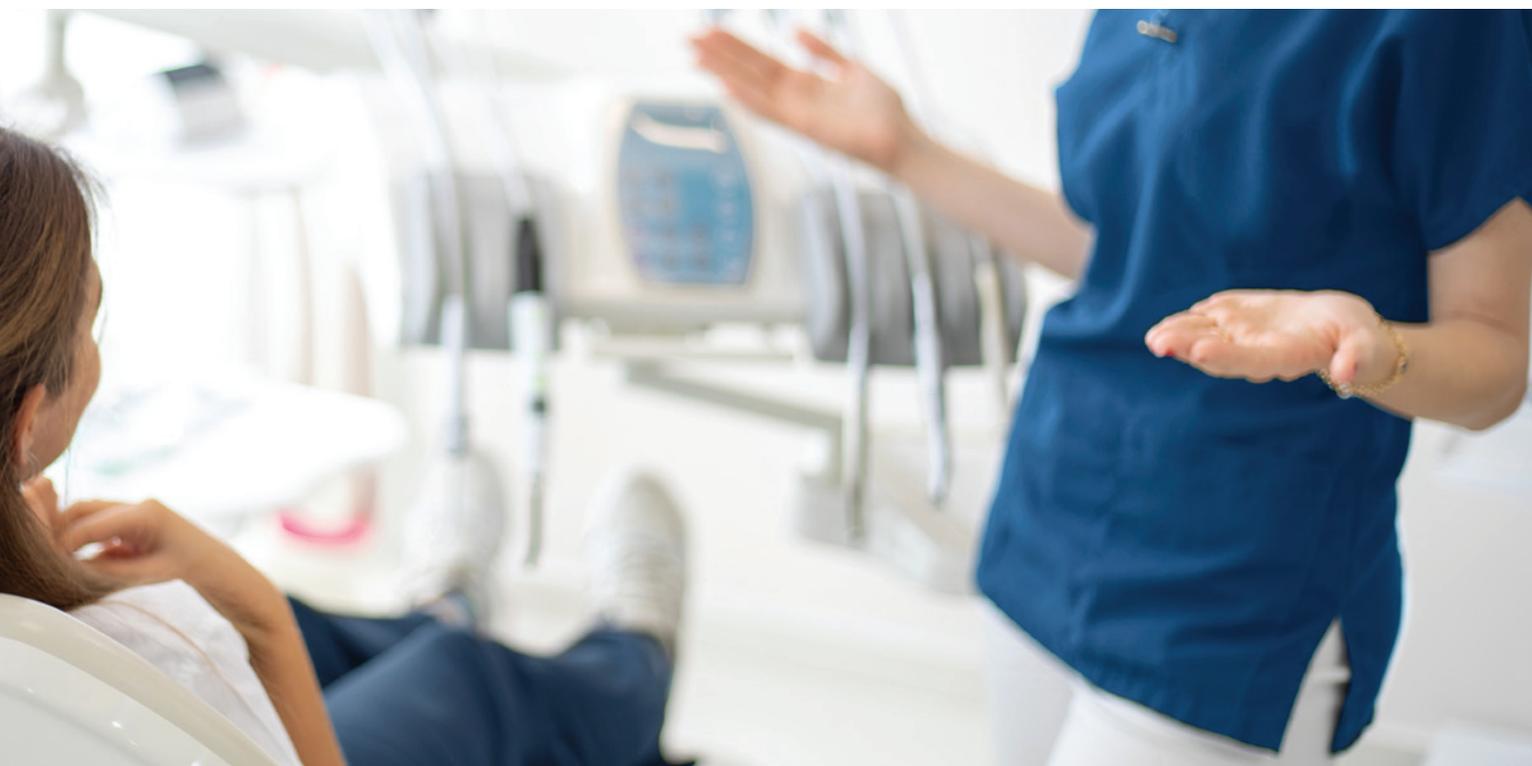
The previous associate had forged strong professional relationships with his patients largely through his likeable character and personality. He was by any standards a ‘hard act to follow’.

The practice principal had assumed and hoped that Dr C would be able to continue where her predecessor had left off. Both dentists were specialists in restorative dentistry but with a different career profile and Dr C had only recently returned after a one-year career break.

Dr C contacted Dental Protection to seek clarity and guidance about the dentolegal aspects of taking over a treatment plans that had been formulated by a different dentist. The second part of her inquiry related to her lack of recent experience in carrying out certain procedures. She also mentioned that she was apprehensive about taking over from a very charismatic colleague. She was aware that her own demeanour was in stark contrast to that of her predecessor.

Her adviser at Dental Protection suggested Dr C adopt a proactive approach and review each treatment plan to identify what procedures she felt comfortable undertaking and which procedures she wished to avoid. She would then need to consider whether any patients should be referred to other clinicians within or outside the practice.

This was a complex scenario for a number of reasons. Competence and confidence impact on a clinician's ability to undertake complex procedures and there are also



patient expectations to manage. There may be situations when a dentist may wish to reformulate a treatment plan or change the order of the treatment. It is important to spend time discussing the options with the patient and giving them time to digest new information. This is particularly the case with extensive or expensive interventions. It is also important to go through the consent process again to avoid any misunderstandings later. The risks and benefits that have been presented to the patient may be identical but the manner in which they are presented and framed can differ from dentist to dentist and this can affect the patient's understanding. The discussions should be recorded in the clinical records.

Most patients will accept seeing a new dentist if they perceive the dentist as caring, conscientious and authentic.

With Dental Protection's assistance Dr C had a clear plan of action in place and the reassurance had an immediate impact on her confidence.

Case study 2

Continuing treatment for a colleague who is who has suffered medical misadventure for an unknown period of time

Dr L was handed the responsibility of looking after a list of patients, as the principal of the practice was deemed by his treating physician as currently not fit to practice. The principal of the practice was in his late 60s and his record keeping was not of the standard that Dr L had expected.

On the first day back in practice after the news had broken, Dr L decided to contact

those patients that would be affected by the principal's absence and introduce himself to them.

His first patient attended midway through his treatment for the 'try-in' stage of a new set of complete dentures. Dr L completed the 'try-in' stage of the denture and noted the severely atrophic mandibular and maxillary ridges. From the clinical records, he discovered that the patient had been edentulous for almost 40 years and had previously experienced difficulties with the stability and retention of complete dentures.

The patient commented on the stability of the denture and said he hoped the final dentures would be "a better fit". It was at this stage that Dr L realised that the patient had high expectations. He reviewed the available radiographs and felt that the patient would benefit from an implant retained denture, but this option was not recorded in the clinical records and after a conversation with the patient, it was clear that no discussions about this or other options had been discussed with the patient previously.

Dr L's immediate reaction was one of disappointment and some frustration. He now faced the challenge of how to offer an alternative treatment plan without any overt or implied criticism of the previous practitioner. There were also other cases that day where Dr L felt that patients had not been given the full range of options and in some cases the risks and benefits of interventions had either not been fully explained to patients, or the patients had not understood them. The clinical records were sparse, and this caused him further concern.

After speaking to an adviser at Dental Protection, it was agreed that each case should be assessed separately and that the situation be discussed with the practice principal, with a view to him contacting his patients – not only to introduce Dr L but also to advise them that given the unavoidable delays due to his illness, the treatment plans would need to be reviewed and reassessed where necessary.

It was also suggested to Dr L that he and the principal could also have a handover discussion about those cases where there was likely to be a difference in clinical opinion. As all dentists are responsible for the care they provide, Dr L would need to feel comfortable with the care and treatment being provided and that the onus would be on him if any aspect of future care was challenged or questioned.

It is not uncommon for dentists to examine a patient and come up with different treatment plans. Some of these may be explained by different perspectives – when, for example, should a discoloured composite restoration be changed? On other occasions a failing restoration may be perceived as a failed restoration and vice versa. After speaking to his adviser at Dental Protection, Dr L was reassured that clinical decision-making is not always as rational as we might believe and that bias can unwittingly affect the decisions clinicians make. Genuine differences of opinion can occur, and just because they do, doesn't mean one approach is right and the other wrong.



Case study

I look like a horse

When a patient makes a comment such as this, it can be difficult to know how to respond, but also figure out where it went wrong. **Dr Annalene Weston**, Dentolegal Consultant at Dental Protection, shares a case where the patient actually made this very accusation

Ms W, a social media influencer, did a great deal of research on achieving the exact smile she wanted. This research was largely within social media, as this is the space she understood and moved freely in. Dr B treated many reality show and sports stars for high-end cosmetic work, and they shared their successful aesthetic outcomes freely across their social media platforms. Ms W reviewed these cases, and other successful outcomes from Dr B's social media profiles; based on this and his flexible payment plan options, Ms W scheduled an appointment for an assessment for veneers.

Dr B assessed Ms W and found that she had small square teeth, which he believed was the root cause of her dissatisfaction with her smile. He designed a smile in accordance with her request that her smile be "bigger" and showed her some of his successful cases who had had similar aesthetic requests. Ms W connected with the outcome of one of the 'models' and, although her smile design did not give her the same breadth of smile she was hoping for, she made some assumptions that her outcome would be exactly the same.

Ms W booked in as quickly as she could and tolerated the temporaries, which she hated. She requested no changes be made to the final shape and size of the teeth, despite

encouragement from Dr B to speak up about any concerns she may have. She did not understand that the temporaries were a replica of her final outcome. This disconnect between the two of them continued, with Ms W focused on what she thought she was getting, and Dr B making the assumption that 'silence equals consent'.

After cementation Ms W was devastated by her appearance. She found the teeth too long, and they affected her speech. She was also experiencing pain. Dr B's practice made several calls to invite her in for a follow-up to check on her, which she ignored because she was upset and embarrassed and no longer trusted Dr B. With the passage of time, the tone of these calls changed to chase up the outstanding account. Ms W became withdrawn, and her feelings about her teeth impacted her ability to work, socialise and leave the house. She did not want to pay for the work because she hated it. This was compounded by the fact she was in pain. As the calls and letters from the practice continued to come thick and fast, Ms W Googled her options, as she felt she needed to act to make it all stop.

Dr B received a statement of claim, which is in essence a document setting out a person's legal claim against you, in this instance,

by Ms W, on the grounds that he provided treatment to her without her consent. A review of his records quickly revealed that there was no documentation regarding the conversation of consent, and that Ms W had not signed her standardised consent form. Things got worse from there for Dr B, as all of his records were skinny at best, and, consequently made it incredibly difficult for him to form a defence.

The matter was settled out of court.

Learning points

- Don't rush into elective cosmetic treatment without first ensuring you understand your patient's needs.
- Ensure that all conversations with patients are documented in your clinical records.

For an in-depth discussion of this case, listen to the CaseMatters podcast "I look like a horse" – available now at dentalprotection.org

Advertising your services: new guidelines take effect

Revised guidelines on advertising a regulated health service came into effect on 14 December 2020, along with updates for the advertising compliance and enforcement strategy for the National Scheme. **Anita Kemp** and **Kristin Trafford-Wiesel**, Case Managers at Dental Protection, look at what these mean for you



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The revised guidelines¹ on advertising have been restructured to allow practitioners easier access to information, and offer new flowcharts, case examples and content relating to testimonials, protected titles, and acceptability of the evidence required to substantiate health claims in advertising.

This article summarises the key changes and identifies what you may need to do next.

What is acceptable evidence?

AHPRA recognises the distinction between acceptable evidence for claims made in advertising and the evidence used for clinical decisions.

The consultation with a patient provides an opportunity for practitioners to obtain consent and discuss the evidence for different treatment options. Individuals are able to consider options, the benefits and risks of each option, and also ask questions, and therefore make an informed decision about their care. Advertising does not support informed decision making as the claims made are generic, and practitioners are not available to clarify whether each specific treatment is appropriate for an individual. Nor does the individual have the opportunity to ask questions, which may be critical to their understanding.

Advertisers of regulated health services must be able to substantiate claims made in advertising by means of “acceptable evidence”. Acceptable evidence mostly includes:

- empirical data from formal research, or
- systematic studies in the form of peer-reviewed publications.

Testimonials and reviews – what you need to know

Testimonials can be construed as misleading and are therefore prohibited as a form of advertising, as is any recommendation or positive statement relating to the clinical aspects of treatment.

Clinical aspects include:

- Symptoms – specific symptom or reason for seeking treatment
- Diagnosis or treatment – specific diagnosis or treatment provided by the practitioner
- Outcome – specific outcome, or skills or experience of the practitioner (either directly or via comparison).

Broadly, practitioners are not responsible for positive or negative reviews on third party websites as they have no control over this content. Nevertheless, practitioners should be wary if they choose to engage with reviews as this may be considered advertising.

Practitioners are, however, expected to monitor platforms that they have control of (eg social media and practice websites) and comply with the prohibition of the use of testimonials in advertising, to ensure full compliance with the guidance.

Protected titles – registration, competence and qualifications

To avoid misleading advertising practitioners should consider how they present their title, qualifications and areas of expertise.

Advertising that uses the words (or variations of) “specialises in”, “speciality”

or “specialised” implies the practitioner holds specialist registration. Alternative descriptions should be utilised. Wording such as “substantial experience in” or “working primarily in” are less likely to be misleading and therefore can be considered.

Advertising compliance for the National Scheme

The updated advertising compliance and enforcement strategy for the National Scheme² sets out a proactive approach to advertising compliance, while encompassing a risk-based approach that determines the severity of a breach and the appropriate penalty should this occur.

Other updates include:

- Recognition that false and misleading claims about public health emergencies such as COVID-19 may be identified as high risk (critical or major)
- Additional education and engagement activities to support advertising compliance
- An indication of AHPRA’s focus on testimonial compliance and enforcement action, specifically those that present greater risk.

Reviewing your own approach

For further resources, information and guidance regarding practitioner obligations and compliance requirements, visit AHPRA’s advertising hub.³

References

1. AHPRA, *Guidelines for advertising a regulated health service*
2. AHPRA, *Responsible advertising in healthcare: keeping people safe*
3. ahpra.gov.au/Publications/Advertising-hub.aspx

Contacts

You can contact Dental Protection for assistance

Membership services

Telephone 1800 444 542

Dentolegal advice

Telephone 1800 444 542

dentalprotection.org.au

Cost of calls to this number depend on your communication provider. Please check with your provider before you dial.

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