



RISKWISE

ISSUE 38 | DECEMBER 2018

AUSTRALIA



Capacity, consent and the older patient

KEY STEPS TO ASSESS WHETHER A PATIENT HAS THE
CAPACITY TO MAKE DECISIONS ABOUT THEIR TREATMENT

WEIGHT AND SEE
Decision-making in
clinical practice

DATA BREACH
What happens when data
is breached?

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HEAD OF DENTAL SERVICES AUSTRALASIA/ASIA

Welcome to this latest edition of *Riskwise*, Dental Protection's flagship publication offering the latest information on dentolegal topics and advice from our dentolegal consultants and professional experts.

In this edition, our dental director, Dr Raj Rattan, explains the importance of building trust with our patients, which in turn enables longer relationships, reduces the incidence of conflict and complaints, promotes satisfaction and can build loyalty. Karen Kumar, one of our highly experienced panel lawyers, explains what happens when data is breached and what responsibilities the dental practitioner has in relation to this increasingly significant area of risk.

Dr Robert Caplin from King's College London explores the clinical decision-making process and how we might reduce the subjectivity in the process to produce a more consistent approach in line with the patient's best interests. Dr Warren Shnider from The Royal Dental Hospital of Melbourne explores the increasingly relevant issue of capacity and consent for the older patient. We follow both of these articles with several case reports for you to review. 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 the situations.

Dental Protection's general manager for Asia Pacific Educational Services, Matthew O'Brien, describes the new workshop, Dental Records for Dental Practitioners, which highlights the importance of well-organised dental records to aid continuity of care and ensure good practice. Through a range of presentations, discussions, case scenarios and practical exercises it highlights the importance of accurate and up-to-date dental records for both patient care and professional defence.

WEBINARS

In believing that prevention is better than the cure we also provide expert advice, support and education to help protect you from risk. Recent additions to our offerings have included webinars, which have been very well received. These live events provide an opportunity for real-time questions and answers during the broadcast and are an ideal way to have the expertise of Dental Protection brought directly to you. I would refer you to our website for updates on these events as well as others and of course to our substantial eLearning portfolio.

COLLEAGUE SUPPORT

I am delighted to say that Dental Protection goes from strength to strength in Australia and our experienced team of professionals based in Brisbane and Melbourne, led by Dr Mike Rutherford, have developed a considerable reputation and indeed recognition from other stakeholders. We believe that colleague-to-colleague support is fundamental to ensure that you receive the advice and support that meets your individual needs.

Thank you for taking the time to read *Riskwise* and I hope there is something useful for every aspect of our profession. Naturally we are always keen to hear feedback from members and if there are other topics you would like us to cover or changes you would like us to make, please let us know.

Best wishes,

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New dental records workshop proves popular

Over 580 members across the Asia Pacific region attended Dental Protection's new Dental Records for General Dental Practitioners workshop launched earlier this year

Over 580 members across the Asia Pacific region attended Dental Protection's new 'Dental Records for General Dental Practitioners' workshop launched earlier this year.

The dental records workshop provides information on the importance of keeping dental records (paper and electronic) to enable the dental team to provide the best possible patient care and dentolegal protection.

Almost all participants agreed that they would change the way they practise as a result of what they had learnt, with the majority of participants strongly agreeing that the workshop was relevant to them, and rating it an average 6.81 score on a 7 point scale.¹

Dental Protection's general manager for Asia Pacific Educational Services, Matthew O'Brien, said: "Complete, contemporaneous and well-organised records are essential for good dental practice and continuity of care. They are necessary for your defence against a claim or complaint and can be seen to reflect the quality of care provided.

"The workshop helps members reduce their risk of patient complaint by covering the legal, regulatory and contractual requirements of record keeping in general practice."

Feedback from members who had attended was overwhelmingly positive. One stated:

"Examples of well-written records were very useful. I was unaware until now that this is the standard we are expected to abide by." Another member said: "The workshop was very good and relevant to all forms of practice."

Members who attended the workshop also received a best practice clinical entries checklist. The checklist is a useful tool to ensure records contain sufficient enough information for a seamless handover of care if required.

The new dental records workshop is one of several in Dental Protection's Risk Management series. Mr O'Brien said the workshops were highly valued by members, who find the case studies, clinical examples and personal experiences relevant to their day-to-day practice.

"It was great to have case studies and personal experiences from both the presenter and each other to learn from," said one attendee.

The workshops were very popular, with most of them oversubscribed across the region. Based on demand, the dental records workshops will continue to run for the rest of 2018 and into 2019.

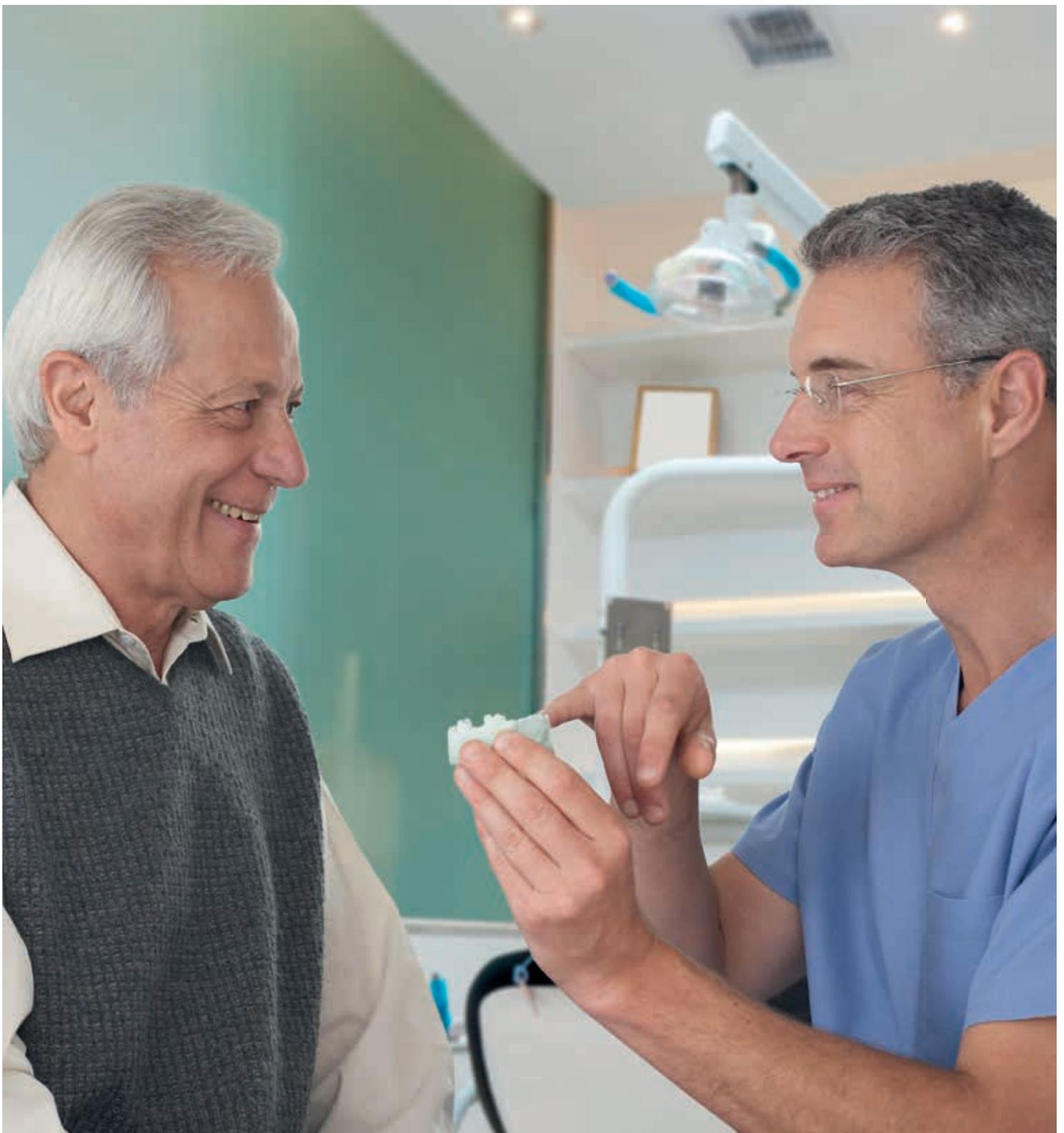
To learn more about attending a workshop in your area, visit dentalprotection.org



The workshop helps members reduce their risk of patient complaint by covering the legal, regulatory and contractual requirements of record keeping in general practice.

REFERENCE

¹ Dental Records for General Dental Practitioners Evaluation Summary statistics for Asia Pacific



Capacity, consent and the older patient

Dr Warren Shnider, specialist in special needs dentistry, The Royal Dental Hospital of Melbourne, discusses the key steps in assessing whether a patient has the capacity to make decisions about their treatment

Each assessment of an individual's capacity should relate to a specific decision – a patient may, for example, be incapable of understanding the complex implications of a major procedure, but still be able to comprehend the risks and benefits of a simple intervention.

Mrs Brown, who has been a regular patient at the practice for years, attends for her first appointment in a year, accompanied by her daughter, and says that she has a sharp tooth that's digging into her tongue. On examination, there is an ulcer the size of a five-cent piece that is associated with an enamel shard of a grossly carious tooth 36. An x-ray film shows periapical pathology and numerous other teeth with recurrent carious lesions. Mrs Brown says she just wants the edge smoothed over.

While discussing the treatment options with her, you sense that she does not have a full understanding of the potential complications that the treatment entails. You feel a little uneasy and question whether she has the capacity to provide informed consent for the necessary treatment.

DECISION-MAKING CAPACITY

Under the Medical Treatment Planning and Decisions Act¹, a person has decision-making capacity to make a decision if the person is able to do the following:

- understand the information relevant to the decision and the effect of the decision
- retain that information to the extent necessary to make the decision
- use or weigh that information as part of the process of making the decision
- communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.²

A person is taken to understand information relevant to a decision if they understand the explanation of the information given to them in a way that is appropriate to their circumstances, whether by using modified language, visual aids or any other means.

An adult is presumed to have decision-making capacity unless there is evidence to the contrary.

A person:

- has decision-making capacity if it is possible for that person to make a decision with practicable and appropriate support
- may have decision-making capacity to make some decisions and not others.

If a person does not have decision-making capacity for a particular decision, it may be temporary and not permanent.

It should not be assumed that a person does not have the capacity to make a decision:

- on the basis of the person's appearance
- because the person makes a decision that is, in the opinion of others, unwise.

A health practitioner needs to record on the patient's clinical records the reasons they were satisfied the patient did not have decision-making capacity.

So, for Mrs Brown, it is clear that you need to proceed with the procedure today to alleviate the pain. However, there should be further investigation into her cognitive function. The steps that you may need to take will be to initially speak with her daughter, as she has accompanied her mother today, and her GP, to illustrate your concerns about her ability to consent to treatment or decline treatment.

It should also be noted that Mrs Brown's capacity is situation-specific. The greater the complexity and/or conflict within the decision-maker's environment, the higher the level of cognitive function or emotional stability/mental health necessary in order to be considered capable. So for Mrs Brown, the considerations about the periapical pathology and the recurrent carious lesions would suggest that she is incapable of making her own treatment decisions.³



An adult is presumed to have decision-making capacity unless there is evidence to the contrary.

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THE DENTOLEGAL CONSULTANT'S PERSPECTIVE FROM DR RAJ DHALIWAL, DENTOLEGAL CONSULTANT AT DENTAL PROTECTION, MELBOURNE

Dental Protection would like to thank Dr Shnider for his interesting case study. Dr Shnider raises some very pertinent points, particularly with our increasing ageing population. We should not be quick to judge and remember that patients may still have the capacity to make certain choices. When patients are lucid, you should try to gain their consent to speak to their next of kin and GP. They may be able to provide information of when it would be best for the patient to attend the practice, as they are more lucid during certain times of the day and so are able to give consent.

Dr Shnider has also raised a very important point of making clear clinical notes and documenting what was discussed. It is important to be able to justify your decision, should the case arise, on why a patient may not have the capacity to give consent, or equally taking consent from those who are in the early stages of dementia.



Weight and see

Dr Robert Caplin, senior teaching fellow, King's College London Dental Institute, looks at how properly weighing up the various factors in a decision can benefit both practitioner and patient

Decisions, decisions... there is no doubt that we spend a lot of time making decisions, major and/or minor, that affect our lives, and of these many are around the area of purchasing goods or services.

In the competitive world that we live in, there is usually a wide choice and, while this is good, we will spend much time researching the advantages (benefits) and disadvantages (risks) of the various options before making a decision. We would like to think that the advice we are given is genuine and unbiased, although this is probably highly optimistic.

As dentists, we are providers of a service and our patients are the 'buyers' of the service that we provide for them. Can they be confident that the advice given is in their interest rather than the interest of the dentist?

The answer should be yes, because as a profession our relationship with those coming to us for care is defined and determined by certain standards set down by dentistry regulators around the world.

DIFFICULT DECISION-MAKING

What does this all mean for us practically? It means that we have to share with our patients the often difficult decisions that have to be made every day in dental practice to

answer the who, how, why, when and where questions about interventions that arise when looking inside a patient's mouth.

Dentistry is very stressful and contributing to this may be some incorrect assumptions, including that there is always a right, precise and perfect solution to a patient's problems, and this solution must always be found.

I want to focus on this misunderstanding and promote the idea that there isn't a probe that we can put on a particular tooth that will tell us what to do. Fill this one. Watch this one. Repair this filling. Put a post in that tooth. These are all decisions that are ultimately subjective and are, therefore, the reason for the variations that we see in care plans between different dentists, and even between the same dentist on different days and at different times.

There are several factors that contribute to these variations:

- undergraduate/postgraduate training
- time available
- financial pressures
- gender

- age

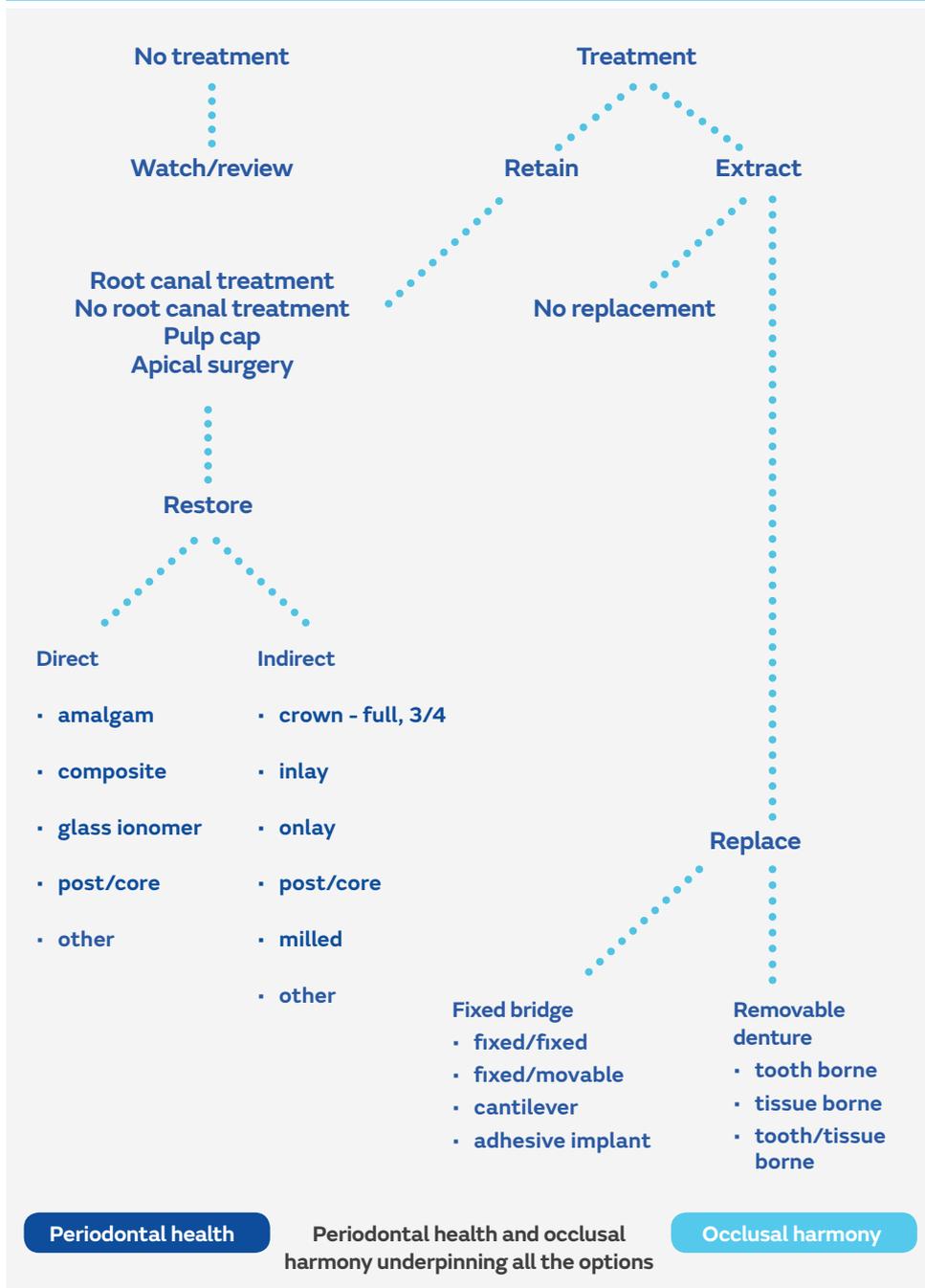
- the environment that one is working in – be it general or private practice, hospital or academic.¹

All of these will influence, more or less, our choice or preference for treatment, even when discussing the options with the patient before us. As human beings, we are not as consistent and reliable as we would like to think. Like it or not, our decisions are going to vary.

Clearly, we have to have a consistent approach when examining a patient, even though we may not have consistent outcomes, and then need to take a holistic view of their problems. Any treatment option, be it active or passive, has to be in the best interests of the patient. The patient has to be better off following the treatment and the dentist, too, has to derive benefit from the interaction – satisfaction from a job well done, patient appreciation and, in some settings, financial reward, although this latter point is not relevant to obtaining consent from the patient.

Our clinical decisions, therefore, can have far-reaching consequences for the wellbeing of our patients and for ourselves. An acceptable

Treatment options



line. The incisal edge of 11 is not level with the incisal edge of 21 (bruxing). The tooth has a range of colours.

The important questions to ask here are: what am I doing and why am I doing this? Whose interests are being served? The flowchart on the left will help to determine the treatment options.³

From this flowchart we can see two main options: **no treatment** or **treatment**.

Since the patient has requested an improvement, no treatment is not really an option, but she should be told that treatment is not required clinically, if that is indeed the case. Assuming that the patient wishes treatment, we have to look at the treatment options. Extraction would be an extreme choice and so should be discounted. The tooth is vital, so root canal treatment is not required, therefore moving on to the next level we can see that there are two main options here, **direct restoration** or **indirect restoration**.

Under direct restoration we can replace the filling with a tooth coloured filling material or cover the whole of the front surface of the tooth with a direct veneer in composite. Under indirect restoration, we can cover the front surface of the tooth with an indirect veneer or a crown, either of which can have a material of choice.

Now that we have established the options, which are you going to choose? How are you going to make this decision? Rather than do this on a subjective basis (gut feeling), we can try to introduce a degree of objectivity into the equation. It will, of course, depend on what the patient wants. We know she wants the appearance of the 11 to be improved because the filling doesn't look nice. So, we have to establish what outcome we, together with the patient, should aim for. This can be either making the filling look better and accepting the other 'faults' in the tooth, or attempting to make the tooth, in its entirety, look nice both on its own and in relation to its adjacent teeth. The two will require different solutions.

care plan is one that can be justified to a third, independent party should the occasion arise. I want to take you on the path of critical thinking so that we can meet the requirements of our regulators by giving our patients all the options with their risks and benefits, for example the Dental Board of Australia provides the Code of Conduct.²

Let's take a common clinical scenario:

This patient, a 70-year-old female, wanted the appearance of her upper right front tooth improved (Figure 1). The tooth is asymptomatic, vital and with no obvious periapical changes visible on the radiograph. The root canal in the upper right central incisor is patent and unobstructed. The gingival condition is acceptable.

Note the following: there is a vertical fracture

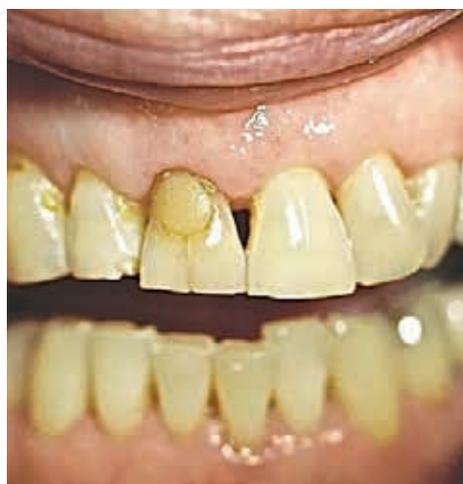
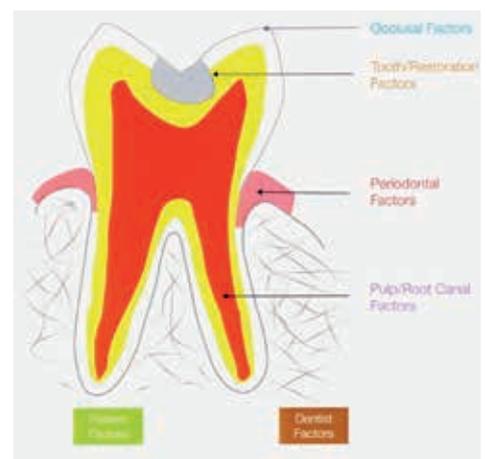


Figure 1. Patient wanted the appearance of her upper right front tooth improved. △

Figure 2. Modifying factors affect the treatment options and the decision outcome. ▷



There are modifying factors that affect the treatment options and the decision outcome, and it is important to take these into account for each of the possible options that we have selected above.⁴

For each of these options here are some points to consider:

OCCLUSAL

Is there evidence of clenching or grinding?
How much force will there be on the restored tooth? Is it necessary to alter the occlusion?

We can consider the options as follows:

	DIRECT - REPLACE FILLING	DIRECT - VENEER	INDIRECT - VENEER PORCELAIN	INDIRECT - CROWN
OCCLUSAL	Not relevant weighting 0	Incisal edge at risk weighting -1	Incisal edge at risk weighting -1	Can replace incisal edge Harder to blend in with occlusion weighting 1
TOOTH/RESTORATION	Minimal tooth tissue loss weighting 2	Some tooth tissue loss weighting -2	Some tooth tissue loss weighting -2	Much tooth tissue loss weighting -5
PERIODONTAL	Not relevant weighting 0	Potential risk to marginal gingivae weighting -1	Potential risk to marginal gingivae weighting -1	Potential risk to marginal gingivae weighting -2
PULP/ROOT CANAL	Little risk to pulp weighting 2	Slight risk to pulp weighting -1	Slight risk to pulp weighting -1	High risk to pulp weighting -4
PATIENT	Will not make whole tooth look better Low cost One visit weighting -5	Will meet patient's wishes Relatively low cost One visit weighting 5	Will meet patient's wishes Higher cost Two visits ? Temporary veneer Impression weighting 4	Will meet patient's wishes Higher cost Two visits Temporary crown Impression weighting 2
DENTIST	Quick Low skill level weighting 2	Quick Relatively low skill level weighting 2	Time Greater skill required Good laboratory support needed Failure harder to manage weighting 1	Time Greater skill required Good laboratory support needed Failure harder to manage weighting 1
	Total 1	Total 2	Total 0	Total -7

I realise that the allocation of weighting is subjective and will vary from dentist to dentist, as will the questions to be considered in each of the modifying factors. However, from the above, with a degree of objectivity, we can say that a direct composite veneer will be the best option to meet the patient's requirements.

All of the above can be discussed with the patient and s/he can then make a more

TOOTH/RESTORATION

How much more tooth tissue will be lost in restoring the tooth? Is an impression required? Is a temporary required?

PERIODONTAL

Is the tooth mobile? Is there pocketing around the tooth? Is there plaque associated with the tooth?

PULP/ROOT CANAL

Is a root treatment required? Is there a risk of pulpal damage/exposure? What is the status of the periapical tissues?

PATIENT

What does the patient want? Cost? Time/visits/impressions?

DENTIST

Does the dentist have the appropriate skill level? Appropriate experience? Adequate chairside support?

How these impact on each of the options will either be a benefit or a risk and can be weighted according to how much the patient or the dentist considers the impact to be on a scale of 1-5. A risk is given a negative rating and a benefit a positive rating.

informed decision about the treatment and the cost, and then sign a document confirming that s/he has been informed of the options, the risks and the benefits of each and the costs, and that the s/he has opted for treatment x.

There is no doubt that good judgment comes from experience and a lot of experience comes from bad judgment. We need to be reflective practitioners to reflect and learn

and so improve our clinical decisions, thereby reducing the risk element of our work.

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The business of dentistry

Dr Raj Rattan, dental director at Dental Protection, explains the importance of managing the relationship with patients when working in a general dental practice



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At the heart of every valued human interaction lies the notion of trust. Our world could not function without it.

Trust is one of the most important constructs in the dentist-patient relationship. It creates longer and more stable professional relationships, reduces the incidence of conflict, promotes satisfaction, reduces complaints and builds loyalty. It is, therefore, one of the key drivers of success in general dental practice.

WHAT IS TRUST?

There are many definitions of trust that identify credibility, benevolence, confidence in honesty and reliability as key components that can lead to trust being established. We make promises to our patients and our patients expect us to keep them. They expect us to be knowledgeable, skilful and competent. As Joseph Graskempner noted in his article in JADA: “dentists should gain the patients’ trust in them as reasonably knowledgeable, reasonably talented, caring dental health providers”.¹

CAN TRUST BE QUANTIFIED?

Degree of trust created = $(R \times C \times I) / SO$

R= reliability, C= credibility and I= intimacy are multipliers and self-orientation (SO) is the divisor.

Significantly, the greater the divisor, the lower the quantity of trust generated.

CREDENCE MARKETS

In economic terms, dental services fall into the category of credence goods. Patients don’t always know whether they need the suggested treatment, and in some cases even after they receive the treatment, they cannot be sure of its value. This is because the ‘buyer’ does not have the knowledge of the ‘seller’ – a feature of the dentist-patient relationship referred to as ‘information asymmetry’. It is this asymmetry that makes the credence

goods market particularly challenging because it may give rise to aberrant behaviours.

It is interesting to note the comments made in 2012 by Brown and Minor in their paper ‘Misconduct in Credence Good Markets’.² “Providers of technical advice are common in the automotive, medical, engineering, and financial services industries. Experts benefit from customers trusting and buying their advice; however, experts may also face incentives that lead them to provide less than perfect recommendations. For example, a mechanic can provide a more extensive fix than warranted and a dentist can replace a filling that has not failed.”



The consumer mantra has long been “caveat emptor” (buyer beware). It is not appropriate for the business of dentistry. It should be replaced with “credat emptor” – let the buyer trust.

The need for regulation to protect the consumer in the credence space is implicit. Another challenge is that perceptions of clinical success and failure in this market are largely subjective for patients, because there is no external verification. It is only because of trust that patients do not routinely seek to independently verify every transaction and clinical outcome.

KEY COMPONENTS OF BUILDING TRUST

Building trust should underpin a practice’s risk management strategy. Without this, any business risks loss of market share and loss of reputation. Trust can be built by making a commitment to:

1. Meet patient needs and preferences when it comes to service delivery.
2. Ensure patients feel cared for – we use the phrase care and treatment in our everyday language and tend to focus on the technical elements of treatment. Remember to show them you care.
3. Get it right when patients most need you – when they are in distress.
4. Manage expectations and create experiences built on continuity of care with individual clinicians. This builds relationships and fosters trust.
5. Improve communications – both clinical and non-clinical.
6. Ensure there is transparency in pricing.
7. Empower your frontline staff – the first contact with the team will form lasting impressions.

The consumer mantra has long been “caveat emptor” (buyer beware). It is not appropriate for the business of dentistry. It should be replaced with “credat emptor” – let the buyer trust.

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What happens when data is breached?

Karen Kumar, partner at Hicksons Lawyers, explains what your requirements are if you discover a data breach following the launch of the Notifiable Data Breaches Scheme

Read this article to:

- ✓ Understand what the Notifiable Data Breaches Scheme is about
- ✓ Learn how to manage and report a data breach
- ✓ Discover resources to help you with the requirements of the scheme

WHAT HAS CHANGED?

In February 2017, Federal Parliament passed the Privacy Amendment (Notifiable Data Breaches) Act 2017, and a year later – in February 2018 – the Notifiable Data Breaches Scheme (NDBS) came into effect. This means that health service providers regulated by the Privacy Act 1988 are now required to notify the Privacy Commissioner and affected individuals of an eligible data breach.

WHO DOES THE NDBS APPLY TO?

Dental practitioners as individuals, and practices, are obligated under the Privacy Act to secure personal, health and sensitive information, and are therefore required to comply with the NDBS.

WHAT IS A DATA BREACH?

A data breach occurs if there has been unauthorised access to, or unauthorised disclosure of, personal information about one or more individuals (the affected individuals), or if such information is lost in circumstances that are likely to give rise to unauthorised access or unauthorised disclosure.

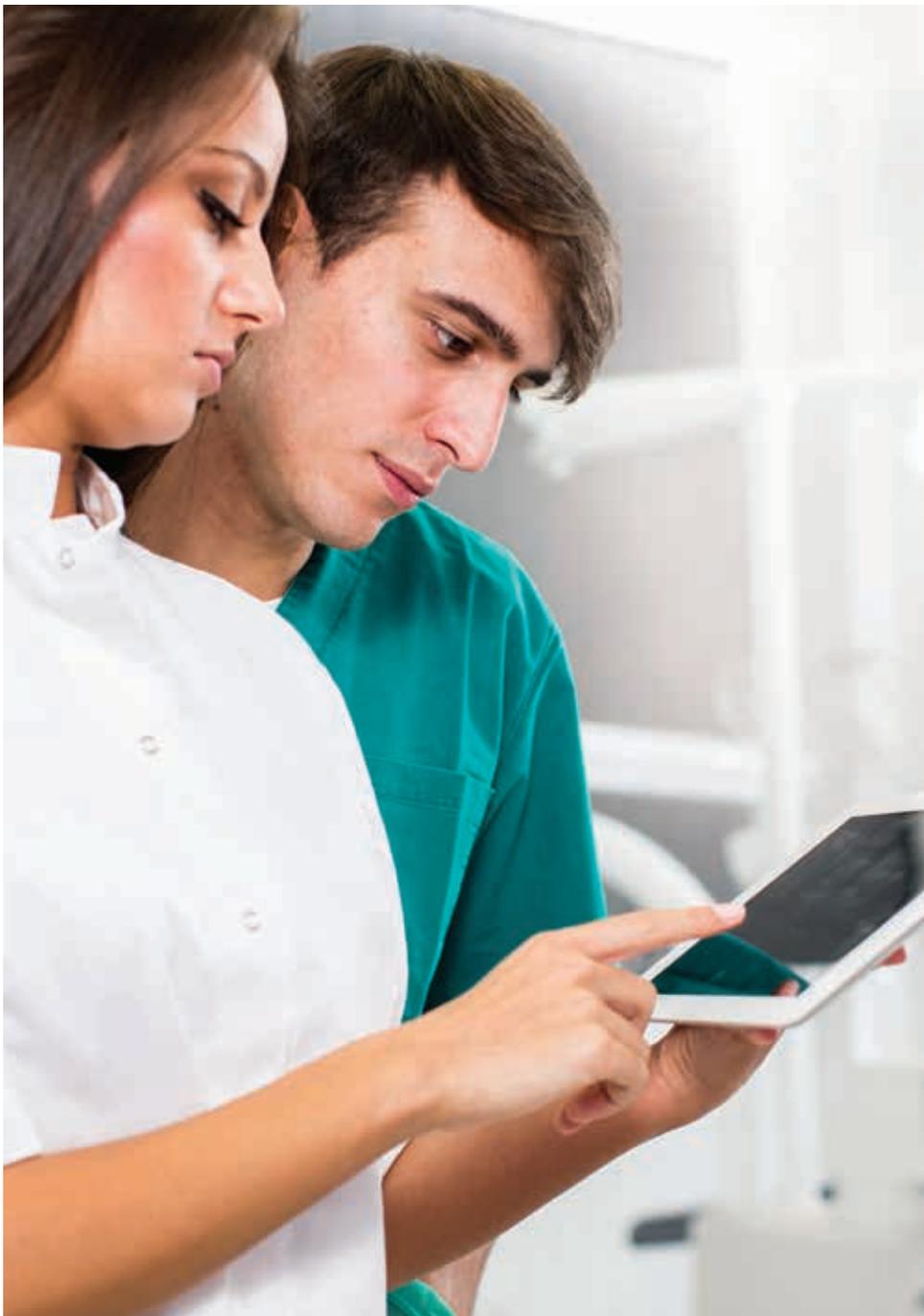
WHICH DATA BREACHES ARE REQUIRED TO BE NOTIFIED?

A data breach is an eligible data breach (and therefore a breach that must be reported) if a reasonable person would conclude that there is a likely risk of serious harm to any of the affected individuals as a result of the unauthorised access or unauthorised disclosure.

Serious harm includes:

- physical
- psychological
- emotional
- economic
- financial
- reputational.

There is a likely risk of serious harm if a reasonable person would be satisfied that the risk of serious harm occurring is more probable than not. In deciding whether this is the case, you are required to have regard to a list of “relevant matters” included in the Act.



If you suspect that an eligible data breach has occurred, you must undertake an assessment of the relevant circumstances. You are required to notify the Office of the Australian Information Commissioner (OAIC) and affected individuals as soon as practicable after becoming aware that there are reasonable grounds to believe there has been an eligible data breach.

These assessments are required to be undertaken and completed within 30 calendar days. While this is the maximum time, the OAIC encourages assessments to be completed as quickly as possible.

The OAIC states that at any time, including during an assessment, you can, and should, take steps to reduce any potential harm to individuals caused by a suspected or eligible data breach. If remedial action is successful in preventing serious harm to affected individuals, notification is not required.

There is an important exception to the notification requirement. If there is a data breach but you take action, and as a result of the action:

- there is no unauthorised access to, or unauthorised disclosure of, the information
- or
- there is no serious harm to affected individuals, and as a result of the remedial action, a reasonable person would conclude that the breach is not likely to result in serious harm then the breach will not be an eligible data breach.

HOW TO NOTIFY IF AN ELIGIBLE DATA BREACH HAS OCCURRED

The notification to affected individuals and the OAIC must include the following information:

1. the identity and contact details of the organisation
2. a description of the data breach
3. the kinds of information concerned
4. recommendations about the steps individuals should take in response to the data breach.

A form to notify the breach can be accessed at forms.business.gov.au/smartforms/landing.htm?formCode=OAIC-NDB

When notifying affected individuals, you have the discretion to notify either each affected individual or, if not all affected individuals are deemed to be “at risk” from an eligible data breach, only those affected individuals who are deemed to be at risk.



The OAIC states that at any time, including during an assessment, you can, and should, take steps to reduce any potential harm to individuals caused by a suspected or eligible data breach.

RESULTS OF A FAILURE TO COMPLY

Failure to comply with the requirements means the Privacy Commissioner has the power to:

- conduct investigations
- make determinations
- seek enforceable undertakings
- pursue civil penalties for serious or repeated interferences with privacy.

It is also possible that a failure to comply will result in referral to the Dental Council for consideration of disciplinary proceedings being brought against the practitioner.

WHAT SHOULD YOU DO NOW?

- Develop or update your data breach response plan: The plan should cover the actions to be taken if a breach is suspected, discovered or reported.
- Plan to utilise the eligible data breach exception: Having to notify customers of a data breach can cause serious damage to your reputation. If a breach occurs and if it is possible, the aim should be to take remedial action. A notification is not required because this action has prevented the data breach from causing serious harm to an individual.
- Review contracts with outsourced service providers: Contracts with outsourced service providers should be reviewed and, if necessary, updated in order to ensure that the provider is required to notify and work with you in the event of a data breach.

SUMMARY

Dental practitioners are now required to notify the OAIC of any unauthorised access to, or unauthorised disclosure of, or loss of personal information where a reasonable person would conclude that there is a likely risk of serious harm to any of the affected individuals as a result of the unauthorised access or unauthorised disclosure.

Subject to what information is disclosed or lost, it may be that a mandatory notification is not required as it is not likely to result in serious harm to the individual. Remedial action taken after a suspected or actual data breach may obviate the requirement to notify the breach.

In the event that you are uncertain of the steps required to undertake the requisite assessment or remedial action, or are uncertain as to your obligations to make a mandatory notification, then you should seek advice from Dental Protection. In order to ensure that you are up-to-date regarding the NDBS, you should refer to the below resources provided by the OAIC.

RESOURCES

Two of the OAIC's publications – the *Data breach preparation and response*¹ and the *Guide to securing personal information*² – provide useful information for practitioners and practices. An OAIC webinar entitled *Preparing for the Notifiable Data Breaches Scheme* may also be of assistance.

Visit oaic.gov.au/privacy-law/privacy-act/notifiable-data-breaches-scheme

MORE SUPPORT

In the event that you suspect a data breach has occurred and you are unsure as to what your obligations are, you should contact Dental Protection for advice. Call **1800 444 542** or email notification@dpla.com.au

REFERENCES

1. Office of the Australian Information Commissioner. *Data breach preparation and response*. February 2018. Available from: oaic.gov.au/resources/agencies-and-organisations/guides/data-breach-preparation-and-response.pdf
2. Office of the Australian Information Commissioner. *Guide to securing personal information*. June 2018. Available from: oaic.gov.au/resources/agencies-and-organisations/guides/guide-to-securing-personal-information.pdf



Case study

A failed extraction handled appropriately

A patient, who had originally been seen by another associate within the same practice six months earlier, attended with a new dentist complaining of a broken tooth. The new dentist identified deep caries in the 47 and carried out further investigations on the tooth.

After review of a radiograph, the tooth was deemed to be unrestorable. After speaking to the patient it was determined that he had been aware of deep caries previously and did not want treatment of the tooth, namely root canal treatment and a crown, both of which had been offered six months earlier. The patient had been prepared to wait until the tooth broke or caused pain, after which he would agree to an extraction at that stage.

There was no pain from the tooth, however as it was broken, the patient found that he was having difficulty with eating and this had prompted a return to the practice. The radiograph indicated the 47 was grossly carious and was broken below alveolar bone level; however, there was good bone and periodontal support. There was no evidence of apical pathology. The patient was advised of the risk that the tooth could break during removal and surgical intervention may be required. The patient was offered an option of a specialist referral at this stage. The patient wished for the tooth to be extracted at the practice and so was also informed that whilst all attempts would be made to remove any broken root, if this was not possible an onwards referral would be required.

The patient was booked for an appointment three days later and as expected, the tooth fractured

during removal, leaving the distal root in situ. The dentist attempted to remove the root, however was unable to mobilise it and after 25 minutes stopped the treatment. The patient was informed of what had happened and that a referral would be required. The patient was not charged for this appointment by the dentist and the referral was duly made.

Two days later the patient returned in pain and saw another associate at the practice. A diagnosis of dry socket was made and appropriate treatment provided. At this point the patient questioned why antibiotics had not

been prescribed at the time of extraction and questioned how long they would need to wait for the referral.

One week later a complaint letter arrived. The patient wanted another explanation as to why antibiotics were not prescribed as soon as the dentist knew the root had broken and expressed concern that the dentist had been aggressive and rough during the extraction process.

The dentist requested assistance from Dental Protection and was advised to send a detailed reply to the patient outlining the consent process, technique of extraction and postoperative care and management of the patient.

The patient accepted the explanation and no further action was taken.



The patient wanted another explanation as to why antibiotics were not prescribed as soon as the dentist knew the root had broken and expressed concern that the member had been aggressive and rough during the extraction process.

LEARNING POINTS

- It is essential that a patient understands what to expect from treatment, both in terms of the procedure itself and any likely outcomes.
- A clear record of the consent process, as well as the pre and postoperative advice given to a patient must be entered in the notes.

Case study

A lacerated cheek



A dentist received a letter of complaint from an elderly patient who had sustained a soft tissue injury to the lining of the left cheek during the restoration of a lower left third molar three months earlier.

At the time the dentist had secured haemostasis with sutures, recorded the incident in the clinical notes and offered his sincere apology to the patient.

In his letter of complaint the patient stated that he wanted recompense for negligence and his unpleasant experience. When the letter of complaint was received, as a gesture of goodwill, the dentist decided to refund the cost of the restoration and to waive the charge for his next routine dental examination. The patient was not satisfied with this and stated in his letter that he was



the patient was very likely seeking some compensation for what he considered was negligence on the part of the dentist leading to an unpleasant experience.

considering taking further action with his complaint. The dentist sought assistance from Dental Protection.

Dental Protection advised the dentist that despite accidents like this occasionally happening during dental procedures, it might be considered that the cheek was insufficiently retracted and therefore there was a breach of duty of care to the patient. However, it was recognised that the injury was transient, probably no worse than could have been sustained by cheek biting and the patient would have likely recovered. In complaining three months after the incident, the patient was very likely seeking some compensation for what he considered was negligence on the part of the dentist leading to an unpleasant experience.

Dental Protection advised the dentist to write a further letter to the patient, offering an apology and explaining that despite endeavouring to provide treatment in a caring and considerate manner, treatment of the molars at the back of the mouth requires the retraction of the soft tissues (tongue and cheek) which can be difficult, and occasionally these soft tissues may be accidentally damaged despite the best efforts of the dentist.

As with cheek biting, any small injuries in the mouth heal very quickly and there is rarely any long-term damage. The dentist mentioned that if the patient had contacted

him in the days or weeks immediately following the incident, he would have been pleased to have provided all necessary care. The dentist then went on to say that he hoped that the patient would be happy with the explanation, reimbursement of the costs of the restoration and, if not, then could he write again outlining what he would consider a suitable response. No further correspondence was received from the patient.

LEARNING POINTS

- **If an unexpected outcome arises whilst treating a patient, keep them informed.**
- **There is no automatic admission of liability in sharing a suboptimal outcome with a patient.**

Case study

The retained root and consent



A patient consulted a new dentist for the first time, complaining of problems with a broken tooth.

The patient had not seen a dentist for many months prior to that and was aware that the tooth had been progressively breaking; as she was now experiencing discomfort, she wanted the tooth to be removed. The tooth that was breaking was the 23 and was a cantilever bridge abutment for a missing 22. The patient explained that she was keen to have implants provided in the near future as she did not want gaps at the front of her mouth, nor did she want another bridge.

The dentist carried out the usual assessments and investigations and took a periapical x-ray of the area, which identified a grossly carious 23 with a periapical area. Even though the x-ray image was not clear, with good lighting, a buried root could also be seen at 22. The dentist did not record that a retained root was present at 22; however, he did recall telling the patient of it at the subsequent appointment, advising that as it was deeply buried and not causing problems it could be left in situ. At the appointment to remove the carious 23, surgical removal was required as the tooth was so grossly decayed. The dentist raised a flap, removed the tooth and sutures were placed. The patient did not return for a review and the dentist did not see the patient again.

Two years later, the dentist received a letter of complaint. The patient reported that six months after removal of the broken tooth (23), she had attended another practice to discuss implant treatment at the site of the 23. The new practitioner had advised the patient that in order to go ahead with dental implant treatment, she would need to have the retained root (22) removed first as it was at the site where an implant would be placed. This would involve a surgical procedure, followed by a period of healing prior to implant

placement. The patient was confused as she was not aware of the retained root of 22 and understood that the root of 23 had already been removed six months earlier. The new dentist showed the patient the retained root, identified following a cone beam CT scan and which on careful review was also visible on a PA film that had been exposed.

The patient's complaint to the earlier dentist was that he should have identified that there was another root present six months earlier and, had she been told of its presence or that it may need to be removed to have implants, she would have opted to have it removed at the same time even when there were no symptoms.

The patient would have preferred to avoid a second, additional surgery, and could have avoided waiting another six months for healing. The dentist could recall telling the patient about the root, but the records did not reflect the conversation and there was no report in the records that a retained root at 22 was present. The dentist's view was that even if he had identified it, as it was asymptomatic at the time, he would not have removed it, as there was no indication for its removal and this would have been the advice given to the patient.

Dental Protection suggested to the dentist that his records did not reflect the nature of the conversation that took place with the patient when she first attended with the broken 23. This was identified as an area of vulnerability. Concern was also raised in that the patient was not informed of all the risks or options of leaving a root in situ, including that a second surgical procedure would be required if it needed removal in the future prior to implant placement, and therefore it could be argued that valid consent had not been obtained when the 23 was extracted.

Dental Protection discussed with the member whether they would be prepared to offer a refund of the cost of the extraction at 23 in view of the patient's dissatisfaction, or alternatively consider offering a contribution towards the cost of extraction at 22. It was considered that as the surgery to have the 22 removed could have been avoided, a contribution to this amount would be preferable. The patient was asked to send a copy of the treatment plan and invoice from the new practitioner to demonstrate the cost to have 22 extracted. With Dental Protection's advice and assistance, a letter was drafted that offered the patient an apology, and the complaint was resolved with a contribution towards the cost of the extraction of the retained root at 22.

LEARNING POINTS

- Ensure that the records accurately represent the true nature of any conversation that takes place and the advice given.
- The material risks need to be discussed with patients, which should be tailored to the specific patient. This includes giving the patient information about the treatment options and pros (benefits) and risks (cons) of these options.
- In this case, the patient had explicitly expressed that she wished to have implants placed in the edentulous sites and the material risk of leaving the root in situ was not identified or discussed.



Case study

Minimally invasive management of caries

A patient attended an appointment, where the dentist's examination and bitewing radiograph identified caries beneath a pre-existing amalgam filling. The patient returned two weeks later for an appointment for a filling to be placed on tooth 34. The patient's notes record that the tooth was restored with a distal reinforced glass ionomer cement (GIC) placed under local anaesthesia. The patient was warned of postoperative sensitivity and occlusion was checked. The patient was advised to return for a review six months later.

The patient subsequently complained to the practice, reporting that they had experienced discomfort the day after the filling was placed. The filling had cracked and so the patient attended another practice and was told there was a dark shadow beneath the filling and that decay was present. The patient was concerned that the filling had failed and that decay had been missed. The dentist was a member of Dental Protection and contacted them for advice.

The member was newly qualified and had been taught techniques of minimal intervention dentistry. This is a recognised, evidence-based approach that preserves tooth structure and allows removal of infected dentine with hand instruments and the placing of fillings over affected dentine. It uses GIC to allow remineralisation of the

previously demineralised tooth structure. The approach requires focus on careful case selection, cavity design and control of risk factors.

The member's view was that all soft decay had been removed and clarified that, in circumstances where there was a risk of nerve exposure, it was her practice to use a stepwise technique for the removal of caries and leave a layer of discoloured dentine. The treatment plan was then to review the tooth at a later date once reparative dentine had been laid down, and replace the restoration at that point to reduce the risk of endodontic treatment being required.

The member responded to the complaint, explaining the clinical procedure and advising that the filling would have been replaced free of charge had the patient returned to the practice. The patient responded that the approach taken to treating the tooth had not been explained to her and she was concerned that the filling had failed and required replacement so soon after being placed.

A further response was made to the patient apologising for the lack of clarity in the advice given and the situation was resolved with the patient accepting a refund of the cost of the original restoration. The patient returned to see the dentist six months later and a definitive restoration was placed.

LEARNING POINTS

This case emphasises the need to ensure clear communication with the patient, and to document the information shared in the patient's records, along with the treatment plan and rationale. With a minimal intervention approach the records should document that the patient is made aware of the need for regular review, likely repeat bitewings, and the focus on preventing decay with fluoride, dietary advice and good oral hygiene. Patients should also be made aware that GIC fillings may need replacement and may not be recognised as a permanent restoration.

If the case had progressed to a clinical negligence claim and caries had been identified on the x-ray, and if the patient's records had not demonstrated that a clear discussion had taken place with the treatment approach and the patient's consent to this, then there may have been some vulnerability to an allegation of failure to diagnose and manage caries appropriately.



Case study

The case of double prescribing

Following a 12-year period of non-attendance, a patient visited the dentist due to recurrent pain at 37. His mouth was healthy overall with no previous restorations. There was, however, a history of recent pain and swelling associated with 37.

Following an examination, a diagnosis was made of cracked tooth syndrome at 37 with irreversible pulpitis. The options for treatment were discussed, including attempting restoration with root canal treatment and later placing a crown, or extracting the tooth. On considering the cost implications and the time involved with restoring the tooth, the patient opted to have the tooth extracted.

The following day the 37 was removed under local anaesthetic without complication. Although the extraction was uneventful, the patient was given a prescription for antibiotics by the practitioner on account of the prior history of pain and swelling from the tooth.

The next day, further pain was experienced and the patient re-attended with the same practitioner. The dentist thought that he was giving a different, second antibiotic to take in conjunction with the first. Instead the patient was given a further prescription of the same antibiotic.

The dentist based the prescription on the previous day's record, but this was inaccurate. The record entry stated that the first prescription was for amoxicillin, when in fact, metronidazole 400mg had been prescribed. When the patient returned the next day,

another course of metronidazole 400mg was prescribed, which he took as he was not aware that he could not take both together.

The patient became increasingly nauseous and dizzy and subsequently attended his local hospital for blood tests. No admittance was required, however he underwent blood testing with, arguably, associated discomfort and inconvenience.

The patient wrote a letter of complaint and requested compensation for the avoidable pain and suffering that he had experienced. The dentist sought assistance from Dental Protection, and the case was able to be resolved directly with the patient without escalation into a formal legal claim involving solicitors.

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The dentist sought assistance from Dental Protection, and the case was able to be resolved directly with the patient without escalation into a formal legal claim involving solicitors.

LEARNING POINTS

- Based upon the record of the clinical findings, there was no clear indication for antibiotics following the extraction. When the patient returned with postoperative pain, once again there was no evidence to suggest any sign of infection which would justify prescription of antibiotics were required. There was therefore a vulnerability in the dentist's position from this.
- No medication should be prescribed in the absence of clear justification. Antibiotics must only be used in accordance with the protocols contained in the *Therapeutic Guidelines Oral and Dental Version 2*.
- A further issue arose from the inaccurate record entry relating to the original prescription, and this was compounded by the effects of the second course of metronidazole. It was clear that on various levels the position of the dentist was difficult to defend and an early resolution of the case was sought to avoid a potentially problematic escalation.
- It is important to ensure records are accurate. This can best be achieved by completing entries contemporaneously with the treatment to which they relate.

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