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Risk management from Dental Protection

Dental Protection

RISKWISE

ISSUE 17 | **JANUARY 2018**

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EDITORIAL

Dr Raj Rattan MBE
Dental Director

Hello and welcome to your January 2018 edition of *Riskwise*. As Dental Protection's flagship publication, *Riskwise* offers the latest information on dentolegal topics and advice from our dentolegal advisers and professional experts.

IN THIS ISSUE

In this edition, we ask whether it is acceptable to use your mobile phone to share dental images with colleagues online. Dentolegal adviser Dr Philip Johnstone considers the advantages and pitfalls associated with digital photography and using your own mobile phone. We also provide advice on handling the media when a patient complains to a journalist. In addition, I use this opportunity to talk about safer practice, specifically discussing the value of checklists.

A real highlight in this issue is an interview with our new Regional Director for Asia, Harris Shum. We are incredibly excited about what Harris' appointment means for Dental Protection and members in Malaysia, and his arrival coincides with the opening of our new office in the region.

While Harris will be overseeing things from an operational point of view, he will be an excellent source of information on how well we are meeting the needs of you, our members. It has been clear from your feedback that you want us to be more local and in tune with your requirements, and Harris will spearhead this move in a way that can only mean further improvements to your service.

It is also a statement of how we want to continue supporting dental professionals in Asia for many years to come. We're proud to have supported thousands of members in the region over the past 45 years, and have seen many other organisations come and go; we are committed to many more years of providing you with support, advice and protection.

CASE STUDIES

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

ANNUAL REPORT FROM MPS

MPS's latest Annual Report and Accounts is now available on our website.

The report contains MPS's full financial statements, together with our strategic report, report of the Council and statements by Professor Kay-tee Khaw (Chairman of the Council), Simon Kayll (Chief Executive) and Howard Kew (Executive Director – Finance and Risk).

In previous years, MPS has posted a summary version of our Annual Report and Accounts to all members worldwide. Following feedback from members, the report will no longer be posted out and, instead, will be published in full on our website each year, representing a cost saving for members.

To view the report, please visit the About section of **dentalprotection.org**.

Thank you for taking the time to read *Riskwise*. I hope there's something useful for every aspect of our profession, but if there's something you'd like to see change or other topics you'd like us to cover, we're always keen to hear your feedback.

Best wishes

Dr Raj Rattan MBE

Dental Director
BDS MFGDP FFGDP Dip.MDE FICD

YOUR QUESTIONS ANSWERED

Our newly-appointed Regional Director for Asia Harris Shum answers some of your most frequently asked questions

IS IT TRUE THAT DENTAL PROTECTION HAS A REGIONAL OFFICE IN SOUTH EAST ASIA?

Yes, the office opened in 2017. We have listened to your feedback and received the clear message that you want the organisation to be more local.

Dental Protection is proud to have supported thousands of healthcare professionals since its inception. Whilst many other organisations have come and gone, we want to continue supporting professionals in Asia for many years to come.

HOW DOES DENTAL PROTECTION SET MEMBERSHIP SUBSCRIPTIONS?

When setting subscriptions, we carry out a detailed and robust actuarial assessment of the cost of supporting members in each country. This involves looking closely at trends in both the cost of individual claims and the number of claims in each area of practice in your country.

We then undertake a detailed analysis of the number of claims and cases experienced by members in this group, the cost of assisting with those claims, and estimate the likelihood of claims arising in future for each specific area of practice.

In addition, we look at how much it costs to provide member benefits and any non-claims costs, such as assisting with cases before the dental council, and estimate how much those costs could go up in future years.

We build this into subscriptions so that we have enough funds set aside as reserves for future assistance. We then set subscriptions to meet the future likely cost of the risk that members face. This means that we can be confident of being there for you, offering you the best protection available throughout your career and beyond.

WHY ARE SOME OTHER COMPANIES CHARGING LESS THAN DENTAL PROTECTION?

Companies may offer different products with different terms and conditions, including market entry strategies, which can lead to price difference. This happens in every industry: new entrants or opportunistic players may enter a market with lower pricing, and then exit it when there are no profits in the short to medium term. However, given that it can be many years between an incident happening and a claim being made, it is crucial that dentists ask themselves whether their provider of professional protection is offering a long-term solution.

Dental Protection has decades of experience in dealing with complex clinical negligence cases in Asia. We're able to use this experience to more accurately price the risks and defend dental members when in need.

Unlike other companies, we have a team of dentolegal experts who are available to respond to your urgent queries and dentolegal emergencies 24 hours a day. As dentists themselves, they can offer impartial advice to help you resolve problems arising from your clinical practice.

We also provide unique education and risk management to dentists through a series of educational programmes. These workshops and online learning resources provide ongoing learning and development opportunities to help you avoid complaints and claims. These are added benefits of membership with us in addition to your right to request indemnity.

Dentistry is endlessly adapting to change. Our business model has flexibility which means we can offer help in unusual circumstances, or where developments in the delivery or regulation of dental care gives rise to new issues.

WHAT MAKES DENTAL PROTECTION MEMBERSHIP DIFFERENT TO AN INSURANCE COMPANY?

I have worked in the insurance sector for almost two decades and can identify many differences between Dental Protection and traditional insurance companies. In the commercial world, traditional insurance companies are profit driven and may enter the market with attractive pricing strategies, leaving the market when claims start to flood in over the subsequent years.

Our organisation has looked after dental members in Asia for more than 45 years without leaving the market, whereas many insurance companies have come and gone.

WILL YOU AUTOMATICALLY REFUSE TO RENEW MY MEMBERSHIP IF I HAVE A CLAIM MADE AGAINST ME?

We would not automatically refuse to renew your membership based upon a claim being made against you. Complaints and claims are a recognised risk when practising dentistry, and as an established provider of indemnity to the dental profession, we understand these risks and want to work with you to help prevent incidents occurring. Our approach to managing risk is to carefully balance the needs of individual members with those of the whole membership.

MORE ADVICE

To keep abreast of dentolegal news or if you need advice, visit **dentalprotection.org**

THE DEVICE IN YOUR POCKET

Is it acceptable to use your mobile phone to share dental images with colleagues online? Dentolegal adviser Dr Philip Johnstone touches on the advantages of digital photography and the potential dentolegal pitfalls in using your own mobile phone

THIS ARTICLE WILL HELP YOU UNDERSTAND:

- **Photographs taken in the surgery form part of the clinical record which is subject to Data Protection Regulation**
- **Obtaining consent to share images online within a closed group**
- **The alternatives to using the camera on your mobile or hand phone**

Most people have a mobile phone; sometimes more than one. With the increasing use of social media and competition amongst manufacturers, mobile phones are now equipped with high resolution digital cameras. How often would it be useful to take a photograph of a patient's teeth using our own mobile?

Advantages of clinical photography

1. Creating a "baseline" record of the patient's presenting condition
2. Recording progress and development of the above
3. Improved usefulness of referral correspondence
4. Improved clinical record keeping
5. Assistance with the consent process
6. Patient education and communication
7. Improved laboratory communication
8. Self-education
9. Gallery of photographs to demonstrate treatment options
10. Oral pathology
11. Treatment planning

Before you start taking photos here are some considerations to bear in mind:

CONSENT

When taking a photograph you must respect patient's privacy and dignity and their right to make or participate in decisions that affect them.

The photograph should only be taken with appropriate consent, ensuring the patient was under no pressure to give their consent. The patient must be aware what the purpose of the image is and how it will be used. This consent process should be fully recorded in the patient's records.
The photograph must not be used for purposes beyond the scope of the original consent, without further consent having first been obtained.

CONFIDENTIALITY

Confidentiality is central to trust between clinicians and patients. Without assurances about confidentiality, patients may be reluctant to seek treatment or to share all the information needed by the clinician in order to provide the most appropriate care. But information sharing by medical and dental teams is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.

Photographs taken in the course of the patient's care, form part of the clinical record and should be treated in the same way as written material in terms of security and decisions about disclosures.

PERSONAL DATA PROTECTION STANDARDS (2015)

The Standards document requires that all public and private organisations are legally obliged to protect any personal information they hold. In relation to this, any individual who takes a photograph of another individual using the camera on their mobile phone, subject to exceptions such as for limited household purposes, will be processing personal data and must comply with the Standard in relation to the circumstances in which the photograph is taken and the use of that photograph. The use of camera phones and other photographic devices can result in the creation of sensitive personal data such as the racial or ethnic origin of the individual or information about an individual's mental or physical health.

You must obtain the patient's consent, which should usually be in writing, to make a recording that will be used in a widely accessible public arena such as the internet, regardless of whether or not you consider the patient will be identifiable from the recording.

BIOGRAPHY

Dr Philip Johnstone

BChD MFGDP(UK) DipResDent FFGDP(UK)

Philip works as a dentolegal adviser for Dental Protection. He practised in a mixed general dental practice and was a chair of the UK's General Dental Council Fitness to Practise Panel. He obtained his Fellowship in General Dental Practice in 2010 and is currently a fellowship assessor. He also holds the Certificate in Mentoring in Dentistry.

SUMMARY

Any image, whether it is anonymised or otherwise, forms part of the dental record, so this data must be stored and processed in accordance with the Standards document. It is therefore not acceptable to be carrying images of patients on your mobile phone or electronically sharing them with other devices in your possession (for example, synchronised via "the cloud"); there is clearly a risk of the data being lost or stolen.

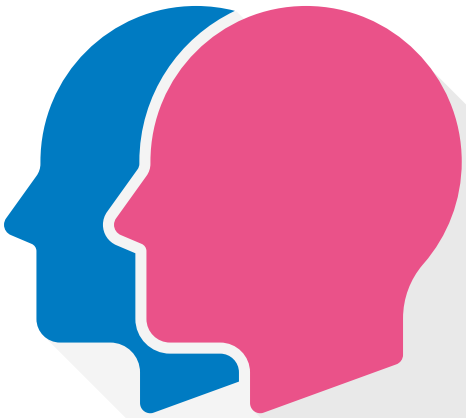
As the individual dentist is a data user who has an obligation to collect, store and use patient data correctly and if the images were lost, the dentist would have a duty to notify their employer/principal and the patient, which could lead to difficult questions being asked.

If there is a clinical need or a desire to take images for diagnosis or education purposes it is not appropriate to use personal cameras and mobile phones. Agreement by a patient to take a photograph does not obviate your obligations to an employer, or your duties of confidentiality.

There are ultimately no circumstances, save for emergencies, when taking patient images on a personal mobile phone, whether or not you have their consent, is justified, so it should not be done. A dedicated digital camera, linked to the practice computer system storing patient details, offers a more secure method of storing photographic data. The practice record keeping system will already be compliant with current standards and will allow the sharing of images between colleagues if the patient has given their consent. But the unintended risks that might arise if a mobile phone is lost or cloud-sharing software is engaged, will have been eliminated. It also looks more professional!

HANDLING THE MEDIA – WHAT HAPPENS WHEN A PATIENT COMPLAINS TO A JOURNALIST

Raj Pattni, a Dental Protection press officer, looks at the best strategies to adopt if you suddenly find yourself in the news as a result of a patient contacting them



While most dentists will have received a complaint from a patient who has taken the trouble to contact them personally, in some cases, unhappy patients are reluctant to complain directly to the dentist who provided their treatment – they go straight to the local newspaper instead.

If a journalist feels there could be a story worth investigating, they may contact the practice, dentist or staff member at the centre of the complaint. When dealing with newspapers, it is important to remember the very tight restrictions imposed by the Dental Council about advertising. In other words, nothing in any news article should be seen as promoting the business or you as an individual dentist.

WHAT WOULD YOU DO?

The following scenarios are two very common examples of situations in which members may find themselves, and something that the Dental Protection press office may be able to assist you with.

In the first instance, you may only hear that a patient is unhappy with the treatment provided after being contacted by a journalist. If a patient has not previously contacted the practice to formally complain, you may not realise they were not entirely satisfied with the service you provided.

Secondly, you may believe that the story as told to the journalist is a distortion of the facts and wish to give your side in full to set the record straight.

TOP TIPS

If you are contacted by a journalist about a patient complaint

- Note the outline of the story
- Take journalist's contact details
- Check their deadline
- Alert Dental Protection
- Remember your duty of confidentiality

SCENARIO 1:

A journalist from a newspaper contacts you at 10am to say they've received an email from an unhappy patient. The journalist wants a response from you about the treatment you provided and your thoughts on what the patient has said by 4pm, as they want to use the story the following morning.

It is important to know who exactly the journalist is and which patient complained so that you can provide an appropriate response.

Make some notes about the story the journalist is writing – who is involved, what is being alleged by the patient, is anyone else being asked about the story. Ensure you also take contact details for the journalist.

Avoid giving any comments or answers immediately – it is important you take time to consider what you want to say in response. You also need to be mindful of your responsibilities to the patient and the over-arching duty of confidentiality you have. Remember that without the patient's express authority you cannot make any comment to the journalist about that person's care.

Journalists often work to tight deadlines, and so you may find that you have only a short time to write a statement. In this scenario, they've given you just a few hours to respond, so it is important that you try and put together a statement by the deadline. In the event that you are unable to provide a statement by the deadline, the story could be published with a comment saying you were asked for a comment, but did not provide one. It is more beneficial for you to have a statement responding to the journalist, rather than simply saying "no comment".

Dental Protection can help you prepare a statement. When you contact us for assistance, it is important that we know the deadlines involved; be sure to ask the journalist where and when the story will be published. You may find that it is both online and in print. Read the story carefully once published and be on the lookout for any factual inaccuracies. We can also help you to have such errors corrected.

SCENARIO 2:

Following a complaint from a patient, a journalist has written an article about you in the paper. Your patients, family and friends are likely to see it and this could impact on your professional reputation. The story is a generally true reflection of the facts of the case, but there are a couple of inaccuracies.

In this scenario, the journalist who has written a story about the treatment you provided has not contacted you for any comment. Instead, they have written the story entirely from the patient's point of view.

It can be quite surprising to open a local paper and see a story mentioning you or your practice, and perhaps even alarming if you are mentioned in a story alleging poor treatment. If you read a story about the treatment you provided, you may find that the story uses very emotive language or perhaps that the story, as written, is a slightly exaggerated account of events.

There might be a temptation to phone the journalist to set the record straight and detail what actually happened during treatment, but remember your duty of confidentiality to the patient. Discussing any conversations or treatment provided without the patient's consent would be a breach of duty – even if the patient has the details of what happened.

Where there are factual inaccuracies in the account however, these can be corrected as long as the inaccuracies do not relate to clinical detail. If you are looking to have something corrected in the news, it is likely that a number of days may have passed since the article was published. Any corrections issued a few days after the publication, may give the story further publicity that keeps it in the paper, or near the top of their website, longer.

If the factual inaccuracies are unlikely to cause you significant distress or reputational damage, there may be greater benefit in letting the story be. News stories do not tend to linger that long and are soon replaced by other news.

WHEN TO CONTACT DENTAL PROTECTION

If you find yourself experiencing either of the scenarios above, or if you receive media attention as a result of clinical practice, the Dental Protection press office is available to offer advice and deal with journalists on your behalf.

While it can be worrying to be approached by the media, contacting Dental Protection as soon as possible allows us to help you to try and avoid any prolonged exposure in the news.

BIOGRAPHY

Raj Pattni is a press officer in our Press Office. If you believe there could be news interest in a particular incident you have contacted us about, please alert the dentolegal adviser so that they can put you in touch with the Press Office Team.

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SAFER PRACTICE

Dental Director Dr Raj Rattan MBE discusses the value of checklists

All professionals are vulnerable to making mistakes – even the very best. Our brain is full of knowledge and experience and it is challenging to analyse and apply that information during our work without the risk of sometimes getting it wrong. There has been a proliferation of research in recent years to identify root causes, human factors and the impact of systems design within healthcare.

WORKLOAD

There are many ways we can prevent errors arising, ranging from the design of clinical procedures and effective communication to the broader aspects of working conditions and culture. Many dentists work under the time pressures created by their workload and the need to achieve targets.

Research has shown that working under these conditions can increase the likelihood of errors significantly. Many members cite time pressure as the root cause of omissions and/or mistakes as a significant factor in adverse outcomes.

In a recent case a member observed "I just wasn't thinking properly. I was running late and we were short staffed...this was waiting to happen". He faced a surgical complication at a time when the nurse was out of the room to locate some instruments he required for the procedure.

When mistakes arise, we must determine why the human error occurred. In other words, we must review and reflect upon the so-called causal chain. It could be a system-induced error (for example, an omission like failing to take a peri-apical radiograph for a planned difficult extraction because of time pressure) or at-risk behaviours (using an inappropriate instrument to elevate a retained root resulting in instrument fracture). For every human error in the causal chain, there must have been a corresponding reason. It is the cause of the error which then leads to prevention-based strategies, not the error itself.

One simple and effective method to reduce error incidence is to use checklists. Checklists can be easily designed according to evidence based and personal working preferences to include pre-procedure elements (such as list of required instruments, patient consent or the need for a pre-operative radiograph assessment), in-procedure elements (this may include patient communications and adherence of clinical protocols) and post-operative requirements (patient advice and follow-up care requirements, for example).

DO CHECKLISTS WORK?

In his book, *The Checklist Manifesto*, Atul Gawande, Professor of Surgery at Harvard Medical School, draws on his experience as a surgeon and notes that checklists "not only offer the possibility of verification but also instil a kind of discipline of higher performance."

He discusses errors of ignorance (lack of knowledge), and errors of ineptitude (we don't make proper use of what we know) and suggests that clinical procedures are now so complicated that mistakes are inevitable in the stress of the moment.

In everyday decision making in clinical practice, we rely on our experience and lean towards what has been described as "fast thinking" by Nobel Prize winner Daniel Kahneman. His work on human judgment and decision making is based on the premise that people have two systems of thought - fast and slow - which are described as system one and system two thinking.

TWO SYSTEMS OF THINKING

System one – fast thinking – is largely automatic and intuitive, whereas system two thinking is more deliberate and effortful. Most of the time we rely on system one thinking; we could not cope with everyday life if every decision and act had to be logically thought through. In the context of clinical care, he surmises that physicians are taught to toggle between system one and system two thinking. He contends that workload pressures may make this very difficult to achieve, forcing us to default to system one based judgments and diagnoses.

What then is the connection between Gawande and Kahneman? The discipline of using checklists forces us towards system two thinking. It means that our decision making and intervention are fully thought out and rational.

Whilst checklists can serve as useful "aides memoire", we must remember they are not a panacea and do not replace process simplification and critical reflection.

RESOURCES

1. Atul Gawande, *The Checklist Manifesto: How to get Things Right*, Metropolitan Books; 2009
2. Daniel Kahneman, *Thinking, Fast and Slow*, Penguin Books; 2012

Case studies are practical examples of claims and complaints that have been faced by members, and we offer learning points and guidance for you based on these situations.

CASE STUDY

LONGSTANDING PERIODONTAL DISEASE

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

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

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

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

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

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

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

LEARNING POINTS

- Keep detailed records of all discussions with patients regarding advice and treatment.
- Ensure that patients clearly understand the significance of periodontal disease and the likely outcomes should treatment advice be ignored.
- Use every appointment as an opportunity to remind patients with periodontal disease of the need to maintain good oral hygiene.
- Keep adequate notes of home care advice given to patients and the importance of flossing, brushing and smoking cessation.
- Patients should be actively involved in their care, rather than just being a passive receiver of treatment.
- Ensure periodontal disease is identified, recorded and monitored appropriately in accordance with current guidelines.

INAPPROPRIATE PRESCRIBING OF ANTIBIOTICS

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

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

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

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

LEARNING POINTS

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

GUIDELINES ON PRESCRIBING

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

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

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

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

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

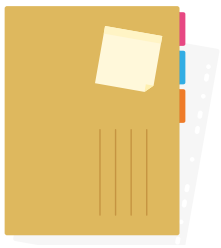
In addition, the national guidelines for this jurisdiction advised that the antibiotic prescribed was not regarded as being the third choice antibiotic for the treatment of dental infections; the guidelines in that jurisdiction suggested clarithromycin as the alternative antibiotic of choice. The expert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

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

LEARNING POINTS

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

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



COMMUNICATION AND CHANGE OF DENTIST

A patient received a letter from his dental practice explaining that his care would need to be transferred to a new dentist. Later, the practice owner received a complaint from this patient. No concerns had been raised about the clinical care, so the letter came as something of a surprise. However, the letter did raise a concern about the lack of information provided to the patient over the changeover. He later said that he had felt pressured into choosing a new dentist at short notice and this had motivated the complaint.

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

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

The new dentist was introduced to the patient and was able to provide reassurance that his experience would complement the range of the other services available within the practice.

An apology was offered to the patient for the earlier poor communication. The practice advised that the concerns would be discussed at a team meeting where ideas and opportunities would be identified to drive an improvement in the way the practice communicated with its' staff and patient base.

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

LEARNING POINTS

- It is always useful to consider and identify beforehand where a generic message may be misunderstood and the impact of this on a small minority may be negative.
- Choice is as much part of dentistry as in any other retail/service industry and it is important to make this clear where choice exists.

A DIFFICULT PATIENT INTERACTION

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

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

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

The dentist contacted Dental Protection, feeling aggrieved because the tooth he had treated had remained functional and symptom free for more than ten years. The root treatment had been carried out using a standard technique, and the radiographs demonstrated a well obturated root canal filling with sound crown margins.

However, the clinical records made by the member only contained information about the actual treatment provided and had no documented record of the consent process to help him challenge the allegations made by the patient. On the other hand there was sufficient information and evidence to demonstrate that the actual treatment had been provided to an appropriate standard. It clearly helped that the tooth had been free of pathology and symptoms for over ten years.

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

This approach clearly contradicted the position taken by the patient around the guarantee. Had the patient also suggested that he should have been made aware of the consequences of failure from a financial perspective, and if so, would have taken a different treatment decision at the time by seeing an endodontist, then our approach to the resolution of this matter might have involved a refund.

Fortunately the patient accepted an empathic response and took the matter no further. Had that not been the case, then our strategy would have turned on our member's recollections and his usual practice when providing information to patients about predicting success in endodontic procedures. Such an approach carries risk and without documented evidence of the consent process it is entirely possible for a Court to prefer the patient's version of events. It makes sense then to manage expectations around treatment outcomes and record the salient points of those discussions. The unpredictable nature of healthcare interventions may be obvious to us as practitioners, but may not be to some patients.

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LEARNING POINTS

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

CONTACTS

Membership

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