



Teamwise

Issue 22 | June 2020

The periodontal paradox



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identifying and managing periodontal disease
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How we assist with a complaint after
a patient swallows an instrument

Quick thinking avoids a claim following a perforation

Why swift action by a dental therapist
prevents a more serious outcome

A difficult call

How did Mrs X resolve a
dilemma over a child patient
safeguarding issue?



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Welcome

I hope you enjoy this latest edition of *Teamwise*, which has been planned and written by Dental Protection's large team of experts to give you specialised advice and guidance on key dentolegal topics – as well as showcasing how we have actively assisted members with difficult outcomes in our case studies section.

In this issue

In this edition of *Teamwise*, we look at some very topical issues affecting all members of the practice team. Dr Alasdair McKelvie and Dr Andrew Walker, dentolegal consultants at Dental Protection, kick things off with a look at controlling your risk when identifying and managing periodontal disease. This is a topic that has been making the dental headlines for a number of years now and, in this latest article, we look at communications with patients and how this has been the source of allegations in many cases – with some patients claiming they weren't sufficiently warned over potential periodontal disease.

Elsewhere we provide an update on scope of practice guidelines and how these are bringing about notable changes for hygienists, dental therapists and oral health therapists. Kristin Trafford-Wiesel, Case Manager at Dental Protection, explains the impact of the changes more in her detailed article.

This edition of *Teamwise* also features an expanded section of case studies that reflect the real-life situations that members have experienced. Many feature hygienists, dental therapists and oral health therapists and are followed by some important learning points and guidance specific to the circumstances.

Educate yourself with our e-learning platform PRISM

The feedback we receive indicates that many dental members aren't fully aware of the professional development offered by Dental Protection, so I would urge you to visit our online learning centre, PRISM, and see what is available and how it could be of benefit to you. You can access PRISM via the Events and E-learning tab on our website, at dentalprotection.org.au

I hope you enjoy this edition of *Teamwise* and continue to benefit from the enhanced advice and support Dental Protection offers now and in the future.

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Update on scope of practice

The key changes to the Scope of Practice Guidelines recommended by the Dental Board of Australia create the opportunity for independent practice for dental therapists, dental hygienists and oral health therapists. *Kristin Trafford-Wiezel*, Case Manager at Dental Protection, provides an update on these proposed changes



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There has been much talk surrounding the revision of the current Guidelines for Scope of Practice. This process first began in late 2017, with the advance copy of the incoming guidance now available on the Dental Board's website for review.

There has been wide-ranging consultation with the public and dental practitioners as well as an independent review by the

Australian Commission on Safety and Quality in Health Care (ACSQHC) – this has been published and can be viewed on the CHC website.¹ The Dental Board also advises through recent communiques that there are plans for further engagement with the dental profession and key stakeholders throughout 2020, as well as a post-implementation review 12 months after the standard takes effect.²

What does this mean for members?

We first discussed what these changes could encompass in the article “Times may be changing”, which was published in our 2018 edition of *Teamwise*. There we looked at what the changes are; now we can look further at how these changes will directly affect us in our everyday practice and professional relationships. The main changes that have been highlighted fall

into four main categories, with items 1 and 2, and 3 and 4, intrinsically linked together:

1. Remove reference to programs to extend scope
2. Clarify expectations around education, training and competence

As previously highlighted, programs to extend scope have largely been phased out over time, as many of the duties that they encompassed have been incorporated into programs of study approved by the Board. The removal of this reference ties in with the Dental Board's discontinuation of approval of these programs in December 2018. The change should have minimal programs, mainly in relation to extending scope to adult populations, are now encompassed by continuing professional development and are addressed in the category regarding clarification of training, education and competence.

There is an overarching reference to assessing your own education, training and competence where professionals are advised to use their own sound professional judgement on their individual scope of practice. The Board provides practitioners with access to a reflective tool to help in this assessment.

This process of self-assessment is similar to current guidelines where practitioners must only perform dental treatments that they have been educated and trained in, and that they are competent in but where undertaking quality CPD enables them to "maintain, improve and broaden expertise, experience and competence".³

It is important to note that it has been highlighted that "CPD will not let you move from one division to another. Dental hygienists, dental prosthetists, dental therapists and oral health therapists cannot become dentists simply by completing CPD courses".⁴

3. Remove the requirements of "independent practitioner"
4. Remove the requirement of a structured professional relationship

The existing *Scope of Practice* requires that we work in a "structured professional relationship". The incoming guidance removes this requirement, allowing allied dental professionals to work as independent practitioners. Structured professional relationships supported autonomous decision making within the individual's scope of practice and a team approach, ensuring that patients receive the best and most appropriate care and treatment from the practitioner most appropriate to provide it. I would like to think that this sentiment still holds true with the new guidelines. We, as trained professionals, will still aim to provide the best quality of treatment to our patients within our training and education, and hold onto the team philosophy that patients can access the best and most suitable care for their needs.

Are there concerns for the quality of treatment and safety of patients?

The independent review from ACSQHC advises they do not believe so, stating: "There is no evidence that the proposed changes to the *Scope of Practice Registration Standard* will have an adverse effect on patient safety and quality."⁵ They also say: "In Australia, an accreditation scheme for education courses for all dental health professionals has been in place for some time. Each of the registrable profession types has a clearly articulated scope of practice and this is supported by a code of conduct that must be adhered to. Systems are in place to address reported breaches of the code or standards of practice."⁵

Will the ability to work as an "independent practitioner" change the way we practise? Possibly.

The reality is that the majority of dentists and allied dental professionals are employed in metropolitan private practices except for dental therapists, where the inverse is true.⁶ In these cases allied dental health professionals and dentists will continue to work in a collaborative team environment and the ability to work as an independent practitioner may have minimal impact in their day-to-day lives.

Where there is possible scope for change – which appears to be high priority for government and public health service providers – is the hope for better access and health outcomes in populations that carry a greater disease burden, such as rural and regional communities and aged healthcare.

Will this allow better access, with screening, treatment and appropriate referral of high-risk patients in nursing homes and rural communities? Which will in turn enable people to access care earlier, reducing treatment needs and improving outcomes? This all remains to be seen and will undoubtedly be investigated during the post-implementation reviews.

All we can be certain of at this time is that we, as a health team collectively, will remain committed to upholding the definition of professionals: "a member of a profession...governed by a code of ethics, and profess commitment to competence, integrity and morality, altruism and the promotion of the public good within their expert domain. Professionals are accountable to those served and to society".⁷

At present you must only practise within a structured professional relationship with a dentist and must not practise as an independent practitioner. The new *Guidelines for Scope of Practice* do not come into action until July 2020.

During these transitional periods, Dental Protection is here to support members and assist with colleague-to-colleague advice. For dentolegal advice call us on 1800 444 542.

REFERENCE

1. ACSQHC. Review of the patient safety, patient quality and consumer benefit implications of the Dental Board of Australia's proposed revised *Scope of Practice Registration Standard*. July 2019
2. Dental Board of Australia Communiqués found at dentalboard.gov.au
3. *Scope of practice guidelines*, dentalboard.gov.au
4. Ibid
5. Ibid 1
6. Ibid 1
7. Cruess, Sylvia R, Sharon Johnston, and Richard L. Cruess. "Profession": a working definition for medical educators." *Teaching and learning in Medicine* 16.1, 2004: 74-76

The periodontal paradox

Dr Alasdair McKelvie and Dr Andrew Walker, dentolegal consultants at Dental Protection, advise on controlling your risk when it comes to identifying and managing periodontal disease



For most patients, periodontal disease and associated tooth loss are largely preventable with good oral hygiene. There are many factors that increase the probability of a patient developing periodontal disease, and both smoking and diabetes are among the most frequently recognised risk factors seen in clinical practice. Early diagnosis, patient-specific targeted treatment, behavioural management and the transfer of responsibility for the outcome to the patient can, in the most part, prevent further periodontal breakdown and reward the patient with teeth for life.

Sounds simple doesn't it? The patient takes charge of the outcome for 360 days of the year. For the other five days of the year you as the clinician accept responsibility for monitoring progress, adapting the targeted treatment plan to the changing clinical presentation and reinforcing the behavioural changes that the patient needs to implement and comply with if they want a successful outcome.

Surprisingly, something that should be straightforward has become more complex. Patients have a right to oral health

yet a combination of factors, including but not limited to the systems we work in and the way we record information, has led to a significant increase in the number of patients looking to sue their dentist for the avoidable loss of teeth. The allegations are straightforward enough:

1. You failed to screen my mouth for periodontal disease.
2. You failed to diagnose periodontal disease.
3. You failed to provide a targeted treatment plan to manage my condition.
4. You failed to tell me I had periodontal disease.
5. You did not explain the increased risk of tooth loss due to my smoking habit and advise me to stop.
6. You failed to monitor the deterioration in my periodontal health and refer me to a specialist.
7. Even if you had not failed with any of 1 to 6 you nevertheless failed to maintain a suitable clinical record.

If your patient is able to prove, on the balance of probability, that the loss of teeth from periodontal disease is your fault and flows from your poor management, the patient will not only be compensated for the loss of those teeth but will seek to have them replaced with implants and not removable dentures. While implants may not actually be appropriate treatment if the patient still has active periodontal disease, the cost of implants may still factor in to any financial compensation.

The literature also suggests that patients who are susceptible to periodontal disease are also more likely to develop peri-implantitis. In many jurisdictions it is incredibly difficult to successfully argue that implants are not suitable compensation for teeth lost due to poorly managed periodontal care. We are completely reliant on the expert evidence we obtain to provide pragmatic and fair resolution of the claims. It cannot be in the interests of a patient to receive compensation in the form of treatment they will struggle to maintain and, even if they do, provision of this treatment may well carry a significant risk of failure in these patients.

Within professional circles there is a feeling that this is wrong. Dentists don't cause periodontal disease and the loss of teeth is almost always caused by the patient's inability to maintain good oral hygiene and reduce or eliminate those risk factors that they can control. Yet the paradox is that a condition that is so basic in its management and control can end up with the most expensive and complex claims for compensation. So what can you do to take control and play your part in improving periodontal health, reducing indemnity costs and placing responsibility for the outcome in the patient's hands?

Steps to good periodontal management

1. Implement, undertake and record a recognised periodontal screenings and classification protocol for all your patients with teeth or implants. You will likely be aware of recent changes to how periodontal and peri-implant diseases are classified after the 2017 World Workshop on the Classification of Periodontal and Peri-implant Diseases and Conditions was held in Chicago. This new classification

system was necessary for clinicians to properly investigate etiology, pathogenesis, natural history, and treatment of the diseases and conditions. It is especially important to note in this context the emphasis placed on the need for a more comprehensive maintenance and surveillance of successfully treated patients. It was accepted that a patient with gingivitis can revert to a state of health, but a periodontitis patient remains a periodontitis patient for life, even following successful therapy, and requires lifelong supportive care to prevent recurrence of disease. All too often there is insufficient information in a record to show the periodontal condition you inherited when the patient came for the first time.

2. Once the patient's periodontal condition has been classified and recorded, tell the patient. There is a reason for their bleeding gums and involve them in the collaboration to address the problem. Agree on an appropriate individualised and targeted treatment plan based on the patient's periodontal classification. It is a bit like checklist dentistry but these protocols are considered good practice, against which your conduct can be evaluated by courts and regulators.
3. If the patient declines the treatment you recommend or fails to comply with your advice and instructions then you need to explain the consequences – and make a clear note of this in the treatment records.
4. If the patient smokes, tell them to quit. Help them to quit and explain what will happen if they continue to smoke. Check and record their compliance with your advice every time you see the patient.
5. Monitor the patient's response to treatment and their ability to manage their own dental destiny. If the clinical condition is deteriorating then you must tell them, adjust the plan and record the key information.
6. Never be tempted to record probing depths that underscore the periodontal condition. Take appropriate radiographs at the right time and carry out six-point periodontal charting in accordance with adopted protocols.
7. Always make sure the patient owns the outcome. They can only do this if the periodontal condition has been accurately diagnosed, correct treatment provided, response to treatment measured, and sufficient information exchanged about the prognosis and how the patient can influence the prognosis.

Our experience in handling claims highlights how much easier it is for patients suing their dentist to prove on balance what was not done by the dentist. The existence of screening and treatment protocols developed to help and direct clinical management also helps the patient and their claim when the protocols have not been followed or recorded accurately in the records.

Appropriate diagnosis and primary care management of periodontal diseases should actually be quite straightforward, as should the transfer of risk for the outcome to the patient, yet these basics are often ignored. On the other hand, the consequences for your patient can be life-changing if they are deprived of the opportunity to take control of their own destiny.

Staying up-to-date saves lives

Guidance surrounding medicine and dentistry is never static – it can be so hard to keep on top of the changes. Some practitioners delegate this responsibility to staff members or don't undertake the relevant CPD at all. *Dr Annalene Weston*, dentolegal consultant at Dental Protection, explores this in the context of a recent case

Medical emergencies can and will happen in dental practice, but are you prepared for them? There are two key things that every practitioner can do to ensure that they are:

Undertake annual CPR updates

The key dental guidance for this comes from the ADA and states that:

“2.1. The management of emergencies and the techniques for resuscitation change from time to time. Dentists should ensure their training and skills remain current. Regular ‘hands-on’ training is recommended for dentists and their staff.

2.2. Dental practices should have a regularly updated written protocol for responding to medical emergencies and all staff should be regularly trained in its use.

2.3. The management of medical emergencies should be based on the current guidelines issued by the Australian Resuscitation Council.”¹

A review of the current guidelines from The Australian Resuscitation Council reveals: “Repeated refresher training is needed for individuals who are not performing resuscitation on a regular basis. All those trained in CPR should refresh their CPR skills at least annually.”²

Pleasingly, the Dental Board of Australia recognise this requirement, and include CPR as a “clinically or scientifically based activity” for the purposes of Continuing Professional Development.³

Review the updated Oral and Dental Therapeutic Guidelines

Released in December 2019, the ‘clown book’ has had a significant overhaul, which impacts on multiple aspects of dental practice. One question commonly asked by members related to the suggested contents of an emergency drug kit, and this is answered in the new guidance expanding on the 2012 requirements:

Drugs and equipment to support the management of medical emergencies by dentists

Drugs and equipment that may be used for the management of medical emergencies occurring in a dental practice include:

- an easily transportable source of **oxygen** – the simplest and safest way of administering oxygen to a patient who is breathing is via a mask (supplemented with oxygen at 6 to 8 L/minute) or nasal prongs (with oxygen at 2 L/minute). For a patient who is not breathing, use a bag-valve mask or start mouth-to-mask resuscitation
- **disposable plastic airways** to secure the oral airway and facilitate mouth-to-mouth resuscitation or ventilation with oxygen
- **adrenaline (epinephrine)** for the management of anaphylaxis, in sufficient quantity to give two doses. Adrenaline (epinephrine) is available in preloaded autoinjectors and ampoules. A preloaded autoinjector is preferred, since an ampoule requires dose calculation and has to be drawn up into a syringe
- **pulse oximeter** for measuring arterial oxygen saturation
- **glucose** for the management of hypoglycaemia, as either a readily available glucose-containing food (eg fruit juice, honey) or pure glucose (eg glucose gel or tablets)
- **glyceryl trinitrate spray** for the management of angina or an acute coronary syndrome. Glyceryl trinitrate spray has a longer shelf life than tablets
- **short-acting bronchodilator inhaler** (eg salbutamol) and spacer for the management of an acute asthma attack
- **aspirin** for the management of a suspected acute myocardial infarction
- **blood pressure monitor** for the assessment of patients with cardiovascular symptoms and collapsed patients
- **blood glucose monitor** for the assessment of patients with diabetes
- **automated external defibrillator** for the management of cardiac arrest.

Regularly check drugs and equipment, and replace expired or damaged items.⁴



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Case study

These guidelines assist practitioners in saving lives.

A member called Dental Protection recently to make a notification regarding an incident at practice. A regular patient, with a documented cardiac issue managed by a pacemaker and medication, attended the practice for the insertion of a crown. Less than 1ml of lignocaine was administered by infiltration and, midway through the procedure, the patient had a cardiac incident and went into defibrillation.

Luckily, the member had recently attended an update on medical emergencies with his staff and had revised the practice protocols and updated their medical kit in accordance with this. As they had all had the opportunity to practise the management of a medical emergency, everyone knew what to do. 000 was called, oxygen was administered and CPR was performed until the paramedics arrived. A pulse was re-established and the patient survived, without brain damage or any other adverse outcome.

Dentolegal consultant's perspective

This good news story could have so easily been a tragedy. The importance of regular updates of all knowledge relevant to dental practice should not be overlooked and, in this instance, a life was saved.

Do

Keep an eye out for updates to the guidance and standards

Undertake regular CPD in all aspects of practice

Review your practice medical emergency plan

Ensure your staff have regular updates in matters relevant to them too.

Don't

Forget to schedule your practice CPR refresher

Forget to check the expiry dates of emergency drugs

Forget to maintain any emergency equipment.

REFERENCES

1. Australian Dental Association. *Policy Statement 6.25. Medical Emergencies in Dental Practice* 2013
2. Australian Resuscitation Council. *Guideline 10.1, Basic Life Support Training*. March 2013
3. Dental Board of Australia. *Guidelines on continuing professional development*. December 2015
4. Oral and Dental Therapeutic Guidelines. *Drugs and equipment to support the management of medical emergencies by dentists*. December 2019



Why can't I use my mask on more than one patient?

As health professionals, we are charged with the responsibility of ensuring the safety and wellbeing of the patients under our care. *Kristin Trafford-Wiesel*, Case Manager at Dental Protection, explores the vital role of surgical mask use


One of the basic standards of care is appropriate infection control and one of its basic pillars is Personal Protection Equipment (PPE), specifically masks. As many of you are aware, due to the huge need for masks worldwide we have been experiencing restrictions in access and a rise in prices. The threat of a shortage such as this has led to questions like: "Do I need to change my mask for EVERY patient?"

The lead document for the relevant advice is the Dental Board's *Guidelines on Infection Control*,¹ which states each practice must have access to four key infection control documents:

1. A practice manual – setting out the infection control protocols and procedures used in that practice
2. The Australian and New Zealand Standard on office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment (dental practitioners work under AS/NZS 4815 unless they work within an organisation that operates under AS/NZS 4187: cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities)
3. National Health and Medical Research Council (NHMRC), *Australian Guidelines for the Prevention and Control of Infection in Healthcare*²
4. Australian Dental Association (ADA), *Guidelines for Infection Control*

These four documents set out our obligations and help us in the implementation of these requirements in our daily practice life. Our practice manual should be our how-to guide for our own practice, and the remaining three documents have a much broader scope. Two of these specifically address surgical mask usage.

The ADA's infection control guidelines state that the filtration abilities of a surgical mask begin to decline with moisture on the inner and outer surfaces of the surgical mask after approximately 20 minutes, and that they must be fitted and worn according to the manufacturer's instructions. However, there is no specific mention of one per patient, so maybe we can?

What are the manufacturer's instructions though? What does disposable mean and what does this symbol mean?  A quick search shows that it indicates a medical device that is intended for one use, or for use on a single patient during a single procedure. The overarching and more finely detailed NHMRC guidelines provide even more helpful information, which is summarised below.

What is a mask?

The guidelines specify that surgical masks are loose-fitting, single-use items that cover the nose and mouth. Healthcare workers wear a mask if there is a risk of them inhaling an infectious agent and masks, eye protection or faceshields are worn by a healthcare worker in situations where the patient's body substances may splash onto his or her face.

Are they disposable?

The surgical masks section (page 129) of the NHMRC guidelines reinforces that masks should be changed between patients and when they become soiled or wet, and then goes on to state that masks should never be reapplied after they have been removed.

Taken together, the various guidelines give us a clear overall picture of what is expected of us regarding the single use of masks. Overall, it is important to remember the responsibility we have to the health and wellbeing of our patients and co-workers, and that correct infection control is imperative for everybody's safety. Let us all take the advice by the NHMRC and lead by example, and champion the appropriate use of PPE in all our settings.

REFERENCES

1. Dental Board. *Guidelines on Infection Control*
2. Australian Guidelines for the Prevention and Control of Infection in Healthcare, page 49

Meeting your obligations under the national law with social media

AHPRA has recently released a revised guideline to assist clinicians in meeting their regulatory obligations when using social media such as Facebook, WhatsApp, LinkedIn, WeChat, Whitecoat, YouTube and Whirlpool, to name just a few. **Dr Simon Parsons**, dentolegal consultant at Dental Protection, reviews the updated guidance and highlights what you need to know

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New guidelines from AHPRA on social media are primarily intended to ensure the safety and welfare of the public, by helping practitioners avoid inadvertent harm to their patients from the inappropriate use of social media. Such harm might arise, for example, when a practitioner posts information about a patient or the patient's treatment on what is thought to be a private social media communication, only to find this information shared publicly without their consent. Any such event might seriously damage the trust between a patient and a practitioner and could lead to a serious complaint or notification to AHPRA, as well as other legal action such as litigation.

What are your obligations?

Dental practitioners must continue to ensure they preserve their patients' privacy and confidentiality, maintain professional boundaries (eg avoid the use of social media dating sites to meet up with patients), comply with codes of conduct, and ensure full compliance with advertising regulations. If making claims about the efficacy of a treatment, any such claims must be based on sound scientific evidence. In addition, commentary about patients, colleagues and treatments must remain professional and respectful, to avoid allegations of defamation. Social media is clearly an unwise channel for airing one's dirty laundry!

How might you meet these obligations?

Perhaps the first issue to remember with social media is that once any information is in the public domain, it can be very difficult to remove. Discretion needs to be exercised, to ensure any content is appropriate to its intended audience and cannot be taken out of its intended context. Ask yourself the question, "Am I comfortable knowing that once this information is out there, I can't remove or alter it easily?" If you aren't, it might be preferable to avoid posting a comment, article or response.

Secondly, ask yourself whether the content might be seen as damaging to another's reputation, or your own. It is not uncommon for prospective employers to search social media sites in their screening of job candidates, and AHPRA have indicated in their guidelines that they may similarly review social media platforms when considering whether a health professional is of appropriate standing to maintain their professional registration. Is your post worded in a professional way, using appropriate language? Is the image of a late-night drunken get-together something that might reflect poorly on you or your colleagues professionally? Do you have the permission of everyone who may be identifiable in an image or post to share their identities in your communication?

If making a communication via social media with another health professional, it can be prudent to emphasise the nature of this communication so that there is no misunderstanding. For example, if sharing information for purposes of referral, this should be clearly articulated. A subsequent communication to the same practitioner, expressing your concerns about a patient's behaviour or attitude, might require a warning to avoid sharing this opinion with the patient concerned.

While some social media options provide effective end-to-end encryption (such as WhatsApp), others may not, and the onus is on the practitioner to ensure that the privacy of a patient's information is maintained at all times. Any images or content being posted in a public domain should have all key identifying information redacted, such as a patient's name, date of birth, address, health fund membership number, Medicare number or other unique identifier. If you are unsure about the privacy of a social media communication, and the scope for the information to be shared without your (or your patient's) express permission, we recommend you avoid using that medium.

Where we may have a particular view about a public health initiative, a new form of treatment, a personal opinion about moral behaviour, or generic advice about preferred treatment options, the use of discretion in airing those views in social media is highly recommended. There may be nothing wrong with holding any of these views privately, but they may have unintended consequences once out in the public domain. Consider the ongoing issues with the social media comments from Israel Folau and remember that in rare instances one's career and public image can quickly become the focus of unwanted media attention.

Finally, consider comments or responses to reviews on social media carefully. AHPRA have clear advertising guidelines around the appropriate use of social media in advertising your services. Practitioners must ensure that where they comment in response to reviews by patients, these are not construed as selective testimonials about the suitability of that treatment for others, or seen as the advertising of one's services. Patient feedback should not be edited nor republished on one's practice website as endorsements about your practice or the quality of your care. It is essential to avoid any allegations of false or misleading claims about the safety or efficacy of treatment you may provide on social media sites, to avoid action from AHPRA or other regulatory bodies.

For further information and practical examples of how to best comply with social media guidelines, we recommend you visit:

- dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Social-mediaguidance.aspx
- dentalboard.gov.au/Codes-Guidelines/Advertising-a-regulated-health-service.aspx

Treating a non-compliant child patient



Miss N was a relatively new graduate and had recently begun work as an oral health therapist in a private practice. The end of year holidays had just begun, and an influx of children were attending for their annual check-ups.

Six-year-old H, a new patient, arrived at the practice for his check-up with his mother. Mrs H explained she had no concerns but felt it was time for his first visit. Miss N began chatting to both Mrs H and her son but soon realised that this may be a difficult appointment as H was hiding behind his mother and avoiding looking at Miss N.

After much desensitisation and the production of many stickers, Miss N was finally able to conduct a limited exam with H sitting on his mother's lap on the dental chair. This exam revealed a number of areas of occlusal caries in his primary first and second molars, as well as some grey interproximal shadowing on his upper primary central incisors. Due to the difficulty in reaching that point, no bitewing x-rays were attempted.

After the examination was completed, Miss N explained her findings to Mrs H, which were H's high caries risk and the potential difficulty achieving the compliance necessary for treatment. With this in mind, Miss N advised that the best course of action would be referral to a paediatric dentist to complete H's extensive treatment under a general anaesthetic, and this could be arranged by the principal dentist at the practice.

Mrs H was openly shocked with this turn of events as she had not thought that H would require any treatment, as he had not complained of any pain. Mrs H was concerned about the finances associated with a referral to a specialist and requested that treatment be completed with Miss N at the practice, especially as H had finally begun to warm to her. Miss N felt compelled by Mrs H's situation and advised that they could at least attempt some desensitisation

and treatment in the chair, but advised that this may result in less than optimal treatment if compliance was an issue. In that case, a referral would then still be necessary. Mrs H agreed with this and thanked Miss N for trying to help them by treating H herself.

A treatment plan was compiled to complete the four posterior occlusal restorations, two interim fissure sealants on lower six-year-old molars and a prophylaxis and fluoride remineralising treatment. It was agreed that their next appointment would be for H's professional clean to attempt to ease him into treatment.

H returned with his mother for his professional clean. The appointment proceeded with some improvement of the patient's compliance but he was still highly anxious and needed significant explaining, encouragement and rewards. Miss N was overall quite happy at the progress and three further appointments were made to complete the restorative phase of treatment, as well as in-depth oral hygiene and dietary advice. These appointments proceeded with varying levels of patient co-operation, making treatment difficult and requiring the use of ART in some instances. Finally, with much relief from all parties, the treatment was completed and H was placed on a short recall schedule, to monitor the treatment and oral hygiene as well as continue with regular exposure to the dental setting.

The holiday season passed and with the beginning of the New Year came a surprise letter for Miss N, who was shocked to be in receipt of a notification from AHPRA, with a complaint regarding her treatment of H a few months prior. Unfortunately, not long after H's treatment was completed with Miss N, H began experiencing pain and attended another practice. At this time, H's behaviour was much improved and the practitioner was able to take a set of bitewing radiographs. These radiographs showed numerous interproximal areas of

caries requiring treatment, and Mrs H was upset that these had not been dealt with in their previous appointments with Miss N. The situation was then compounded in that H's Commonwealth Dental Benefit Scheme allowance had been almost fully utilised, and they were now experiencing the possibility of significant out of pocket expenses, which they could not afford.

Miss N was rightly concerned about the best course of action and contacted Dental Protection for advice. We assisted Miss N with her response to AHPRA, which included an explanation of the decisions she had made and an apology for the distress to the family. Fortunately, Miss N's records were very thorough and detailed surrounding the discussions she had with Mrs H and, consequently, AHPRA dismissed the matter, albeit with a caution to Miss N.

Learning points

Clear communication with parents and patients about the implications of treatment that is influenced by limited patient compliance is an essential component of treatment.

It is important to follow through with radiographs when able, to ensure thorough planning and treatment. As above, clear communication and advice to parents and patients about the implications of treatment without radiographic assessment is vital.

Be aware of the pitfalls of feeling pressured into providing treatment for patients when you don't believe you can offer an acceptable treatment outcome in their best interest.

This case underlines the importance of documenting all discussions in the clinical notes.



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A difficult call

Mrs X saw two sisters, aged 8 and 10, for a routine examination. They attended with their mother who explained it had been some time since the family had attended a dentist. Both children had a number of carious lesions and the family was provided with preventive advice.

The mother, Mrs C, brought both children back for two more appointments. Treatment was carried out successfully on each occasion for both patients.

At the third appointment only the eldest child was brought by her father, Mr C, who accompanied her into the surgery. He explained gruffly that the mother was “away”.

The actual treatment proceeded without any incident but Mrs X felt that by contrast with the previous appointments, when the patient was relaxed, the child was very subdued and glanced nervously at her father who was watching her very intently.

Mrs X felt uncomfortable with the atmosphere and the intimidating way the father interacted with the child. Mrs X felt that the child was frightened, but not about the dental treatment. There was a gut feeling that something was not right.

After the appointment Mrs X spoke with her dental nurse who shared her view of the father’s demeanour and the child’s reaction. The matter was then discussed with the

safeguarding lead at the practice and after some consideration, advice on the situation was sought on an anonymous basis from the local child protection services, who suggested contacting the social service department to flag the concern. Mrs X duly got in touch and provided her observations.

It later transpired that social services were already aware of child safety concerns in relation to the father from other sources and were already in contact with the family about other matters. This latest information fed into the bigger picture.

Although this meant the family obviously had some troubles, Mrs X was at some level reassured that she had done the right thing in flagging her concerns as she had originally had reservations about escalating her misgivings for fear of creating trouble.

Some weeks later, Mrs X received a threatening letter from Mr C complaining that he had been treated unfairly and had been the subject of discrimination. Although he had not been told of Mrs X’s input officially in his recent dealings with social services, he had surmised that Mrs X must have “said something to stir things up” and he was going to seek legal advice. Mrs X sought assistance from Dental Protection in dealing with the complaint.

Mrs X and the practice had kept contemporaneous notes of the matter with details of the initial concern, the steps

followed within the practice, including the internal discussion, and the decision to seek professional external advice. It was clear that the practice protocol had been followed. This enabled Mrs X to demonstrate that the practice team had acted appropriately and in line with professional responsibilities rather than the situation being one where the father had been discriminated against.

With assistance from Dental Protection, Mrs X provided a robust letter of response vindicating the approach taken by the practice and which included an explanation of the ethical duty on dental professionals to act if they have any concerns regarding child welfare and safety. There was nothing further heard from the father.

Learning points

The dental team often face instances involving safeguarding concerns. It is important to follow practice protocol and to document each step, including discussions and decisions.

Dental Protection is here to support and advise members who are facing what can be difficult situations. Always contact us for help and advice in these circumstances – we’re here to help you.

Quick thinking avoids a claim following perforation

A new patient, Miss Y, attended a practice complaining of pain from an upper primary first molar that had been recently restored at another practice. When questioned about the dental history, Miss Y's mother advised that they had been told that the restoration was very deep; however, they had not wanted to proceed with a pulpotomy and stainless steel crown on the day and so had elected on just placing a restoration that day.

Mr O examined the patient and it was clear that the tooth was tender to percussion and exhibiting signs of irreversible pulpitis. Mr O discussed the need to access the root canal and begin RCT to alleviate symptoms at that visit.

Mr O was confident of the diagnosis and started access once local anaesthetic had been provided. He planned to provide relief of pain at this appointment with a pulpotomy and stainless steel crown but did not consider a radiograph was necessary, as the diagnosis was predictable and there was little time left to provide the emergency care required.

Access was uneventful, but there was significant bleeding from the tooth, which was subsequently stopped and the tooth dressed and restored with a stainless steel crown. Unfortunately, Miss Y and her mother returned the next day still very much in pain and unhappy. Mr O took an x-ray of the tooth and, to his horror, the radiograph revealed that there was a clear perforation of the floor of the pulp chamber with the eruption of the permanent premolar imminent.

Mr O was a little panicked, but after an in-depth discussion with both Miss Y and her mother, it was decided to remove the primary molar to allow eruption of the permanent tooth. Mrs Y was not charged for that day's treatment.

Given the error, Mr O approached Dental Protection for advice on how best to handle the situation with regard to the management of the patient. In discussing the matter with a Dental Protection dentolegal consultant, Mr O was advised to call Miss Y's mother,

be honest and open with them by apologising that the situation had occurred and reassure them of onward care.

Naturally Mrs Y was not happy that her daughter had undergone unnecessary treatment; however, Mr O showed true concern and integrity, and Mrs Y was appreciative of Mr O's apology, openness and overall concern for her daughter.

Dental Protection's knowledge and expertise allows us to offer advice to resolve matters early and prevent escalation. Embracing the issue early on means we can proactively manage the problem rather than wait until a claim is received and, in this example, had the patient not been offered remedial treatment from the dental therapist – who demonstrated genuine regret and empathy – then the outcome could have been very different.

When a patient instructs a lawyer to pursue a claim, the matter becomes adversarial and a sour taste is left with all parties following a protracted antagonistic episode. If resolution can be achieved with the relationship still intact, then the stress and anxiety for the member (and indeed the patient) in the long run is much reduced.

Dental Protection has the ability to assist members in a multitude of situations, and we would urge members to contact us as early as possible when a potential conflict arises. Early advice and intervention can be invaluable.

Learning points

For emergency appointments, ensure enough time is allowed and avoid being pushed into cutting corners, as errors with long-term consequences can occur.

When an adverse outcome happens, it is advisable to inform the patient at the time and to ensure suitable steps are taken to deal with the consequences.

When the time is right

A hygienist member of Dental Protection contacted us to report that the practice she worked in had received a strongly worded telephone complaint concerning an initial calculus debridement she had provided

The patient, who had not had any oral hygiene treatments in eight years, had complained that the procedure was unnecessarily rough and prolonged, and had resulted in bleeding, puffy and infected gums, as well as severe cold sensitivity. The patient had attended his medical practitioner who had diagnosed gingival infection and prescribed antibiotics.

Unfortunately, this patient was convinced that the hygienist had either used non-sterile instruments that caused the infection and the practice had failed to prescribe antibiotics for the gum infection which he felt must have been visible at the time of treatment. The receptionist had recorded in writing the details of the complaint, and the practice, which was part of a large group of practices, had forwarded the complaint to the hygienist for a response.

The hygienist felt overwhelmed by the situation and also “outranked” by the medical practitioner’s diagnosis, and dwelled on the complaint for a few days before contacting Dental Protection. A suitable letter was written showing sympathy for the patient’s discomfort and a detailed explanation of the treatment and likely cause of the postoperative symptoms (including the effects of this patient’s low dose aspirin medication).

Unfortunately, the practice manager insisted on reviewing the letter before it was sent and awaited the principal dentist’s return from an overseas wedding, as she had concerns about the sympathetic style of the letter and the use of the words “I am sorry that...”, worried that this may be interpreted as admitting liability. This delay left the patient believing that no reply was forthcoming and he formalised the complaint to the AHPRA.

The hygienist was, in time, cleared of any wrongdoing, with a response assisted by Dental Protection relying on instrument tracking and the *Therapeutic Guidelines Oral and Dental* for antibiotic usage protocols. This was a fortunate outcome, though the AHPRA investigation did note the member’s lack of response to the complaint (until too late). Being the subject of any investigation by a regulator such as the AHPRA is understandably a very worrying time for any dental practitioner, and the process is necessarily time consuming, both in responding to the complaint and waiting for a decision back.

Learning points

We will never know whether this complaint would have been resolved simply by a timely response of sympathy and explanation, but we do know the patient’s decision to escalate the complaint was based on the lack of a reply and the feeling that he was not being listened to and taken seriously.

The member was feeling overwhelmed and unsure of how to deal with the complaint. She also felt that the practice had left her isolated in demanding that she deal with the complaint personally and had little experience with a complaints process. Fortunately, the experts at Dental Protection deal with these situations on a daily basis and could provide advice on responding appropriately. When the complaint became an AHPRA investigation, Dental Protection could again guide the member through the process and provide collegiate support through the anxious wait for a decision.

After the complaint had been resolved, Dental Protection encouraged the member to discuss the delay in replying, caused by the practice wishing to review her response. While a practice owner’s desire to review any reply involving their practice is understandable, it is the individual practitioner’s responsibility to respond to a patient complaint. If a complaint is received by the AHPRA it will be directed at the practitioner personally and not the practice. These discussions resulted in a streamlined process for the practice to deal with any future complaints, recognising the need to support employed practitioners in the process and accept the role of dentolegal consultants in providing expert support to the member involved.



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A sharp intake of breath

With our patients generally supine, there is always the risk of dental instruments and materials being swallowed or even inhaled. When this happens, there may be an immediate danger to the airway. Subsequently, the patient may face an unpleasant procedure to remove the item if it gets lodged in the airway or does not pass through the digestive tract.

The use of a rubber dam is a well-recognised strategy not only to maximise the quality and predictability of outcomes during dental treatment, but also as a means of controlling the risk of inhaling or ingesting any of the instruments and materials used in the mouth.

Although a rubber dam is routinely advised for endodontic procedures, it is not routinely used for other dental procedures such as restorative dentistry, prosthodontics, orthodontics or implant dentistry. All these procedures result in small items being placed in the mouth with an associated element of risk. Although the risk is small, if

something goes wrong the event can be very distressing for the patient and the dental team. Should the offending item become lodged deep in the lungs, subsequent retrieval can involve major surgery.

Included in the list of surprising bits and pieces that have recently been found in patients' guts or airways are:

- Cast post and core
- Crowns
- Veneers
- Inlays
- Implant healing caps
- Orthodontic wire, bands and brackets
- Copper rings
- Dental burs
- A denture clasp
- Ultrasonic scaler tip
- The 'screwdriver' for an intra-oral screw post system (Figure 1).

Case study

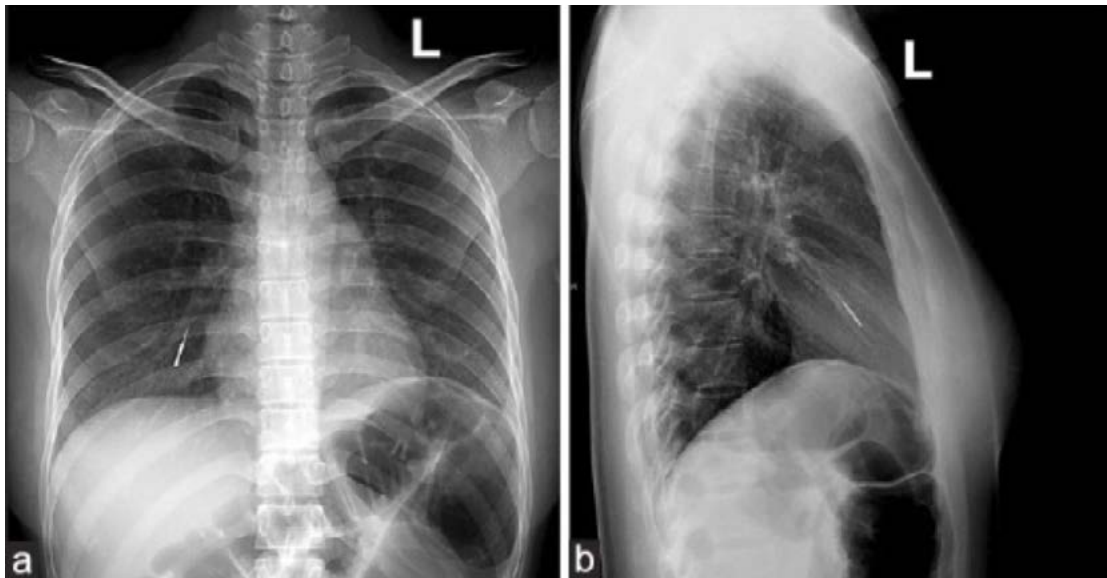


Figure 1

During a routine ultrasonic scale and polish, a prophylactic cup became dislodged from the patient's upper second molar. There followed the seemingly slow-motion drop of the cup onto the posterior tongue, where it settled momentarily before disappearing down the oropharynx.

The patient was immediately sat up and assessed. They thought they had swallowed something but were not sure. They were not breathless and when asked to cough, there was no indication that the cup was in the airway. However, after some discussion, apology and explanation, the patient was persuaded that it would be sensible to seek medical opinion at the local hospital.

The hygienist was careful in managing the somewhat shocked patient and, in order to assist the medical team in assessing the situation, rang ahead and informed the hospital of the incident and the patient's imminent arrival. They also sent a member of the team with the patient, who took with them an identical cup to help the hospital see what had been ingested.

To be safe, the medical team suggested taking a chest radiograph and, despite the lack of symptoms, the results unfortunately showed the prophylactic cup had lodged in the middle lobe of the right lung. With fiberoptic bronchoscopy, the cup was successfully removed and postoperative recovery was uneventful; however, the patient obviously had a very unpleasant and unexpected experience.

Given the adverse outcome, the hygienist was naturally concerned that the patient may sue or complain to the dental regulator. Thankfully, neither happened, which was directly linked to how the member and Dental Protection acted to resolve the matter.

When the incident occurred, our member focused upon the patient and the subsequent care, providing support and empathy, with a team member accompanying the patient to the hospital. Having spoken to Dental Protection, the member was assured of the correct steps to take and we also advised that they should assure the patient that any hospital costs and out of pocket expenses would be reimbursed. With Dental Protection's approval

of this approach, the member was informed that they would then be reimbursed of these costs. Our knowledge and expertise enables Dental Protection to assist with members resolving matters at the earliest stage and not having to wait for a formal claim to arrive before financial help can be provided.

While the patient and their family were naturally very concerned, they were grateful that the member stayed in contact with the patient throughout the journey and, having been invited to a meeting at the practice to discuss the matter, they accepted an apology and reimbursement of all medical bills and expenses as a resolution.

As we are healthcare workers, such events can weigh heavily upon us and it can take time to recover and regain confidence. Members often comment that talking the event through and taking advice from a dental colleague in Dental Protection can be very helpful and we always invite members to contact us as we are here to help.

Nobody gets up in the morning with the intent to harm a patient. Adverse outcomes can and will happen. Be honest with the patient, be seen to facilitate whatever remediation is required and, of course, contact Dental Protection – we are here to help support and protect you through these events.

Learning points

Be seen to act and don't abandon patients – if this patient had not been so well cared for (eg just told that they might want to go to hospital and not contacted again) then a claim or regulatory complaint would be much more likely to occur.

Adverse incidents occur – how we manage them will influence the outcome. If possible, follow up with a meeting to ensure all the patient's concerns are addressed and the patient is reassured.



The whole truth?

Patient Ms H contacted the practice of Dr A as a new patient. She wanted to see the hygienist for regular cleaning as she had been used to at her previous practices.

Ms H saw Dr A for an initial assessment. She gave a history of antibiotics for a gum condition and explained that she had a “genetic tendency” and “previous medical issue”, which had predisposed her to bone loss, but this had been dealt with.

Dr A noted that Ms H’s oral hygiene was poor, with food trapping and mature plaque deposits. To help ensure she understood how best to keep her mouth clean Dr A demonstrated some different types of interdental brushes.

Ms H said she knew all about interdental brushes; she found them uncomfortable and was not prepared to use them. Dr A moved on to discuss floss, which the patient also dismissed. Ms H declined to have radiographs taken as she did not agree with them; Dr A respected the patient’s wishes on this but explained that radiographs can be helpful in allowing a full assessment to be carried out.

There was some bleeding on probing and a full-mouth periodontal charting was completed. This confirmed widespread pocketing, subgingival calculus and some mobility. Ms H asked Dr A to explain what she had found.

Dr A outlined her findings and also provided advice on the effects that Ms H’s smoking had on gum health – Ms H became very upset by the information. She was unhappy with what she felt was an inaccurate assessment and left the surgery. Dr A was puzzled by her angry response to her findings.

A letter of complaint was received the following week. It stated that Dr A had exaggerated the extent of the problem and was “trying to find work looking for pockets” and putting pressure on Ms H to have x-rays. She also claimed that Dr A was “completely unprofessional” in her approach and was making things up to upset patients and worry them into getting unnecessary treatment.

Dr A was concerned by the way the letter questioned her professionalism and sought advice from Dental Protection, who assisted with the preparation of a robust reply.

The record entry for Ms H’s appointment was of great assistance in providing a comprehensive response. Dr A had recorded details of the clinical findings and diagnosis, including a full periodontal charting, as well as her advice on hygiene, interdental brushes, radiographs and her efforts with explaining the impact of smoking. In short, the notes provided a very clear picture of the appointment and the information given to the patient.

The response to the complaint included an expression of regret that Ms H was unhappy, but it was clarified that the treatment, information and advice given had been entirely appropriate. It was made clear that dental professionals have an obligation to provide accurate information to patients so they can make fully informed choices. Ms H was of course free to seek another opinion if she did not have confidence in Dr A’s advice.

Ms H wrote back to say that she would obtain another opinion from a dentist “she knew she could trust” and then she was going to “take it further” with Dr A’s lack of professionalism. Nothing further was ever heard.

Learning points

Although patients sometimes do not like being told the truth, it is in everyone’s interests for the real picture to be presented. Shielding a patient from an unpleasant truth does not help anyone.

Comprehensive notes are a very useful asset when defending against criticism.



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Who doesn't love a crown?

Mrs K was an oral health therapist working in a private practice. Miss A, six years old, presented with her mother for a check-up as she was concerned about a possible hole on a back tooth. Examination and bite wing radiographs revealed that Miss A had a large carious lesion on her 75. Miss A's mother was very keen to try to keep the tooth until natural exfoliation and, after extensive discussion of the options, it was decided to undertake pulpotomy and restoration with a stainless steel crown. To ease Miss A into the treatment, a clean and polish was completed that day, and the patient was reappointed to complete the treatment on the 75.

Miss A returned in the school holidays, accompanied by her father, to complete treatment. The appointment proceeded with no issues and a great final result. Miss A seemed excited about returning to school after the holidays to show all her friends her new "princess crown" tooth.

Mrs K completed her morning of patients and, while writing the records for her final patient, she was interrupted by the practice manager who informed her that Miss A's mother was on the phone, wanting to discuss Miss A's treatment that morning. Thinking this call was likely to check on how treatment had proceeded, Mrs K happily took the call, ready to report how well things had gone.

Unfortunately, Miss A's mother was not calling for an update. She was calling as she was quite distressed about the appearance of the stainless steel crown in her daughter's mouth and to complain that she had not been informed prior to treatment about the lack of aesthetics of the definitive restoration.

Mrs K was somewhat surprised by these statements due to the extensive discussions they had had prior to the appointment as part of the consent process and the mother's insistence on wanting the best option for the long-term maintenance of Miss A's tooth. The mother maintained that she did not realise that a stainless steel crown would look black in her child's mouth and would never have proceeded had she been aware.

Mrs K felt quite unprepared to respond and so invited Mrs A to come to the clinic for a discussion about the situation, to give them both time to gather their thoughts. She wanted to respond in the best way to ensure a positive outcome for everyone. Mrs K called Dental Protection to discuss what had happened and to get guidance on the best way to proceed.

Mrs A arrived at lunchtime and was invited into the practice manager's office to openly discuss the situation. Mrs K began by acknowledging that there had been a miscommunication and apologised for the situation they now found themselves in.

Mrs A had had a chance to collect herself on the way to the clinic and they were able to calmly talk through the options again and the best course of action to ensure a functional, pain-free tooth for Miss A until her tooth exfoliated.

After processing the information, Mrs A agreed that she wanted the best treatment for her daughter and though not optimal aesthetically, she accepted a stainless steel crown was the best long-term option. The meeting was concluded with Mrs A feeling 'heard' and reassured that her daughter was receiving the best treatment for her overall health and wellbeing.

Learning points

It is critical to have a clear and thorough consent process, where even things that seem obvious to you are discussed.

Consider the use of written information pamphlets to complement the consent process.

This case underlines the importance of inviting an open communication pathway to deal with the resolution of complaints.

Contacts

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

Membership Services

Telephone 1800 444 542

Dentolegal advice

Telephone 1800 444 542

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