



RISKWISE

ISSUE 20 | JANUARY 2019

NEW ZEALAND



Supervising others

WHAT RISKS ARE YOU EXPOSED TO WHEN SUPERVISING COLLEAGUES?

GOOD RECORD KEEPING
The benefits of making and retaining treatment records

WEIGHT AND SEE
Decision making in clinical practice

CASE STUDIES
Practical guidance and learning from real life scenarios

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WELCOME TO THIS LATEST EDITION OF **RISKWISE**, DENTAL PROTECTION'S FLAGSHIP PUBLICATION OFFERING THE LATEST INFORMATION ON DENTOLEGAL TOPICS AND ADVICE FROM OUR DENTOLEGAL CONSULTANTS AND PROFESSIONAL EXPERTS.

IN THIS ISSUE:

In this edition, our dental director Dr Raj Rattan explains the importance of building trust with our patients, which in turn enables longer relationships, reduces the incidence of conflict and complaints, promotes satisfaction and can build loyalty.

Dr Robert Caplin from King's College London explores the clinical decision making process and how subjectivity might be reduced during the process, producing a more consistent approach in line with the patients' best interests. The role of the mentor is also reviewed – a role which appears to bring far more rewards than risks.

These articles are followed by several case studies which demonstrate examples of situations that have been experienced by members. Learning points and guidance are offered based on the individual scenarios.

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

WEBINARS

Dental Protection has recently begun hosting webinars, which have been very well received. These live events provide an opportunity for real-time questions and answers during the broadcast and are an ideal way to have the expertise of Dental Protection brought directly to you. Please visit our website for updates on these events - as well as others - and of course to view our other substantial e-Learning opportunities.

OFFERING YOU MORE

Your membership with Dental Protection gives you access to a range of benefits – from a robust dentolegal service, to assistance in responding to and resolving complaints, advice and legal representation for DCNZ procedures, disciplinary matters and inquests, along with support with criminal investigations or allegations arising from your clinical practice.

Even as a highly-trained clinician, at some point you might find yourself the subject of a complaint or regulatory procedure. You may even find yourself facing allegations concerning your professional conduct, competence and performance, provision of clinical care to patients, or in relation to health problems that are having a significant effect on your clinical performance.

Any of these would be a challenging and stressful experience, but as a member of Dental Protection, you do not have to face these situations alone. Dental Protection can provide you with advice and legal representation from the outset, whether it is assisting in drafting a letter in response to a patient complaint or providing top quality legal representation at a Dental Council inquiry hearing.

As a member of Dental Protection you have access to some of the best dentolegal experts in the world. Dental Protection is dedicated to protecting members and their reputations, and, with over 60 years of experience and expertise assisting healthcare professionals in New Zealand, we are best placed to help you should things go wrong.

Thank you for taking the time to read *Riskwise* and I hope you find it useful. We are, as always, keen to hear feedback from you and for you to let us know if there are other topics you'd like us to cover or changes you would like us to make.

Best wishes,

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New dental records workshop proves popular

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

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

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

Dental Protection's general manager for Asia Pacific Educational Services, Matthew O'Brien, said: "Complete, contemporaneous and well-organised records are essential for

good dental practice and continuity of care. They are necessary for your defence against a claim or complaint and can be seen to reflect the quality of care provided.

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

Feedback from members who had attended was overwhelmingly positive. One stated: "Examples of well-written records were very useful. I was unaware until now that this is the standard we are expected to abide by." Another member said: "The workshop was very good and relevant to all forms of practice."

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

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

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

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

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



Weight and see

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

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

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

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

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

DIFFICULT DECISION-MAKING

What does this all mean for us practically? It means that we have to share with our patients the often difficult decisions that have

to be made every day in dental practice to answer the who, how, why, when and where questions about interventions that arise when looking inside a patient's mouth.

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

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

There are several factors that contribute to these variations:

- undergraduate/postgraduate training
- time available
- financial pressures

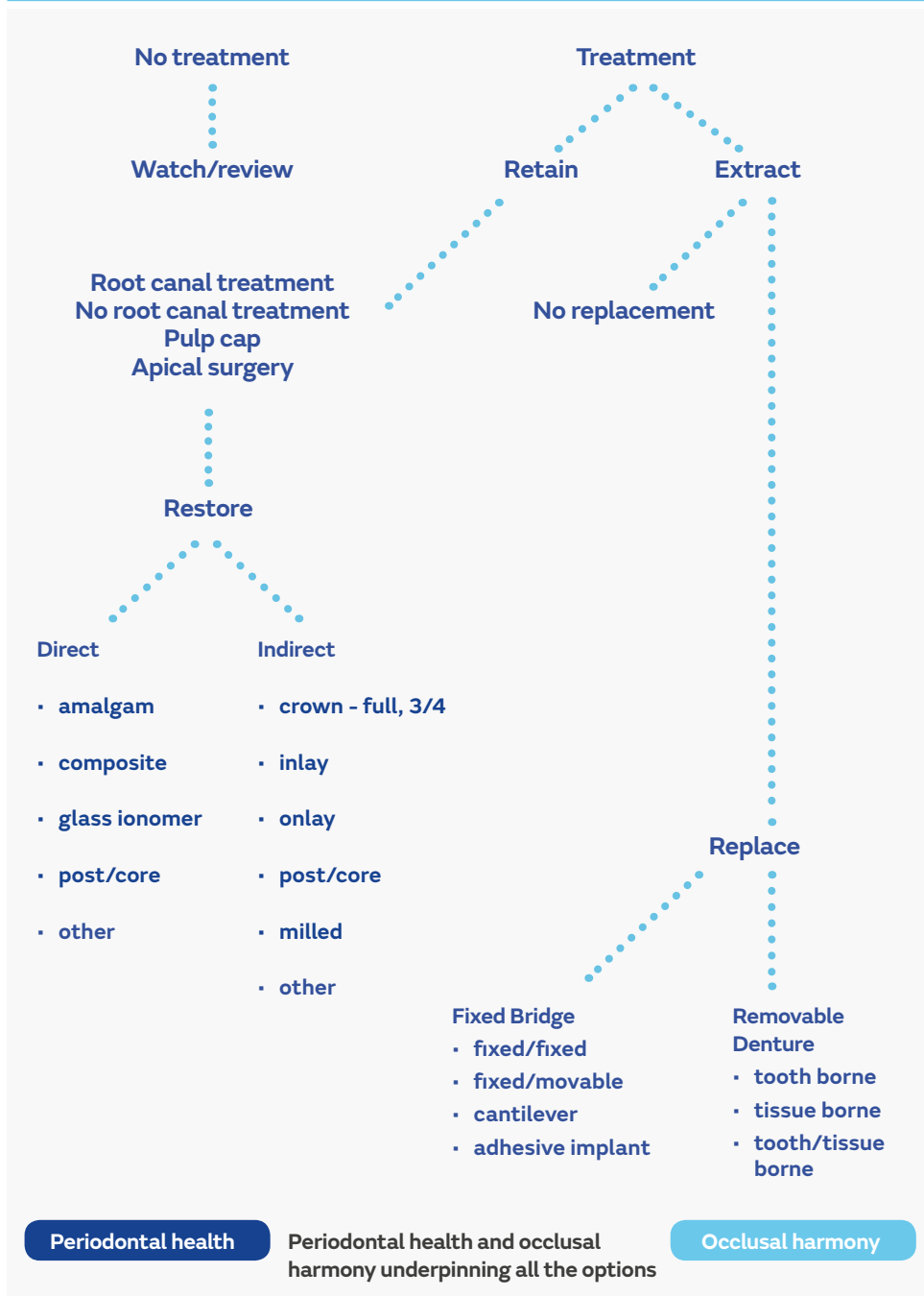
- gender
- age
- the environment that one is working in – be it general or private practice, hospital or academic.¹

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

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

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

Treatment options



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

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

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

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

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

care plan is one that can be justified to a third, independent party should the occasion arise. I want to take you on the path of critical thinking so that we can meet the requirements of our regulators by giving our patients all the options with their risks and benefits (for example, in New Zealand, the Dental Council provide standards 5, 13, 14, 15 and 16. [Reference 'Standards Framework- for Oral Health Practitioners'. Available from The Dental Council website].

Let's take a common clinical scenario:

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

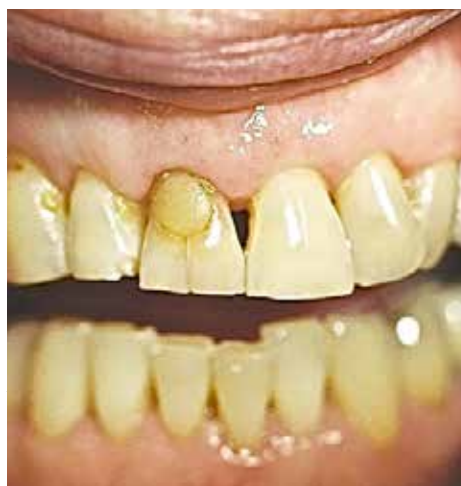


Figure 1. Patient wanted the appearance of her upper right front tooth improved. ▲



There are modifying factors that affect the treatment options and the decision outcome, and it is important to take these into account for each of the possible options that we have selected above.³

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

OCCLUSAL

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

We can consider the options as follows:

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

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

TOOTH/RESTORATION

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

PERIODONTAL

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

PULP/ROOT CANAL

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

PATIENT

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

DENTIST

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

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

All of the above can be discussed with the patient and she can make a more informed decision about the treatment and the cost. She would then sign a document confirming that she has been informed of the options – including the risks, benefits and costs of each – and that she had opted for treatment x.

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

reflective practitioners to reflect and learn and so improve our clinical decisions, thereby reducing the risk element of our work.

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3. Ibid., p.49



The business of dentistry

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

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

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

WHAT IS TRUST?

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

CAN TRUST BE QUANTIFIED?

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

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

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

CREDENCE MARKETS

In economic terms, dental services fall into the category of credence goods. Patients don’t always know whether they need the suggested treatment, and in some cases even

after they receive the treatment, they cannot be sure of its value. This is because the ‘buyer’ does not have the knowledge of the ‘seller’ – a feature of the dentist-patient relationship referred to as ‘information asymmetry’. It is this asymmetry that makes the credence goods market particularly challenging because it may give rise to aberrant behaviours.

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

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

KEY COMPONENTS OF BUILDING TRUST

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

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

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

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Wise words

Patients usually attend for removal of their 'wisdom teeth' fearing the worst

While developments in dental technology, equipment and materials have transformed many dental procedures over the years, the removal of third molars still presents many of the same dentolegal risks as in former years. Perhaps the most significant factor, of which we need to be aware, is that while the procedure itself might be broadly the same, many of the patients involved are not.

The fact that today's patients have greater expectations, and are often more aware and more questioning is only half the story; it is equally important to appreciate that today's patients are generally less forgiving and less tolerant of adverse outcomes.

PREOPERATIVE ASSESSMENT

- Correct diagnosis – if you are considering the extraction of a third molar because of non-specific pain, how sure are you that the third molar is actually the cause of the pain, rather than being seized upon as a convenient scapegoat to explain it, where other investigations have failed to do so?
- Appropriate investigations – include one or more good quality radiograph which not only provides a clear image of the tooth, its root configuration and anatomy, and the surrounding bone, but also the relationship of the tooth to adjacent teeth and to other structures. Significant amongst these are its relationship to the maxillary tuberosity and sinus, to the lower border of the mandible, to the ascending ramus and to the inferior dental (alveolar) nerve bundle within the mandible.

- Check the medical history carefully, and in particular, any relevant risk factors (including medication) that might influence:

- a) bone and soft tissue healing
- b) the likelihood of postoperative bleeding, swelling or infection.

Of increasing concern is the potential for postoperative complications related to patients on bisphosphonate medication, which can affect wound healing and increase the risk of medication-related osteonecrosis of the jaw (MRONJ).

- The social history is particularly relevant when contemplating this procedure and it is sensible to enquire specifically as to the patient's occupation and any important life events. Nerve damage and the associated sensory deficit can have devastating consequences for patients in certain industries where they need their mouths. Pericoronitis is not uncommonly associated with stress and other factors influencing the host response, and with appropriate management, the symptoms will often resolve without needing to extract the tooth at all.

Taking all the above into account, the consequences of any adverse complication need to be carefully balanced against the indications for the extraction(s), in the specific circumstances of each individual patient:

- Are the risks of leaving the tooth in situ greater than the risks of extraction?
- How many episodes of pericoronitis have there been, of what severity, how were they managed and with what success?

- Is there caries in the third molar or in the adjacent tooth?
- Is there any clinical or radiographic evidence of pathology associated with the third molar?

One final consideration in the preoperative assessment is whether the clinician has the necessary skills, experience and competence to carry out the proposed extraction safely and successfully. Where there is any doubt in this respect, a referral to a specialist may be indicated.

INFORMATION, WARNINGS AND CONSENT

Any surgical procedure has risks. It is important to take the time to explain carefully to the patient, in terms that the patient can understand:

- a) why the extraction is considered to be necessary
- b) what the procedure involves
- c) what the possible outcomes might be.

It is equally important to record in the notes the fact that this has been done. Patients will generally not be able to anticipate these complications for themselves, and the clinician has a duty of care to give the patient any explanations and warnings necessary to enable the patient to consent to the procedure with a full knowledge and understanding of what to expect.

Although information leaflets and advice sheets can be very helpful in assisting the patient to understand what the procedure involves, one must bear in mind that each procedure, and each patient, is different.



Patients need to know what the risks are in their individual case, rather than being given information of a general nature, perhaps accompanied by statistical assessments of the incidence of complications reported in the professional literature.

Those who accept referrals from colleagues for the removal of third molars need to be aware that one of the treatment alternatives is still to leave the tooth (or teeth) in situ.

There is a danger that both the referring clinician, and the clinician who accepts the referral, will each be assuming that the other is responsible for the consent process, including discussing with the patient whether or not it is sensible to be considering the extraction(s) at all.

SURGICAL TECHNIQUE

There is a commonly held misconception that the raising of a buccal flap only, and avoiding bone removal on the lingual or disto-lingual aspect of the tooth, will avoid any risk of lingual nerve damage. It is true that in the literature, the raising of lingual flaps, the use of lingual retractors and/or the use of relieving decisions in the retromolar area have all been associated with a higher risk of lingual nerve damage. It is equally true; however, that many experienced oral and maxillofacial surgeons use these techniques routinely and yet experience a very low incidence of lingual nerve damage.

In the case of inferior dental nerve damage, where there is close proximity between nerve bundle and root apex, the surgical technique (for example, sectioning the tooth) must be such as to minimise the risk of severing, stretching, tearing or compressing the nerve bundle.

COLLATERAL DAMAGE

In addition to nerve damage, one needs to be mindful of the risks of fracturing the mandible (or leaving the mandible weakened and vulnerable to spontaneous fracture postoperatively), fracturing the maxillary tuberosity, or damaging adjacent teeth. This can range from dislodging fillings and crowns, to iatrogenic damage from burs and other instruments, to the distal surface of the second molars.

In each of these situations, by remaining alert to the potential risks and taking some simple steps to minimise them, the clinician can help many of the associated problems.

POSTOPERATIVE MANAGEMENT

Patients who are not adequately prepared for some of the adverse complications of third molar surgery, can find them very distressing.

The extent of any swelling, pain, bruising and discomfort can vary widely from one patient to another, but altered sensation can be very worrying for patients unless they have been made aware that temporary sensory disturbance of this kind is not unusual, and does not necessarily indicate that anything has gone wrong with the procedure. Caring and attentive aftercare is the key to preventing this commonly encountered complication, from becoming the basis for a complaint.

Where postoperative complications do occur, the records should show clearly what the patient was complaining of, what steps were taken to investigate the problem, the differential diagnosis and the treatment provided or advice given (including any medication given, prescribed or recommended). If a referral for specialist advice / management is considered or

discussed, a note of this should appear in the records.

Record negative findings (e.g. 'no lymph node enlargement or tenderness' or 'checked for mandibular fracture/lower border intact') as well as positive findings (e.g. 'swelling reduced'). The importance of this lies in being able to demonstrate that all the appropriate investigations were carried out, before reaching the diagnosis and treatment plan.

Postoperative instructions should be given, perhaps with the help of a printed advice sheet, and this fact should appear in the clinical records. If the patient chooses not to follow the advice given, this should also be clearly recorded.

Arrangements to review the patient's progress should be clear, mutually agreed and recorded in the notes.

RECORDS

Each one of the steps described above needs to be meticulously recorded in the clinical notes. In our experience, deficiencies in such records are much more likely to render a regulatory investigation or complaint indefensible, than any shortfalls in the clinical technique itself.

Accurate, contemporaneous clinical notes are critical when dealing with allegations of inadequate postoperative assessment, or a failure to warn appropriately of risks, or problems arising from a poor technique, or shortfalls in postoperative management.





Supervising others

Mentoring can be great for career progression, job satisfaction and skill development, but how is your protection affected when you are supervising a colleague?

Dental Protection often gets asked by members whether they require additional indemnity when it comes to advising or supervising their professional colleagues. Following on from this another commonly asked question is whether they are liable for any acts by their mentee.

In New Zealand the Dental Association has developed a very well-run mentorship programme for young dentists. Dental Protection fully encourages this activity, as it provides elements of training for both mentors and mentees and provides real value to the profession. The programme creates opportunity for interaction around the many nonclinical aspects of establishing young dentists through the transition from a non-clinical environment to that of the dental practice.

Every individual practitioner has a duty of care to their patients, but there is also one in a mentoring relationship. So, while each individual practitioner has responsibility for patients in whose treatment they are involved, mentors should be aware that there could be assumed an ethical dimension even when they are not treating the patient personally. While it does depend on the relationship between the practitioner and their mentee, the mentor may, in some respects, have a limited responsibility for the outcomes.

MENTEE AUTONOMY

The best way forward in a “true” mentoring arrangement is to have clear documentation confirming that the mentee is autonomous and working independently. This would mean that regardless of advice and guidance provided by the mentor, it would be very difficult to demonstrate responsibility for treatment on their part.

It may be helpful to consider the following when embarking upon mentoring:

- expectations and outcomes agreed upon before any supervision begins
- frequency of sessions, where they will take place and how long for
- professional boundaries.

In any case, a mentor should never assume that they cannot be considered partly responsible if there are any adverse outcomes from the mentee’s treatment of a patient. A mentor could end up being drawn into investigations if the mentee feels that the end result is due to advice or guidance provided by the mentor. Dentists participating in Dental Council mandated supervision of another dentist need to be particularly careful that they are fully aware of the Council’s requirements of that arrangement and seek advice from Dental Protection should they feel they are exposed to difficulties or risk related to their supervision of the practitioner concerned.

MENTOR ENDORSEMENT

If the supervision or mentoring position is within a training organisation, complaints can be brought against the organisation, especially if they have approved or endorsed someone as a mentor.

If the mentee has paid an individual or organisation for the mentoring service, then the contractual obligations are even easier to demonstrate.

PART OF THE JOB

As a mentoring role is part of your professional activity, additional subscriptions will not be charged. This is unless you have chosen your membership in a non-clinical category that excludes any involvement with patients.

Implant dentistry is an area that mentors are sometimes called in to supervise with when junior colleagues are working on their first cases. As a practitioner, if you are mentoring a colleague who is placing implants, then you must both be appropriately registered by the Dental Council and have adequate and appropriate indemnity in place.

Members are welcome to turn to us for advice and support when it comes to taking on a mentoring role, however, we wouldn’t normally extend this advice or support to the organisation or individual they may be providing the mentoring service for.

Case Study

A failed extraction handled appropriately



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

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

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

The patient was booked for an appointment three days later and as expected, the tooth fractured during removal, leaving the distal root in situ. The dentist attempted to remove the root, however was unable to mobilise it and after 25 minutes stopped the treatment. The patient was informed of what had happened and that a referral would be required.

The referral was duly made. Two days later the patient returned in pain and saw another dentist at the practice. A diagnosis of dry socket was made and appropriate treatment provided. At this point the patient questioned why antibiotics had not been prescribed at the time of extraction and questioned how long they would need to wait for the referral.

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

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

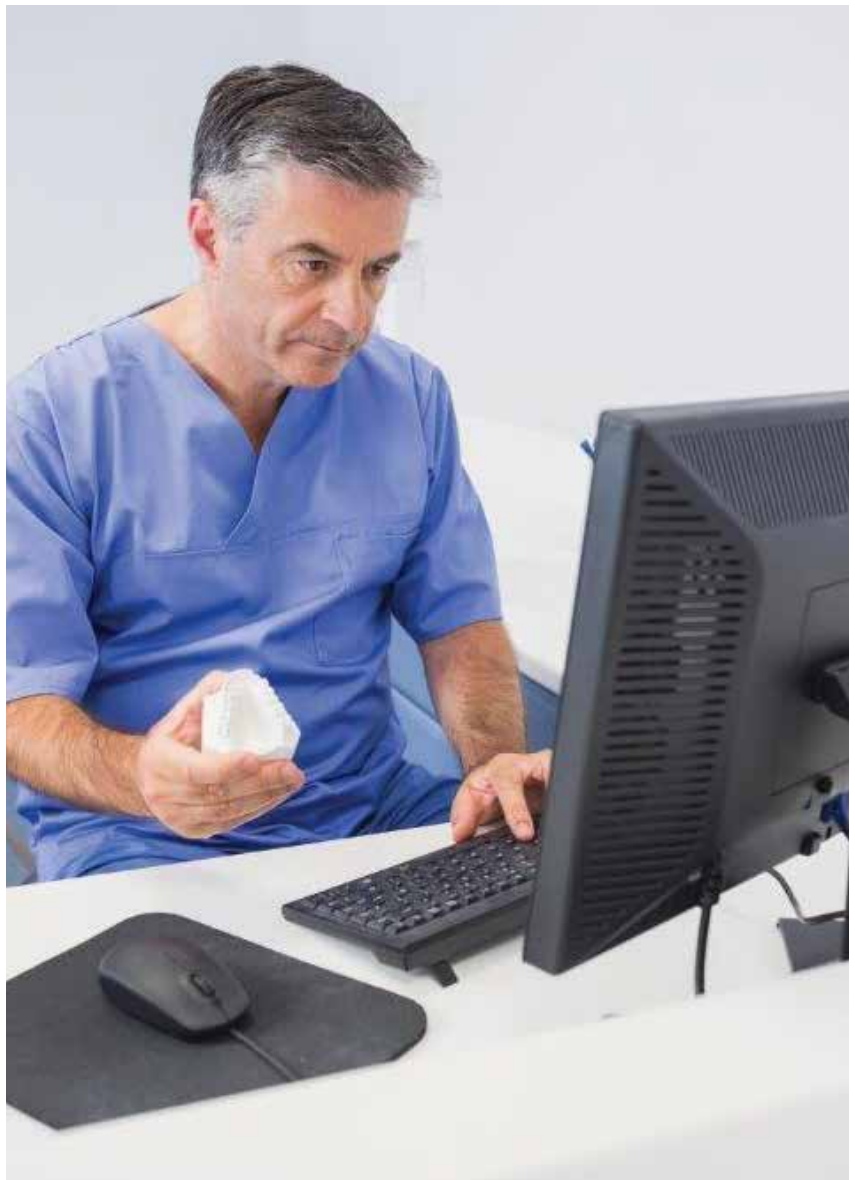
The patient accepted the explanation and no further action was taken.

LEARNING POINTS

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

Case Study

Out of shape



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A middle-aged female patient had badly imbricated lower incisor teeth. She responded to an advertisement placed by a dentist who declared a special interest in cosmetic dentistry.

After an initial consultation, various options were outlined in her treatment plan, ranging from orthodontic treatment and crowns, to the most conservative option of reshaping the tooth using enamel reduction and the selective addition of bonded composite. The patient was unsure about using fixed orthodontic treatment, even though it could achieve more than selective reshaping, so she opted to have the four lower incisor teeth crowned.

After having the crowns fitted, the patient was still unhappy with the appearance of her lower incisors. Although the buccal aspects of the teeth were now aligned, any view from above the incisal edges (the patient was short in stature so this became an important consideration) would reveal a strikingly excessive lingual to buccal width of the two teeth that had previously been in standing. As a result, the patient refused to pay for the crowns and threatened to escalate a formal complaint.

The dentist contacted Dental Protection for advice. On investigating the background to the case, it transpired that the patient had been shown several 'before' and 'after' pictures of cases where crowded and badly angulated teeth had been corrected into normal alignment. In none of these cases had there been any instance where a tooth ended up with excessive buccal to palatal width, and nor had there been any discussion of this possibility in the pre-treatment consultation between dentist and patient.

An expert opinion was sought, which stated that given the original position of the teeth it was never likely to be possible to create well-aligned teeth of normal dimensions without devitalising the teeth and placing posts and cores. This fact had not been considered or discussed with the patient and as a result the dentist was open to criticism given that treatment had been provided without informed consent. Dental Protection assisted the dentist to achieve an amicable resolution.

LEARNING POINTS

- Whatever the treatment plan, all options need to be given to the patient in order for them to provide valid consent to the treatment that is finally selected. If the information provided by the clinician to the patient is incomplete or not accurate, the consent process is very likely to be challenged if the patient is dissatisfied with the outcome.



Case Study

An adverse reaction to ibuprofen

Medical history cannot be viewed at face value – sometimes you must dig a little deeper to ensure you do no harm.....

A patient completed a medical history form for treatment under sedation. Under the allergies section was the entry: 'Allergic to aspirin – facial swelling.'

The practitioner, on his own admission, stated that the patient was seen for two appointments with regard to removal of a lower carious wisdom tooth. At both of these consultations, the patient confirmed his allergic reaction to aspirin and even noted the severity of the reaction by indicating he had a facial swelling from a previous reaction.

The wisdom tooth was removed and the dentist provided written and verbal postoperative instructions which included advice to take paracetamol and ibuprofen.

The patient rung later that day to advise he had developed a facial swelling with itchy skin and shortness of breath. The

patient confirmed he had taken ibuprofen and shortly afterwards he developed the described adverse symptoms. The dentist advised the patient to immediately attend the local Emergency Department (ED). He also promptly emailed and phoned the ED to alert them of the procedure that had been provided along with medication taken by the patient.

He was not aware of the crossover of the allergic nature of aspirin and ibuprofen even though he knew they were both NSAIDs.

A few hours later the dentist rung the patient to ensure he was alright. The wife of the patient answered and thanked the dentist for his prompt advice and referral to the ED. The patient had been admitted to hospital but was now comfortable and due to be discharged tomorrow morning.

LEARNING POINTS

- It is important to remember accidents do happen and a warm heartfelt apology can go a long way in reducing the likelihood of a complaint.



Case Study

A lacerated cheek

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

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

In her letter of complaint the patient stated that she wanted recompense for negligence and her unpleasant experience. When the letter of complaint was received, as a gesture of goodwill, the dentist decided to refund the cost of the restoration and to waive the charge for her next routine dental examination. The patient was not satisfied with this and stated in her letter that he was considering taking further action with her complaint. The dentist sought assistance from Dental Protection.

Dental Protection advised the dentist that despite accidents like this occasionally happening during dental procedures, it might be considered that the cheek was insufficiently retracted and therefore there

was a breach of duty of care to the patient. However, it was recognised that the injury was transient; probably no worse than could have been sustained by cheek biting, and the patient would have likely recovered. In complaining three months after the incident, the patient was very likely seeking some compensation for what she considered was negligence on the part of the dentist leading to an unpleasant experience.

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

As with cheek biting, any small injuries in the mouth heal very quickly and there is rarely any long-term damage. The dentist mentioned that if the patient had contacted him in the days or weeks immediately following the incident, he would have been pleased to have provided all necessary care. The dentist

then went on to say that he hoped that the patient would be happy with the explanation, reimbursement of the costs of the restoration and, if not, then could she write again outlining what she would consider a suitable response. No further correspondence was received from the patient.

LEARNING POINTS

- If an unexpected outcome arises whilst treating a patient, keep them informed.

Case Study

The retained root and consent



@mediaphotos@gettyimages.co.uk

A patient attended at a new dentist for the first time, complaining of problems with a broken tooth. The patient had not seen a dentist for many months prior to that and was aware that the tooth had been progressively breaking. As she was now experiencing discomfort, she wanted the tooth to be removed. The tooth that was breaking was tooth 23 and was the abutment for an adhesive cantilever bridge replacing the missing tooth 22. The patient explained that she was keen to have implants provided in the near future as she did not want gaps at the front of her mouth, nor did she want another bridge.

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

The dentist raised a flap, removed the tooth and sutures were placed. The patient did not return for a review and the dentist did not see the patient again.

Some time later, the dentist received a letter of complaint. The patient reported that six months after removal of the broken tooth 23, she had attended another practice to discuss implant treatment at the site of the 22/23. The new practitioner had advised the patient that in order to go ahead with dental implant treatment, she would need to have the retained root 22 removed first as it was

at the site where an implant would be placed. This would involve a surgical procedure, followed by a period of healing prior to implant placement. The patient was confused as she was not aware of the retained root of 22 and understood that the root of 23 had already been removed six months earlier. The new dentist showed the patient the retained root, identified following a cone beam CT scan and which on careful review was also visible on a PA film that had been exposed.

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

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

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

prior to implant placement, and therefore it could be argued that valid consent had not been obtained when the 23 was extracted.

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

LEARNING POINTS

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



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CONTACTS

You can contact Dental Protection
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Scheme of cooperation

If your membership with Dental Protection has been arranged through the NZDA scheme you should contact the NZDA as soon as you become aware of any complaint or other need for assistance.

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