Risk management from Dental Protection

Dental Protection

Riskwise

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Editorial

Dr Mike **Rutherford**
Senior Dentolegal Consultant

Welcome

I hope you enjoy this latest edition of *Riskwise*, 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

Professor Leonie Callaway explores some of the issues around dentistry and pregnancy, where perhaps a lack of clear understanding can limit clinical care, often leading to problems, dissatisfaction and the development of complaints down the line. The article aims to help dentists overcome the fear and uncertainty over treating pregnant patients by providing clear guidance on the level of required care and some key treatment and prescribing risks to be aware of.

Dr Simon Parsons, based in Sydney and one of our five dentolegal consultants in Australia, describes the unfortunate but relatively common event of fracturing a file during endodontic treatment and how best to manage this problem.

Following these articles, we have a range of case studies reflecting real-life situations that members have experienced – all of which are followed by some important learning points and guidance specific to the circumstances.

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**.

Changes in the West

In other news, I thought I would use this editorial to announce some big changes affecting advisory and case management services for Dental Protection members in Western Australia. As some of you may know already, Dental Protection has had a scheme arrangement with ADA WA for many years whereby we have supported our Western Australian members with risk management advice and training through workshops, lectures, webinars and publications. In March we began the process of extending this support to also include advisory and case management of complaints and legal challenges – plugging Dental Protection members in Western Australia into the in-house expertise and extensive global network of dentolegal knowledge that is central to the benefits of Dental Protection membership.

Before this change, Dental Protection members in Western Australia have received their advisory and case management services from the dental cases panel of ADA WA.

By modifying this now, we will be able to apply the accrued knowledge from our extensive dentolegal global network and provide members with the same level of hands-on support that has long been enjoyed by Dental Protection members across the rest of Australia. Our team of five dentolegal consultants – all dentists – together with our case manager (who is a dental practitioner) will provide an empathic and professional service to help members when you need us most. Our size allows us to provide a comprehensive and agile service with same-day decisions if required, and a 24/7 emergency advice line.

We are delighted with this development and are proud to serve our ever-growing membership. Dental Protection Australia is stronger than ever before, reflecting the dedication and commitment of the team in their work to help colleagues. Any indemnity enquiries or reports of incidents should be made by calling **1800 444542** or by emailing **notification@dpla.com.au**.

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

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Managing endodontic file separation

One of the most frequent adverse events reported is the separation (or fracture) of an endodontic instrument within a tooth. ***Dr Simon Parsons****, Dentolegal Consultant at Dental Protection, looks at what we can do to reduce our risk of procedural error and how we might manage these cases should they arise.*

A young, recently graduated dentist commenced RCT on a lower molar for a patient who had recently given birth. At the second appointment, a file separated, unknown to both the patient and the clinician.

The tooth remained symptomatic and, due to the part-time availability of the treating dentist, the patient sought urgent pain relief at another dental practice where the separated file was discovered during preoperative radiography. The unhappy patient was referred to an endodontist who was unable to retrieve the file. It was agreed, due to the ongoing symptoms, that it was best that the tooth be extracted by an oral surgeon.

The oral surgeon could not achieve adequate local anaesthesia to extract the tooth conventionally, so the patient was subsequently booked in for treatment under general anaesthesia. This incurred considerable inconvenience and expense to the new mother who needed to make alternate childcare arrangements.

Once the clinician became aware of this, they sought advice from Dental Protection and the case was resolved by reimbursing the patient for over $4,000 of specialist and hospital costs. This was essential as the patient had not been warned about the possibility of file separation, and consequently there was no valid consent in place for this case. Regretfully, the patient had already complained to AHPRA, and the clinician endured considerable anguish during the protracted management of the complaint. While the actual occurrence of file separation may not necessarily have been avoidable in this instance, early identification of it may have expedited appropriate patient management and eliminated a complaint to the Dental Board, improving the outcome for all parties.

How likely is file separation and should we forewarn about it?

It can be difficult to know exactly how often files fracture within teeth and remain there because they cannot be removed. This may be due to reasons such as lack of awareness of the fracture itself, a failure to inform the patient or deal with the issue, or endodontic failure requiring tooth extraction. Clinicians may have fractured a file and then successfully retrieved it, in which case such an event would be unreported.

However, it is not uncommon for patients to be first advised of a file separation when seeing a new dentist and having radiographs taken. This naturally raises doubt in a patient's mind about the ethics and clinical ability of the previous treating dentist and can lead to a complaint or claim.

So why don't we tend to forewarn our patients of this risk? It may well be because we don't see it as a likely outcome to our care, given that studies typically report the incidence of file separation as being between 0.5% and 5% of cases investigated.[1]
A recent study of 571 Protaper Next rotary files discarded by endodontists according to conventional reuse protocols showed an incidence of fracture in almost 20% of X1 files and unwinding in a further 10%, despite these not being discarded due to known failure but simply in accordance with protocol.[2] These authors noted that the fracture of rotary nickel-titanium instruments (NiTi) can occur from torsion (exceeding the elastic limit of the alloy due to binding of the file while torqued), cyclic fatigue, or a combination of both factors. Such research underlines the need for careful protocols in the reuse of rotary endodontic files and suggests that fractures may arise during instrumentation without the clinician being aware of it, especially when using fine rotary files.

Although file separation may indeed occur much less frequently than some other endodontic complications, such as overfilling or underfilling, its detrimental impact can be significant especially in cases of periapical infection, resulting in a reduction in success of up to 14%.

Clinicians are obliged to communicate common adverse outcomes, as well as uncommon but potentially serious complications, as part of achieving consent for procedures. We recommend that all endodontic patients are forewarned of the risk of file separation as part of the routine disclosure of the risks associated with endodontic therapy before treatment commences. Naturally, this would also need to be documented in your clinical records.

How might we reduce the risk of file separation?

Some file separations may be unavoidable due to crystallographic issues in the alloy that can predispose to failure, or manufacturing defects. While we have all heard occasional reports of new NiTi rotary files fracturing soon after first being used in a canal, most file separations seem to arise from errors in instrumentation technique, or reuse of rotary files an excessive number of times.

Clinicians can reduce the risk of file separation by careful preoperative case assessment (with referral of cases with anatomical complexity or likely procedural difficulty to specialists), ensuring straight line access into canals wherever possible, removal of coronal constrictions through a crown down approach and fastidious irrigation.

Careful use and reuse of files is a must. Visual inspection of files under magnification is essential where they are being reused, even on the same patient, eg from one canal to the next. Visibly damaged files must be discarded and reuse protocols for rotary files strictly adhered to. Clinicians are wise to set rotary motors at correct speed and torque settings prior to starting each and every case.

Management of a file separation

Determining the best long-term approach to these events depends on the individual case, since the objective of the endodontic treatment with or without a fractured instrument remains the same, namely to disinfect the root canal system and prevent its recontamination.[3]

Disclosure of the complication to the patient must occur if you are unable to correct the situation during the normal course of treatment and avoid irreversible harm or a compromised outcome. If file retrieval is not possible, prompt referral to a specialist for assessment and remedial treatment is wise. This is usually at the referring practitioner's cost unless the patient has been specifically forewarned of a high risk of this complication and offered a specialist referral, but has elected to proceed with treatment regardless.

Any decision to monitor, bypass or remove a separated file fragment should be made in consultation with the patient. Factors to be considered may include any constraints in the root canal accommodating the fragment, the stage of root canal preparation, the potential complications of the treatment approach adopted, the strategic importance of the tooth involved and the presence (or absence) of periapical pathosis.[4] The presence of a fractured instrument need not reduce the prognosis if the canal system is already well-disinfected and there is no evidence of apical disease, in which case file retention or bypass may be considered.[5]

Endodontics is never easy and complications can occur even in experienced hands. Always contact Dental Protection if you are unsure about how best to manage a patient following a treatment complication.

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Dentistry and pregnancy

***Leonie Callaway**, Professor of Medicine at the University of Queensland, tackles the fear and uncertainty many dentists feel when treating pregnant patients, by advising on what level of care is required and what the key risks are.*

One of the main difficulties dentists struggle with is their fear around treating pregnant patients. It is an emotive time and everyone is aware of the need to ensure the very best outcomes for the foetus. As a result of this fear, and a lack of clear understanding, clinical care can often be more limited than it should be, with a series of unfortunate and unintended consequences for both mother and child. The purpose of writing this is to try to put your mind at ease and provide some clear guidelines about what is and is not okay during a patient's pregnancy.

My area of expertise is as an obstetric physician. We care for women with medical disorders in pregnancy and therefore have particular expertise in the issues around radiation, drugs and surgery in pregnancy, the provision of pre-conception care, and the care of women with high risk pregnancies as a result of pre-existing illness or illness that arises during the pregnancy.

Globally, there are obstetric physicians in all of the major tertiary obstetric hospitals. We work in multidisciplinary teams with obstetricians, neonatologists, pharmacists, radiologists and specialists of all kinds with an interest in pregnancy (eg rheumatology, endocrinology, cardiology, nephrology and oncology).

If you ever have a tricky question regarding care for a pregnant woman, feel free to call your closest tertiary maternity hospital and ask to speak to the obstetric medicine registrar or physician who is on call for the maternity service. They should be able to provide you with advice, and if they do not know the answer to your question, they will be happy to point you in the direction of help. Pharmacists can also be invaluable in providing advice regarding drugs in pregnancy.

The level of care required

We know that pregnancy worries many healthcare providers and results in fear-based clinical decisions that are often not in the best interest of the mother or foetus. As a general observation, pregnant women often do not receive the care they need from a range of health professionals due to misconceptions about medications, radiology and surgery during pregnancy.

We have seen pregnant women hobbling around with undiagnosed fractures because their doctor was fearful of doing an x-ray during pregnancy, or struggle with a sudden deterioration in their asthma because their doctor thought their asthma medication was unsafe during pregnancy. And we see women with toothache and dental sepsis because dentists were afraid to treat them.

Most dentists find it reassuring to know that the care they might consider providing is quite minor in terms of risk, compared to what goes on for pregnant women on a day-to-day basis within Australia's hospitals. For example, a dental radiograph results in a foetal radiation dose of 0.0001 rads, compared to a chest radiograph involving 0.001 rads.

We teach all medical students that if a pregnant woman requires a chest radiograph at any point during her pregnancy, the radiation dose to the foetus is so insignificant that the risk of not doing the radiograph and not assessing the lungs and heart properly may far outweigh any minor risk of extremely low doses of foetal radiation.

Pregnant women who develop cancer are often given multiple cycles of chemotherapy during pregnancy and women who develop appendicitis, cholecystitis or hypercalcaemia from parathyroid adenomas are all cared for with appropriately-timed surgery during pregnancy. So, in comparison to the kinds of medications, surgical procedures and radiation exposure that is required to care for pregnant women on a daily basis, dental procedures and dental radiation generally falls into the relatively minor category.

What you need to know

There are a few key messages for dentists providing care for pregnant women or women within the reproductive age range:

1. Women of reproductive age need excellent oral health prior to falling pregnant.

   It is ideal for women considering a pregnancy to ensure that all major necessary dental work is undertaken prior to pregnancy if possible.

   Dentists should ideally enquire about pregnancy plans when women of reproductive age have dental issues identified and encourage them to complete treatment plans prior to conception. This provides peace of mind for all involved. Adverse events such as miscarriage, congenital anomalies, growth restriction and premature delivery are common. People tend to associate adverse events with whatever happened to them recently. Providing excellent preconception dental care prevents women associating their dental care with common adverse pregnancy events in their own mind. It also reduces pregnancy associated anxiety for the dentist, which is a well-documented problem.

2. All required routine and emergency dental treatment is indicated at any time during pregnancy.

   There are multiple guidelines to encourage and reassure dentists about providing regular and emergency dental care to pregnant women. References to these guidelines are included below.

3. Dental imaging should be used when required.

   Fear of dental radiation during pregnancy is generally misplaced. The foetal exposure from dental radiation is vanishingly low. Therefore, if there is concern about dental infection during pregnancy and dental radiation is required to assist in determining an appropriate treatment plan, women should be strongly reassured about the risk benefit ratio of dental radiation.

   Untreated dental sepsis can trigger pre-term birth and result in overwhelming maternal infection. High quality dental care, including appropriate dental imaging, can prevent these adverse outcomes.

4. Pregnant women from 28 weeks onward need careful positioning in a dental chair.

   In advanced pregnancy, women are often very uncomfortable lying on their back and can develop hypotension from the foetus compressing the inferior vena cava. Therefore, from about 28 weeks onwards, a wedge or rolled up towel should be placed under one side of the woman's back while in the dental chair, to ensure the foetus is not sitting on top of the vena cava.

5. Non-steroidal anti-inflammatory drugs need care during pregnancy.

   In the third trimester (from 28 weeks gestation onwards), non-steroidal anti-inflammatory drugs (NSAIDs) should be avoided, due to significant foetal risks. These drugs are associated with persistent pulmonary hypertension of the newborn due to premature constriction of the patent ductus arteriosus, foetal renal injury, oligohydramnios (reduced amniotic fluid), necrotising enterocolitis and neonatal intracranial haemorrhage. Unfortunately, the constriction of the ductus arteriosus in the foetus can be related to even a single dose of NSAIDs.

   For dental pain relief, we recommend paracetamol. If additional pain relief is required opioid based analgesia is safer, and we would suggest the use of codeine or oxycodone. NSAIDs can be considered in the second trimester (12-28 weeks) if absolutely required. If women have been taking over the counter NSAIDs for dental pain in the third trimester, encourage them to see their obstetrician so an ultrasound scan to assess foetal wellbeing can be arranged.

6. Individualised decision-making is often required, and communication with other healthcare professionals involved in the woman's care is strongly recommended.

   Each woman's situation is unique. There are many variables in clinical decision-making for pregnant women who require medications, imaging and surgical procedures. These variables include the woman's own preferences, the stage of pregnancy, delivery plans, foetal growth and wellbeing, weighing of risks and benefits, access to specialised services, newly published research, variations in guideline-based recommendations regarding the safety and acceptability of various medications (for example, local anaesthetics, nitrous oxide, antibiotics), decision-making in the context of limited information, and the skills of the healthcare providers involved.

Conclusion

All of the guidelines encourage communication between the dentist and the woman's other healthcare providers. We strongly recommend good communication with the woman's obstetrician, general practitioner or pregnancy healthcare team in cases where the best plan of action is unclear. We also recommend seeking expert, up-to-date guidance in situations where the published evidence and guidelines lack sufficient clarity to guide decision-making in a particular woman's unique situation.

Helpful reading

American Dental Association, *Guidelines on Dental Care during Pregnancy.*

Oral health care during pregnancy and through the lifespan, Committee Opinion No. 723. American College of Obstetricians and Gynecologists, *Obstet Gynaecol* 2013 (Reaffirmed 2017);122:417 -22.

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Case study

A sharp intake of breath

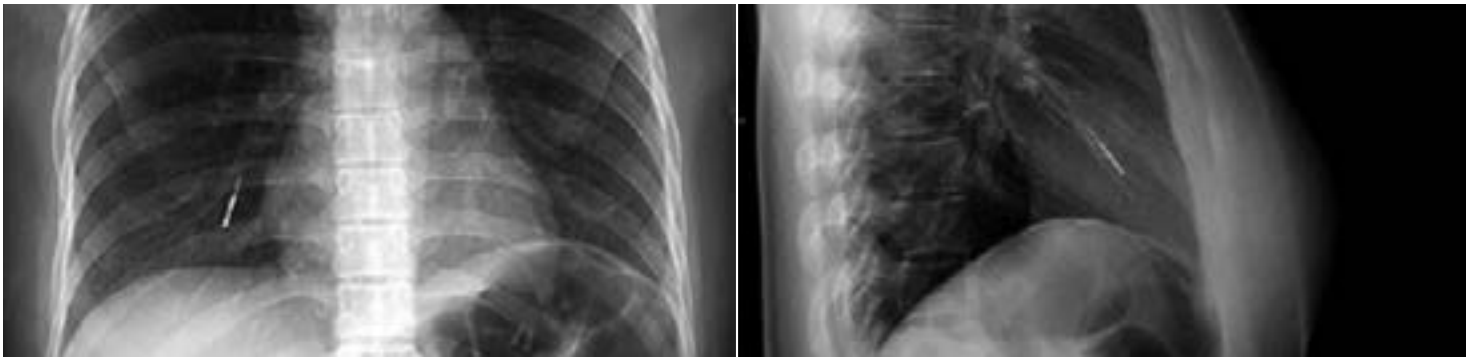

Fig 1

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 (Fig 1)

Case study

During the removal of decay from an upper second molar, a bur became dislodged from the slow handpiece. There followed the seemingly slow-motion drop of the bur 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 bur 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 dentist 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 bur 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 bur had lodged in the middle lobe of the right lung. With fiberoptic bronchoscopy, the bur was successfully removed and postoperative recovery was uneventful; however, the patient obviously had a very unpleasant and unexpected experience.

Given the adverse outcome, the dentist 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.

Case study

Quick thinking avoids a claim following a perforated root

A new patient, Ms Y, attended a practice complaining of pain from an upper lateral incisor that had been recently crowned at another practice. The new crown was aligned with the arch and when questioned about her dental history, Ms Y said that she had not wanted to have orthodontics to correct the slightly tilted and crowded lateral, so had decided upon a crown to realign it.

Dr O examined the patient and it was clear that the tooth was very tender to percussion and there was slight swelling and redness in the buccal sulcus. A periapical abscess was diagnosed, and Dr O discussed the need to access the root canal and begin RCT to alleviate symptoms at that visit.

Dr O was confident of the diagnosis and started access once local anaesthetic had been provided somewhat distal to the swelling to avoid injecting into the infected area. He planned to provide temporary relief at this appointment and 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 seemed a little difficult; there was eventually some bleeding and exudate from the tooth, which was subsequently dressed. Unfortunately, Ms Y returned the next day still very much in pain and unhappy that the crown had fractured in separate pieces, leaving the tooth preparation visible. In wishing to help Ms Y as best he could, Dr O set aside time to reopen the tooth and investigate further to see if more drainage could be obtained before providing a temporary crown.

This time he placed a file to obtain a working length and was planning to instrument and clean appropriately. To his horror, the radiograph revealed that there was a clear perforation of the root approximately halfway to the apex. He also realised that the root was acutely angled in relation to the crown he had drilled through the day before.

Dr O had not taken a preoperative radiograph or probed the root surface to establish the angulation, despite the patient's history.

Dr O was very concerned and a little panicked, but he was able to access the root canal and dressed the tooth. He informed the patient that there was difficulty with the procedure and that he would book them in for a review the next day.

Given the error, Dr O approached Dental Protection for advice on how best to handle the situation clinically and with regard to the management of the patient. In discussing the matter with a Dental Protection dentolegal consultant, Dr O was advised to meet Ms Y, be honest and open with her by apologising that the situation had occurred and reassure her of onward care to resolve the problem.

A referral to an endodontist was made, which Ms Y would not have to pay for, and an opinion would be sought about the

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best way forward. Naturally Ms Y was not happy; however, Dr O showed true concern and integrity, and Ms Y was agreeable to the recommendation. Unfortunately, the endodontist's opinion was that the size and position of the perforation rendered the tooth unrestorable and recommended it be extracted and replaced by a single tooth implant.

Having discussed the situation further with Dental Protection, Dr O advised Ms Y that he would ensure she was not financially disadvantaged and that an implant would be provided for her without cost. A colleague removed the lateral incisor and placed the implant, which was successfully restored to the patient's satisfaction. The treatment was subsequently paid for by Dental Protection and the matter resolved without escalation to either a claim in negligence or a regulatory complaint.

Dental Protection's knowledge and expertise allows us to resolve matters at an early stage 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 dentist – who stayed with her on the journey and who demonstrated genuine regret and empathy – then the outcome would 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 intervene and 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. Members are reminded to contact Dental Protection before making any promises of a financial resolution.

Case study

A difficult call

Dr 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 Dr 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. Dr X felt uncomfortable with the atmosphere and the intimidating way the father interacted with the child. Dr 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 Dr X spoke with his dental nurse who shared his 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. Dr X duly got in touch and provided his 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, Dr X was at some level reassured that he had done the right thing in flagging his concerns as he had originally had reservations about escalating his misgivings for fear of creating trouble.

Some weeks later Dr 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 Dr X's input officially in his recent dealings with social services, he had surmised that Dr X must have "said something to stir things up" and he was going to seek legal advice. Dr X sought assistance from Dental Protection in dealing with the complaint.

Dr 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 Dr 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, Dr 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.

Case study

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.

Case study

To prescribe or not?

Mr T, a 57-year-old male and a long-standing patient of the practice, attended an emergency appointment with pain from tooth 14. The tooth had a deep MOD restoration which had been placed six years ago and had been symptom-free for that time. The medical history was updated at the time and it was clear. The patient was a non-smoker and took no medications.

Mr T complained of pain for two days, which had kept him awake at night, and he was taking painkillers. He reported no other symptoms and was not pyrexic. Upon examination the tooth was very tender to percussion and did not respond to vitality testing. There was no observable inflammation or swelling and a periapical radiograph revealed that the tooth had periapical periodontitis. The dentist Dr F discussed the options to manage the situation and these included doing nothing, which was unsuitable as the patient had symptoms, RCT and the extirpation at that appointment, and the last option was extraction. Pros and cons were explained for every treatment option. Mr T opted for RCT and extirpation and Dr F proceeded with that. After completing extirpation of the diseased pulp, advice was given about further painkiller usage and an appointment was made in two weeks' time to complete the RCT.

Mr T failed to attend that appointment and two months later the dentist received a letter of claim from solicitors. From the letter it was apparent that Mr T attended hospital a few days after the extirpation appointment with facial swelling, which was treated with IV antibiotics. Unfortunately, he clearly considered that his experience was the result of poor treatment at the emergency appointment.

The solicitors alleged that Dr F failed to provide adequate emergency treatment and prescribe systemic antibiotics; had these been prescribed, the solicitors alleged, the outcome could have been avoided.

After comprehensive assessment of the records and discussions with Dr F, the case was successfully defended as Dr F's records evidenced a thorough assessment took place at the emergency appointment. The cause of the symptoms was correctly identified and appropriate advice and treatment had been provided. It was argued that Dr F had acted in accordance with the Oral and Therapeutic Guidelines, as there had been no indication based on Mr T's presentation that systemic antibiotics were required.

Learning points

- The law on consent provides a framework that protects patients' rights to decide about their treatment. In this case all treatment options were explained with their associated risks and benefits.
- The full symptoms of the patient were assessed and recorded in the notes, where it was clearly indicated that the lack of systemic involvement meant that local measures were indicated, and not systemic use of antibiotics.
- Had the records not been as thorough, then defending the claim could have been much more difficult.

Case study

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 or 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 unfortunately 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 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 *Oral and Dental Therapeutic Guidelines* 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 role and place of antibiotics in dentistry is unfortunately a poorly understood process by many of the general public, and often the subject of patient complaints. Dental Protection can guide you towards appropriate references to reflect protocols for non-usage of antibiotics.
- 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.

Contacts

You can contact Dental Protection for assistance

Membership services

Telephone 1800 444 542

Dentolegal advice

Telephone 1800 444 542

dentalprotection.org.au

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