

RISKWISE

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CARIBBEAN AND BERMUDA



Managing stress

THE IMPLICATION FOR YOUR EVERYDAY WORK

SYMBOLIC ATONEMENT
The best response to a
refund demand

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Decision-making – it's all
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DENTAL DIRECTOR



HELLO AND WELCOME TO THIS EDITION OF *RISKWISE*. AS EVER WE HAVE A RANGE OF ARTICLES COVERING DENTOLEGAL TOPICS AND ISSUES AFFECTING THE DENTAL PROFESSION.

THERE IS NO BELL

Dentists make decisions all the time and, in making those decisions, we exercise choice. There is an expectation that our decisions are unbiased, in the best interests of our patients and based on sound clinical judgment. This derives from experience, knowledge and the critical analysis of our work. It is almost as important as the technical execution of the work itself.

Clinical decisions must also be evidence-informed: it differs from evidence-based decision-making because it highlights the importance of individual expertise. It considers the preferences and circumstances of the individual patient in light of the best available evidence, which is presented to us as 'facts'.

Are we as disciplined and do we exercise the same approach when it comes to making other decisions and judgments that impact our daily work, or is there a risk that myths and values may play a part? Facts are verifiable statements of truth, myths are what people believe to be true, and values are notions about how things should be. Without facts and context, our decision-making is flawed.

The social media echo chamber provides an example. It creates a narrative that blurs the distinction between facts and myths. An example is the myth that we at Dental Protection settle cases too early. The commentary is necessarily brief, and often without context and lacking validity when viewed through the lens we apply in making clinical decisions. Myths are amplified inside this closed system, which may become a home for those who post information that confirms their existing beliefs and opinions.

The myths are mistaken for verifiable statements of truth – but of course there is no verification. There is no mention of the 'best interest of the member' argument, the context, risk containment and the value of a highly experienced team. In other words, the very elements that we promote for evidence-informed clinical decision-making are often ignored. It is an incomplete story that is often posted, and it is this lack of detail and context that prevents anyone from making an objective assessment. Case management strategies are frequently determined by the detail, and without this information any third-party commentary is at best conjecture.

This, in turn, may lead to what psychologists call confirmation bias and motivated reasoning.

Confirmation bias is the propensity for people to select only the information that confirms their existing view. It is most pronounced where there are emotionally-charged opinions and deeply-ingrained viewpoints. Motivated reasoning is our tendency to accept what we want to believe with more ease and less analysis than what we don't want to believe. As a result, there are erroneous beliefs and distorted attitudes are perpetuated.

I am reminded of a quote from the legendary investor Warren Buffett who said: "What the human being is best at doing is interpreting all new information so that their prior conclusions remain intact."

The challenge of confirmation bias is that it is very difficult to overcome unless we are aware of the concept. All de-biasing strategies are underpinned by this awareness. Next time you read or hear something negative about our modus operandi, force yourself to look at alternative views and ask yourself whether your judgment may be clouded by cognitive bias. Avoid pre-conceptions and resist the temptation to go with the flow of the echo chamber.

If you are in doubt about what you have read or heard, then as a member you can ask us for the facts; make an evidence-informed decision about any aspect of our work and service to you, in the same way our patients expect us to do when they place their trust in us.

Daniel Kahneman, in his 2011 book *Thinking, Fast and Slow*, writes: "We would all like to have a warning bell that rings loudly whenever we are about to make a serious error, but no such bell is available."

Instead, we must just think about our thinking. That's the truth.

Best wishes,

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SUPPORTING YOU ON ALL FRONTS

This year we have been able to meet many more of you than ever before, listening to problems you have experienced and the areas in your practice you find difficult to resolve.

I am pleased to say that many of these areas have been addressed in this issue of *Riskwise*, including dealing with difficult patients and handling a failed extraction. The ever-important issue of consent is also highlighted.

In the Caribbean we face so many additional problems of adverse weather patterns, changing governments and increased taxation, all of which affect our practice. The two articles "Reflection and risk management" and "Managing stress" will help you to cope with the daily stress of practising dentistry, allowing you to enjoy the profession you chose.

It is really encouraging as we meet members again and again to see how much more aware you have all become of the principles and use of risk management. We hope through these publications to be able to help you along that road, but we can only do so with your feedback and comments.

I look forward to your continued interaction and help so that we can improve our services to you.

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Symbolic atonement

There are occasions when Dental Protection will advise financial redress in circumstances where it would seem this is simply responding to the patient's demand. Dr Jane Merivale, head of policy and technical at Dental Protection, explores the rationale for such a recommendation

Patients may voice dissatisfaction directly or in writing. Either way this is distressing and begs the question, what is the patient saying and trying to achieve – an apology, a remedy, an expression of sympathy or empathy, accountability or just revenge?

In today's culture there is an unfortunate attitude that when something isn't to a person's satisfaction or indeed the outcome isn't what was anticipated or hoped for, then someone must be at fault and 'someone' or some organisation will have to pay, either literally with financial redress or reputationally. The latter is all the more worrying with the opportunity for online comments available at the click of a finger.

We encourage Dental Protection members to seek advice as soon as a complaint is received to obtain professional advice and, importantly, to avoid the possibility of compromising the future handling of the complaint. A poorly worded response is difficult to undo and can be professionally embarrassing if aired in another forum.

HOW WE HANDLE A COMPLAINT

At Dental Protection, the complaint will be assessed and the dental records evaluated by one of our dental advisers. The skill is to 'horizon spot': to assess if the complaint has merit and where it may land if it is not resolved at the earliest opportunity. This assessment relies on both clinical expertise and the experience of having handled many complaints. From the available information the adviser will look at what has happened (the treatment or lack of) and how the care has been delivered.

The technical focus is to identify any element of the clinical treatment that could be regarded as below a reasonable standard (a breach in the duty of care) from which some problem has resulted (causation). If so, then the advice would be that the complaint has the makings of a claim if the patient decided to instruct a solicitor. The records would then be subject to scrutiny by an independent expert.

The complaint is also evaluated to see if there is any aspect that could give rise to criticism should the patient draw their concerns to the attention of the regulator. The focus then is more on how the treatment was provided; the attitude and behaviour of the registrant, as well as the treatment itself.

Early resolution in either scenario is advised in an effort to resolve the complaint at a local level, and to hopefully avert escalation along either of the above routes.

However, nothing is ever quite so straightforward and there are times when the complainant is dissatisfied and none of the above vulnerability is identified. What then?

THAT REFUND DEMAND

A well drafted letter, explaining the care provided (supported by the contemporaneous records) and an apology that the person has found the need to complain may suffice, or it may not; the complaint remains and the demand for a refund is all that sits between escalation and resolution.

We often hear "on a matter of principle, as I've done nothing wrong, I will not give in and refund". Here the concept of the 'no negligence loser' can be considered. In a sense, someone has to defuse rather than aggravate the situation, and make every effort to draw the unhappy situation to a close. A failure to do so could cost time whilst a third party explores the issues raised, additional money and a loss of practice goodwill and local reputation. Human nature being what it is, the facts are likely to be shared inaccurately and exaggerated.

And so to the concept of symbolic atonement: giving the 'customer/patient/client' something to make up for the problem they've experienced. That something would usually be a refund of fees as a goodwill gesture, with no admission of fault, and accompanied by a kindly worded explanation. Research shows that a complaint handled well often enhances reputation and leads to customer loyalty.

There are a variety of reasons why a refund of fees will be advised, and the suggestion to do so will always be given with members' best interests in mind.



Managing stress

Dr Martin Foster, dentolegal consultant, considers why dentists experience stress and how it can be overcome

Stress can impact on a dentist's health and practice in a number of ways. It can affect confidence, clinical judgement, morale and even lead to performance issues.

REASONS FOR STRESS

Dentists face significant pressures within the profession from a variety of sources. Rising patient expectations, heavy workloads, complex treatment options, negative media coverage and an increased fear of litigation and formal investigation all contribute to stress and anxiety within the profession. The work is intensive, and for many the responsibilities of providing healthcare are added to by running a business or managing staff. Poor management and difficult professional relationships can also contribute to feelings of stress. These aspects of dentistry can have a detrimental impact on clinicians, leading to burn-out and potentially placing professional standards and patient safety at risk.

DEALING WITH THE PROBLEM

Stress is a threat to our quality of life and to physical and psychological well-being. You should seek help if you become aware that you are suffering from a stress related condition. You should also act responsibly if

you suspect that a colleague needs help or support. As employers, dentists have a duty to ensure that staff are not put under undue pressure as part of their normal duties.

A successful practice (or dental department) is one where effective stress management strategies are firmly in place. This contributes to the atmosphere of well-being and competence within the practice. Its positive effect emanates throughout – staff and team members feel valued and motivated and patients feel more relaxed and welcome. We need to have systems in place to ensure that staff are coping with their duties and workload, for example a practice appraisal system.

TOP TIPS TO ALLEVIATE STRESS

Review stress factors

Consider the factors that can lead to stress or anxiety. This review process will help you to develop a better understanding of what stress 'looks like' and what action can be taken to control it.

Attend Risk Management events

Reduce the risk of stress through receiving a complaint by attending one of our workshops aimed at how to deal with challenging

interactions, better manage your risks, improve your communication and focus on delivering improved patient care.

Counselling

Accessing a confidential and independent service is often the best way of identifying and dealing with the issues that are at the core of stress and anxiety problems. Dental Protection can provide access to such a service to members who require assistance.

Look after yourself

Work-life balance is really important. Spending time with family and friends, taking up a hobby or going on holiday will help you to maintain a clear focus and positive outlook. It goes without saying that regular exercise, eating well and keeping hydrated will also help in keeping you healthy and counter the stresses of the surgery.



Dealing with a difficult patient

Difficult interactions can be distressing for both patients and members of the dental team. They can be a catalyst for complaints and claims, and dealing with them effectively can lead to a better outcome for patients and members of the dental team.

A VOID PRECONCEPTIONS

A brief scan through the names of patients on your morning list may reveal a few that are familiar – and not always for positive reasons. It is likely that you will form a very quick assessment as to how challenging the forthcoming clinical encounter will be, based largely on your previous contact with the patient. In some cases this may be clinically related, or it may be because you have already labelled the patient as ‘difficult’ due to their behaviour at a previous appointment.

Once you have made this assessment then it becomes easy to stereotype or label a patient and make assumptions about them. Our perception of difficulty can then affect our greetings, body language, the degree to which we listen and the information we provide. This can make the consultation increasingly difficult. A consultation is a dynamic, interactive process and both patients and healthcare professionals respond to each other’s behaviours.

MANAGING AN INCIDENT

Difficult interactions don’t only take place in the consultation room. Patients can behave in an aggressive manner towards administrative or nursing staff. If an incident arises that you are not witness to, it is wise to seek a clear understanding of what has taken place as quickly as possible. It is important to offer support to staff, but also to request a written, contemporaneous statement of events.

Once the situation is understood, the patient should be approached at the earliest opportunity by an appropriate person, for example the dental practice manager. Enough time should be set aside to have this conversation and a record of the exchange should be kept. Sometimes, having the conversation with the patient can defuse the situation and the patient may accept that their behaviour was inappropriate.

TERMINATING RELATIONSHIP WITH A PATIENT

It is entirely understandable that following a difficult interaction one of the first considerations is whether or not to remove the patient from the practice list. If it is decided to no longer see a patient who is currently under treatment, then as far as possible arrangements should be made to transfer the patient’s care or offer referral to a colleague. If patients display violence to any members of the practice staff or are threatening to the point where there have been fears for personal safety, Dental Protection would recommend that the incident should be reported to the Gardaí straightaway.

Defuse a difficult interaction with:

- a warm, friendly greeting and a smile
- eye contact and open body language
- active listening, with open questions and no interrupting the patient
- exploration of the patient’s values, concerns and preferences
- discussing all options and offer explanations
- involving the patient in the decision-making.

Outcomes from difficult interactions include:

- increased investigations and referrals
- decreased patient satisfaction
- unmet expectations
- increased dentolegal risk.



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

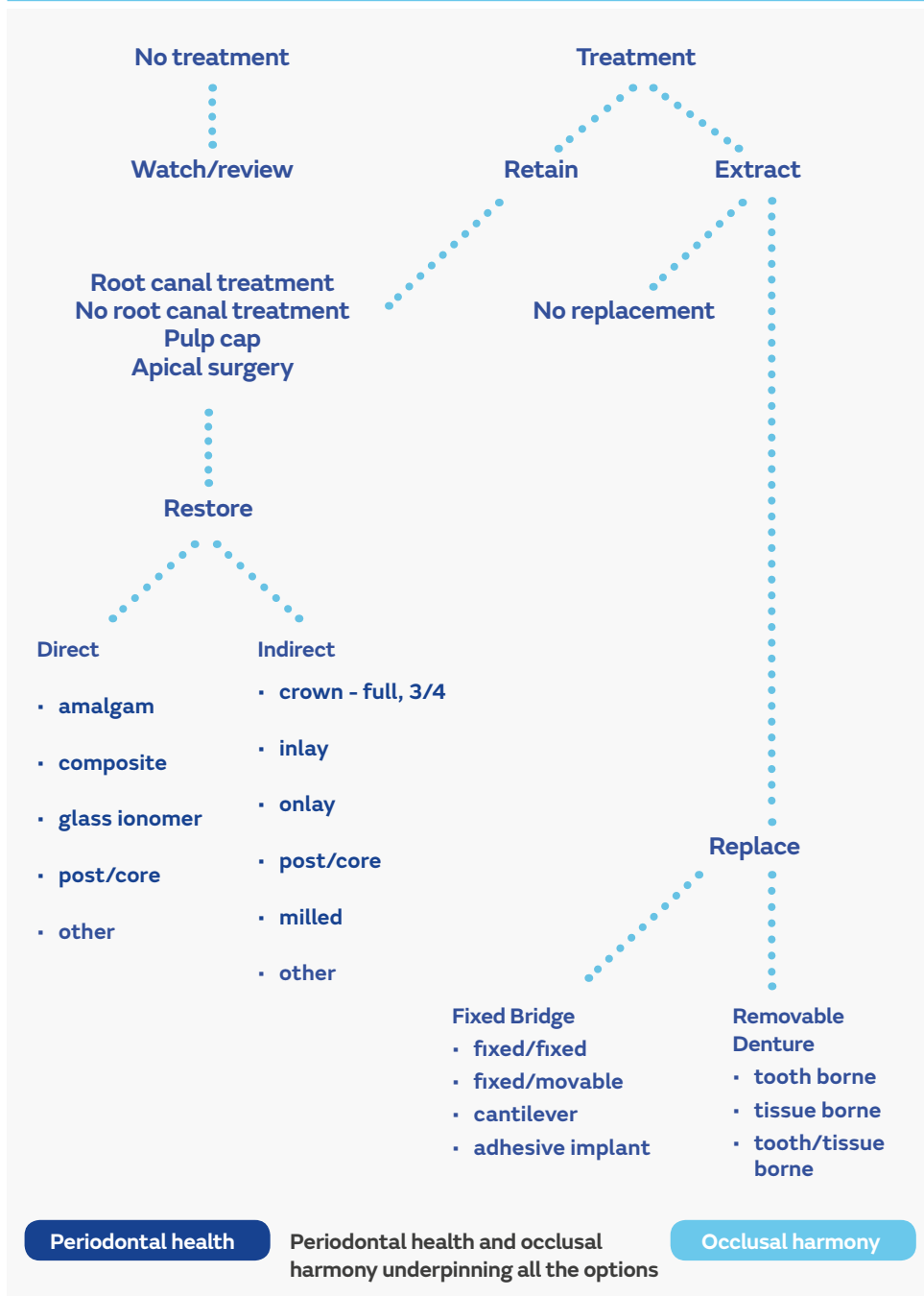
- Gender
- Age
- The environment that one is working in – be it general or private practice, hospital or academic.¹

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, too, it is to be hoped, has to derive benefit from the interaction – satisfaction from a job well done, patient appreciation and, in some settings, financial reward, although this latter point is not relevant to obtaining consent from the patient.

Our clinical decisions, therefore, can have far-reaching consequences for the wellbeing of

Treatment options



Note the following: there is a vertical fracture line. The incisal edge of UR1 is not level with the incisal edge of UL1 (bruxing). The tooth has a range of colours.

The important questions to ask here are: what am I doing and why am I doing this? Whose interests are being served? The flowchart on the left will help to determine the treatment options.²

From this flow-chart 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 UR1 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.

our patients and for ourselves. An acceptable 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.

Let's take a common clinical scenario:

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

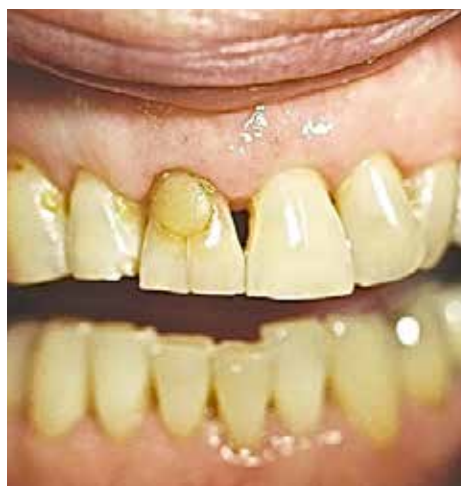


Figure 1. Patient wanted the appearance of her upper right front tooth improved. △

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



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

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.

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 1	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 4	Total 2	Total -7

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

All of the above can be discussed with the patient and she can then make a more

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

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

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

REFERENCES

1. Bader JD, Sugars DA, Understanding Dentists' Restorative Treatment Decisions, *J of Public Health Dentistry* 1992; 252: 102-110
2. Caplin RL, *Grey Areas In Restorative Dentistry - Don't Believe Everything You Think* Guildford; 2015 p.19. J and R Publishing
3. Ibid., p.49

Reflection and risk management

Dr Raj Rattan, Dental Director, discusses how to effectively reflect on clinical practice and its importance for risk management



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It was the Greek philosopher Heraclitus who said: “No man ever steps in the same river twice, for it’s not the same river and he’s not the same man.” He was referring to the fact that change is constant.

It could be said that no dentist carries out the same procedure twice because each clinical situation is different and that, by definition, each procedure adds to the experience of the clinician and therefore s/he is not the same dentist.

Clinical practice is informed by experience but only if it triggers reflective practice. As the American philosopher and educational reformer John Dewey put it: “We do not learn from experience...we learn from reflecting on experience.”

It requires self-awareness, critical analysis, synthesis and evaluation, and helps gain new insights into self and practice. It’s been likened to a spiritual process – connecting the inner self with the outer world.

There are two main types of reflection – reflection-in-action and reflection-on-action. The main difference is that the first takes place in real-time. It happens during the procedure/event and the second takes place after the event.¹

Studies have shown that reflective practices are connected to outcomes, so the principle is beyond the theoretical. From a risk management perspective, both are of equal value but in very different ways.

Reflection-in-action provides opportunities for corrective actions and may prevent error and harm to the patient. It is usually intuitive.

Reflection-on-action is retrospective. It takes place sometime after the situation has occurred. It requires protected time and commitment. Schön emphasises its importance “to discover how our knowing-in-action may have contributed to an unexpected outcome”.

For this reason, reflective capacity is regarded as an essential element of professional

competence. It integrates theory and practice from the outset. The risk management lessons derive from the ‘reflection corridor’ (figure 1, yellow highlighted zone) that encompasses the totality of the process over a timeline – where t1-t2 demarcates reflection-in-action from reflection-on-action at t3. Reflection-in-action should be a continuous process. It informs the procedure and vice versa, so that real-time modifications and actions can be taken to ensure optimal outcomes for the patient.

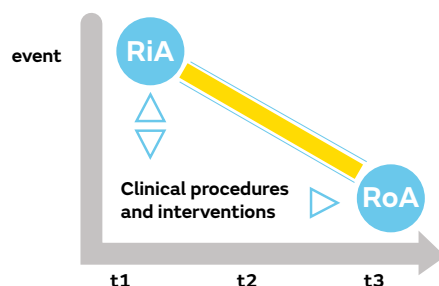
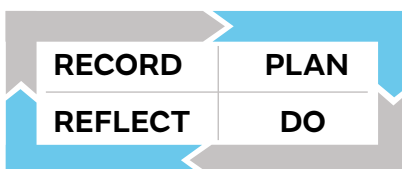


Figure 1. Risk management lessons and the reflective corridor

Demonstrating reflection is essential for dentists appearing before the GDC. It demonstrates insight into the concerns under investigation and can impact the outcome. It is an integral part of our preparation in GDC cases to support members over and above the dentolegal aspects alone.

Activities to promote reflection are now being incorporated into undergraduate and postgraduate education across a variety of healthcare professions. For example, reflection is a requirement in the professional development portfolio during the foundation training year, and we encourage it after any unexpected incident or adverse outcome. It can also inform the content of a complaint response.

It also features in the GDC’s Enhanced CPD guidance, see **Figure 2.**²



The key elements of the reflection are:

- Review your activity
- Reflect on impact on your daily practice and patients
- Make a record of your reflection
Adjust your personal development plan as needed.

The REFLECT model, devised by Butcher, Whysall and Barksby, uses the mnemonic REFLECT to summarise the seven steps of reflection shown below.

R	RECALL the event
E	EXAMINE your responses
F	Acknowledge FEELINGS
L	LEARN from the experience
E	EXPLORE options
C	CREATE a plan of action
T	Set TIMESCALE

Reflective practice promotes changes in our thinking and our approach to the delivery of clinical care, which is also influenced by legislation, regulation, new technologies and innovative treatment modalities.

The focus must be on feedback and actions – going beyond the simple descriptive narrative of what happened and why these actions must lead to change – to realise the full value of the process. By adopting this approach, risk management becomes an integral part of experiential learning and not an afterthought.

REFERENCES

1. Schön, D. *The Reflective Practitioner: How Professionals Think in Action.*, New York: Basic Books, Inc; 1983.
2. General Dental Council. *Enhanced CPD guidance.* Available from: <https://www.gdc-uk.org/professionals/cpd/enhanced-cpd>.
3. Barksby J, Butcher N, Whysall A. A new model of reflection for clinical practice, *Nursing Times* 2015; 111:(34/35): 34–35.



Case Study

A failed extraction handled appropriately

A patient, who had originally been seen by another associate within the same practice six months earlier, attended with a new dentist complaining of a broken tooth. The new dentist identified deep caries at the LR7 and carried out further investigations on the tooth.

After exposure of a radiograph, the tooth was deemed to be un-restorable. After speaking to the patient it was determined 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 LR7 was grossly carious and was broken below alveolar bone level; however, there was good bone and periodontal support. There was no evidence of apical pathology. The patient was advised of the risk that the tooth could break during removal. The patient was also informed that whilst all attempts would be made to remove any broken root, if this was not possible an onwards referral would be required.

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

fractured during removal, leaving the distal root in situ. The member attempted to remove the root, however was unable to mobilise it and after 25 minutes stopped the treatment. The patient was informed of what had happened and that a referral would be required.



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

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

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

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

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 member 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 member decided to refund the cost of the restoration and to waive the charge for his next routine dental examination. The patient was not satisfied with this and stated in her letter that she

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

Dental Protection advised the clinician 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. He mentioned that if the patient had contacted the dentist 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.**
- **There is no automatic admission of liability in sharing a suboptimal outcome with a patient.**

Case Study

A request for compensation

A patient had attended a practice on three occasions and was registered with the practice principal, although he had not attended for three years. He had recently seen an associate dentist due to a fractured filling at the LL6, which had been placed many years earlier at another practice. The associate placed a temporary dressing and advised that the patient return for a check-up and filling appointment with his usual dentist.

At this second appointment, the patient saw the practice principal, who carried out an extensive clinical examination and placed an amalgam DO filling at the LL6. The dentist also identified early stages of periodontal disease and recommended a course of periodontal treatment. This was completed over two visits and it was advised that the patient return for a follow-up appointment in three months.

The patient did not attend for the follow-up but telephoned the practice one year later, requesting a scale and polish to remove stains that had built up on the teeth as he had a family function that he would be attending the following week. The patient was advised on the phone by the receptionist that he was due for a check-up, and asked whether he would like to book for this and a scale and polish at the same time.

The patient booked in for an examination and scale and polish. At the appointment he mentioned that he had experienced some

food packing in the region of the LL6, where the previous filling had been placed. A clinical examination identified that the filling was stable, but the patient was given the options of either smoothing the filling interproximally or replacing it to see if the contact point could be improved. As the filling had been placed more than one year earlier, a new charge would apply for a replacement filling.

The patient left and the following week a complaint email was received. The patient was unhappy that he was going to be charged for a replacement filling when the dentist had identified that there was a problem with it.

Both dentists involved were members of Dental Protection, and they sought our advice. An explanatory letter was sent and the patient was offered a refund of the charge that he had paid for the examination and for the scale and polish. The patient responded requesting a refund of the fee charged for the filling placed at the LL6 the previous year and asked for compensation of US\$100.

A decision was made to offer the patient a refund of the fee for the filling, as a gesture of goodwill and in an attempt to resolve the complaint swiftly and amicably. It was, however, decided that an offer of US\$100 in addition to the refund of the fee for the filling was not appropriate so this additional amount was not offered.

The patient accepted the refund and the complaint was satisfactorily resolved.

LEARNING POINTS

- This case raises the question of what to do when a patient asks for 'compensation'. The term has a specific meaning legally which differs from the common use of the word, and so compensation demands need to be viewed in the circumstances of the complaint. Depending upon context the case may or may not be considered a clinical negligence claim. Situations often arise when a patient writes a letter of complaint to a dentist and mentions that they are seeking compensation. A decision needs to be made as to whether the patient is actually making a valid clinical negligence claim and is acting as a party litigant (ie an individual conducting their own litigation), seeking compensation for pain and suffering, or whether the complaint raised can be managed in line with the practice complaints policy, with the offer of a refund of fees or assistance with remedial treatment costs. In many cases, the latter option is entirely possible.

Case Study

A solid defence of a foundation dentist

Note – this case took place in England and refers to local procedures and organisations



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Dr F, a first year foundation dentist, contacted Dental Protection for assistance as he had been suspended from his foundation dental training.

When he telephoned Dental Protection, Dr F said that he had attended a meeting with the postgraduate dental dean, who had suspended him from his training practice after his trainer (principal of the practice) had raised concerns. Dr F was suspended while there was an ongoing investigation by an independent investigator. Naturally, he was very concerned about this, especially as he had secured a dental core training position following satisfactory completion of his foundation training.

IN THE BEGINNING

Dr F explained that he had been excited about starting his foundation training: he got on well with his new colleagues and the staff at the practice, but had never felt fully supported by the practice principal. The relationship had always been strained and over time it had become increasingly worse. It now appeared irreconcilable. Dr F had sought support from the programme director/patch associate dean as early as three months after starting the position, so they were already aware of the poor relationship.

Dr F met with his trainee support tutor and the patch associate dean to discuss his multisource feedback, which was surprisingly poor. He reflected on this and sought assistance from a professional support unit at his deanery, who had offered mentoring, guidance, and CPD courses in areas including communication, negotiation, difficult relationships and diversity. Dr F had shown commitment and reflection by signing up for the courses.

As part of the normal review of competence of foundation dentists, Dr F was asked to attend an interim review of competence progression (IRCP) panel meeting with the postgraduate dental dean. At this meeting he was informed that his trainer had raised concerns directly with the postgraduate dean about Dr F's behaviour and performance. The trainer raised concerns regarding inappropriate comments made to staff in the

practice, a breach of patient confidentiality and communication issues. The deanery considered that these concerns may impact on patient safety and a decision was made to suspend Dr F from dental foundation training immediately, so that an investigation could take place.

HOW DENTAL PROTECTION ASSISTED

Dr F did not know who to turn to for support: because the deanery was carrying out the investigation, the normal support structure for a foundation dentist was not available. The BDA informed Dr F that it was not within its scope to assist. Dental Protection therefore used its discretion and offered assistance to Dr F. If the investigation established misconduct of Dr F, it was very likely that the case would be referred to the GDC. Dental Protection was also able to offer CPD to Dr F.

Postgraduate dental training is part of Health Education England (HEE) and the independent investigation was to be carried out in line with the guidance *Maintaining High Professional Standards in the NHS*. The case manager at HEE, on behalf of the deanery, appointed an independent investigator to carry out the investigation.

Dental Protection's dentolegal consultant – dentists with legal training – accompanied Dr F to the meeting with the investigator. The investigator presented the terms of reference and explained that her responsibility was to investigate and establish the facts in the investigation of misconduct. She explained that she would also be getting statements from the trainer, other staff members and the programme director.

During the meeting the member was given the opportunity to respond to the allegations made by the trainer. These included reports of allegations from other staff in the practice about Dr F's inappropriate behaviour and comments of a racist and sexist nature. Dr F was able to present his understanding of the situation and comment on the allegations.

Following this meeting the investigator considered it was safe for Dr F to return to clinical practice, and the postgraduate dental

dean was able to secure him a position in another practice to complete his dental foundation training. He was, however, informed that the investigation was ongoing and may result in a disciplinary outcome. Dr F had been suspended from clinical practice for 26 days.

THE INVESTIGATOR REPORTS

More than nine weeks later, Dr F received a copy of the draft investigation report, for his comments prior to a meeting with the deanery. He shared the report with Dental Protection. Both Dr F and Dental Protection felt it was unfair and that there had been undue process, in that the independent investigator had not met again with Dr F after receiving statements from the other parties, including the trainer and his staff.

Dental Protection wrote to the case manager at HEE on behalf of Dr F, setting out the errors in the report. It was also considered unfair that the investigator had not tested the accuracy and validity of statements included in the report, many of whom the investigator had not met.

A senior dentolegal consultant accompanied Dr F to the trainee support meeting with the postgraduate dean, the case management team from HEE and the associate deans covering the foundation dentist's new practice, to discuss the outcome of the investigation. At this meeting it was agreed that the factual errors would be redacted from the final report.

Dr F presented his reflection on the investigation. The panel noted the CPD that he had completed, and there was very positive feedback from Dr F's new foundation trainer and associate deans. Dr F would be able to complete his foundation training and was encouraged to continue to engage with the local professional support unit in his new training post.

Dental Protection was able to support Dr F very early in his career, at a time when his professional reputation was challenged and he felt very vulnerable.

Case Study

An incorrect extraction



A patient attended a new practitioner for the first time and a routine examination was completed. The patient reported previous problems from both lower wisdom teeth which had caused discomfort, swelling and infection, for which antibiotics had previously been prescribed. However, the patient was not reporting any specific problems at that time.

As part of the examination, the dentist took the view that an assessment of the wisdom teeth would be advisable, and the patient agreed to two periapical radiographs. The x-rays were processed and, as was usual practice, the dental nurse placed the films into a plastic film packet. The LL8 was identified to be carious, but was incorrectly recorded as the LR8.

The LR8 displayed an area of radiolucency around the crown of the tooth which suggested to the dentist that there had been repeat episodes of infection, and that potentially this tooth would need to be removed should there be a recurrence of symptoms. The patient was informed that the LL8 was un-restorable and needed to be removed.

The patient was aware of the reason for removal of tooth LL8 and booked an appointment to return the following week to have the tooth removed.

One week later the patient returned and the dentist checked the records and x-rays, informed the patient what was involved in the procedure in so far as numbing the tooth

and removing it, and of his impression that it would be a straightforward removal.

The dentist checked the records, which corresponded with the x-ray, and proceeded to numb the LR8 and the tooth was removed without complication. Postoperative advice was given and the member checked the area for haemostasis. During a review of the socket and mouth, the dentist identified that the carious tooth was still present.

The dentist checked the records and radiographs, as well as the tooth that had just been removed, and identified the mistake. The patient was informed immediately of the error and an entry of the same was documented in the records. The dentist apologised profusely and the patient understood and accepted the situation.

The dentist later called Dental Protection to seek advice on whether anything further needed to be done and how to follow up on the error made. As there was no complaint letter, the advice was that the patient should be contacted again to ensure that they were healing well and invited to attend a review appointment.

The member was advised to discuss the issue at the next practice meeting and to carry out a risk assessment and analysis to determine how a repeat situation could be avoided in the future. The patient did not make any formal complaint and there was no further outcome.

LEARNING POINTS

- The importance of double-checking radiographs with an intra-oral examination and with the clinical records to ensure that there are no discrepancies.
- The importance of having failsafe processes for orientation and labelling of radiographs, being mindful that human errors do occur.
- Prior to an irreversible intervention, clinicians should ensure that they are content with the rationale for the specific tooth removal and this is backed up with a clinical diagnosis, which is well documented in the clinical records.
- All records should be completed contemporaneously to reduce the risk of incorrect recording.
- It is vital to be honest and open with patients when treatment does not go as planned.

Case Study

Incorrect use of reversal agent during sedation



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An anxious patient needed extraction of LL6, which was deemed to be un-restorable by the treating general dental practitioner. The patient was subsequently referred to the local hospital for treatment. Various treatment modalities were discussed, including the option of LA only or sedation with LA. The patient, who had undergone previous extractions with LA, opted for sedation with LA, as he was aware that it would be a surgical removal and likely to be a more lengthy process.

The patient attended for the treatment at the dental hospital where he was referred and the treatment was to be completed by a consultant oral surgeon. The patient was greeted by a trained dental nurse, who checked the presence of a suitable escort. Also present was a trainee nurse, who at the time was observing the trained nurse.

The patient was brought into the oral surgery clinic and, whilst the patient was getting seated, the oral surgeon drew up the midazolam. The procedure started and it soon became apparent after titration of 20mg of the drug that the patient was not sedating appropriately. The patient was questioned on drug use, which was denied. The trained nurse then noticed that flumazenil, which is the reversal agent, had been given rather than the midazolam. The two drugs had been placed side by side and both had orange and white labels on the ampoules.

The surgeon, realising the mistake, then administered the midazolam; however, the patient did not sedate and so nitrous oxide

was administered. The extraction was completed with the patient fully aware and uncomfortable throughout the procedure.

After completion of treatment the patient was taken to recovery. However, he was not advised of the incident and was monitored for only 20 minutes without being warned of the risk of rebound sedation.

The surgeon completed an incident form one week later, but did not clearly explain that after giving the patient flumazenil, midazolam was then given.



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His employers were advised of the incident form and after reviewing what had taken place, they decided to carry out a full investigation, and interviewed the surgeon in question. Despite the patient not having any untoward reaction after treatment, the surgeon was criticised for not informing the patient of the incident. He was also not honest when completing the incident form. The hospital guidelines outlined that when drawing up medication it should be checked and witnessed by a second appropriate person, prior to the patient entering the room, which had not been done. Furthermore, the patient had not provided consent for the provision of nitrous oxide.

It is clear that in this case, the oral surgeon failed to adhere to the responsibilities and requirements for treating a patient under sedation. After being made aware of his vulnerabilities in terms of how he managed the incident he carried out audits on his practice and worked with his employers to put together a protocol to ensure a similar situation did not occur again. The surgeon was a member of Dental Protection and, as part of a review of his practice, he contacted us for advice.

The patient made a formal complaint and the surgeon co-operated fully with his employers in their management of the subsequent complaint. The patient accepted the hospital's apology and the case was closed.



Case Study

Keeping up to date

A dentist, Dr V, was working in a dental practice and one of his patients was an eight-year-old girl.

At the first appointment with the child, Dr V discussed with the mother the benefit of placing preventive fissure sealants on her primary molar teeth. She agreed to the treatment and Dr V proceeded to place a composite resin sealant on the lower left first and second primary molar teeth.

The child subsequently went to another dentist who said that no sealant was present, and that there was no clinical indication for the placement of sealants in the child because she had a low caries risk. The child's mother made a complaint against Dr V, who contacted Dental Protection for support.

We advised Dr V to review the current guidance available on current preventive approaches to dental caries for child patients. These were all valuable resources when considering the preventive management of dental caries. We also assisted Dr V in his response to the complaint, apologising for any oversight in adhering to current guidelines. There was no further action taken by the patient's mother.

LEARNING POINTS

- The continued awareness of current guidelines is key to avoiding professional criticism.

Case Study

The retained root and consent



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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 the UL3 and was a cantilever bridge retainer for a missing UL2. 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 UL3 with a periapical area. Even though the x-ray image was not clear, with good lighting, a buried root could also be seen at UL2. The dentist did not record that a retained root was present at UL2; 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 UL3, surgical removal was required as the tooth was so grossly decayed. The dentist raised a flap, removed the tooth and sutures were placed. The patient did not return for a review and the dentist did not see the patient again.

Two years later, the dentist received a letter of complaint. The patient reported that six months after removal of the broken tooth (UL3), the patient had attended another practice to discuss implant treatment at the site of the UL23. 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 (UL2) 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 UL2 and understood that the root of UL3 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 the patient 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 and 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 UL2 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.

It was identified to the dentist by Dental Protection that his records did not reflect the nature of the conversation that took place with the patient when she first attended with the broken UL3. 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 UL3 was extracted.

Dental Protection discussed with the member in question whether they would be prepared to offer a refund of the cost of the extraction at UL3 in view of the patient's dissatisfaction, or alternatively consider offering a contribution towards the cost of extraction at UL2. It was considered that as the surgery to have the UL2 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 UL2 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 UL2.

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.

CONTACTS

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for assistance **dentalprotection.org**

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