



RISKWISE

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IRELAND



Good enough dentistry

Is it time to change the conversation from 'perfection' to 'good enough'?

The sum of all fears
How can we manage risk and uncertainty?

Erosive tooth wear
The third most common oral condition in Europe.

Case studies
Practical advice from real life scenarios.



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Contents



05 What is good enough dentistry?

Restorative dentist James Darcey looks at what constitutes 'good enough' dentistry.



08 The sum of all fears

Raj Rattan, Dental Director at Dental Protection, looks at how we can stay confident and competent throughout our careers.



10 Monitoring erosive tooth wear

Professor Bartlett and Dr Dattani examine the importance of documenting tooth wear as part of a standard dental examination.



12 Case studies

From the case files: practical advice and guidance from real life scenarios.

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Editorial



DR MARTIN FOSTER
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Welcome

One of the things that 2019 will be notable for is the launch of the long-awaited National Oral Health Policy. It is good that the profession has this policy at long last, but it is a pity that the optimism and positivity that this could have potentially engendered across the profession was undermined at the outset. This is due to the widespread concern that the lack of effort made to engage the wider profession in a meaningful consultation was a lost opportunity.

The document itself has clearly had a lot of work put into it and there are a number of laudable aims contained within the pages. No one can possibly argue that oral health should not be the focus of concerted action if improvements are to be delivered to the population the profession serves. Ideas are only good however if they are reflected in corresponding actions by people who make things happen. The policy now needs the profession as much as the profession needed a policy.

Implementing the policy will clearly have challenges for the dental team. There is a scarcity of detail on a number of practical points and in due course, a direct impact upon the work pattern of clinicians can be expected in the future. The primary focus of members is to use their skills to best effect in providing appropriate care for all of their patients. There is a risk that unless the details of the changes envisaged in some parts of the policy are handled carefully, it may make the expected improvements more difficult to deliver in practical terms. Dental Protection is fully aware of the potential pressures that some of the far-reaching changes proposed may create, and we are committed to supporting and assisting our members in dealing with these.

Members who hold DTSS contracts continue to receive communications of various types from the HSE PCRS in relation to record requests and questions around the validity of claims submitted. Some members have recently received letters from the Director General setting out potential sanctions that certainly do not add to the enjoyment of the working day for any busy clinician. We know there is a lot of inconvenience and work involved for a dentist in responding to such communications, some of which involve considerable numbers of patient records. Dental Protection is also keenly aware of the potential upset, anxiety, and indeed anger that our members can experience when such communications are received.

As an organisation, we are committed to supporting and standing up for our members. We would encourage any dentist who is on the receiving end of such a communication to contact Dental Protection as soon as possible and we shall be more than happy to assist.

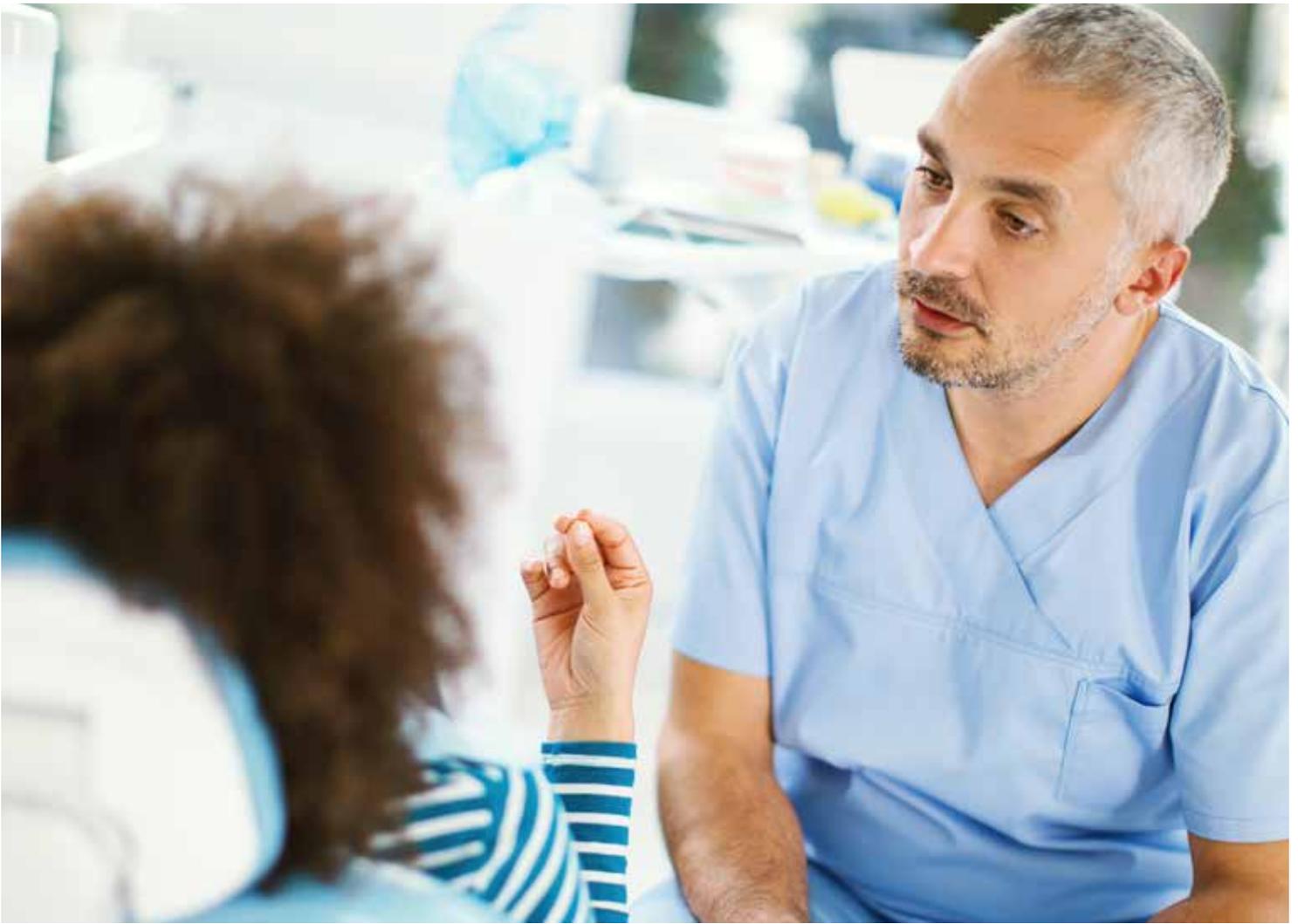
It would be wrong not to talk about the elephant in the room. The issue of an increase in membership subscriptions for dentists involved in placing or restoring implants has been a sore point with many members. It is fair to say that no one wants price increases, and certainly not Dental Protection. The difficulty is that implant-related cases can, and do, lead to very expensive claims, which can encompass all dentists involved in the treatment – all too often because the records do not accurately reflect the complexity of the treatment. There is a case study in this issue which illustrates a situation which was resolved with a simple refund, but unfortunately, this is not always the case. Dental Protection will always defend any case that it can but the sad reality is that the old adage “poor records, poor defence, no records, no defence” is still all too applicable. I know it sounds like a broken record to keep banging on about records but they really can be your best friend – or your worst enemy – so it is worth spending a bit of time on them.

Enjoy this edition of *Riskwise*.

All the best

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What is good enough dentistry?

Changing the conversation and moving the bar – restorative dentist James Darcey looks at what constitutes ‘good enough’ dentistry.

The world of dentistry is changing at pace. The internet and social media provide unparalleled access to education, peer support and updates on techniques and clinical advancements. Everyone’s opinion appears to be equally valid and the ‘expert’ can often offer no better contribution than the generalist. This gives clinicians the ability to partake in the bigger conversation and broaden their knowledge base. This may, however, come at a price.

The nature of this type of learning often leads towards excellence, with clinicians posting cases that raise the bar of quality to a level that is worthy of the highest praise, but one that may be unattainable by the masses. Dentistry in these forums can often

be glamourised and invariably unattainable. There also remains the huge question of publication bias; clinicians rarely discuss their failures in their postings.

BEING ‘GOOD ENOUGH’

The British psychoanalyst Donald Winnicott coined the term “good enough mother”.¹ The phrase began to change the vernacular about how we raise our children. Implicit in this was the concept that perfection is not always, if at all, possible. Going one step further, Bruno Bettelheim, in his book *A Good Enough Parent*, wrote that perfection may not be a healthy pursuit:²

“In order to raise a child well one ought not to try to be a perfect parent, as much

as one should not expect one’s child to be, or to become, a perfect individual. Perfection is not within the grasp of ordinary human beings. Efforts to attain it typically interfere with that lenient response to the imperfections of others, including those of one’s child, which alone make good human relations possible.”

Seeking perfection focuses the parent on the problems and not the aspects of nurturing, support and key milestones that are good and healthy. Every failure and every blemish is subject to microscopic scrutiny. We live in a world with infinite independent variables beyond our control and it should quickly become apparent that no mortal could lay claim to be independent of these.



WHAT DOES THIS MEAN FOR DENTISTRY?

It may be time to change the conversation from ‘perfection’ to ‘good enough’ dentistry. There will be times when we must strive for perfection, but we may have to settle for ‘good enough’. This doesn’t mean lowering our standards, but rather identifying a threshold supported by a group of fundamental minimum standards, from the examination to the discharge of the patients in our care. If we operate above this threshold, this gives patients a high quality service and great outcomes.

Fortunately, we do not have to leave this to chance; frameworks exist by which we can establish baseline parameters of good clinical practice. Look no further than the pillars of clinical governance.

PILLAR	OBJECTIVES
Quality	Ensuring patient safety, patient satisfaction and meticulous evidence informs clinical practice. Reflecting on outcomes, be they good or sub-optimal, and addressing aspects that may continue or correct such performance.
Audit	Quantifying performance and comparing this to predetermined expectations. Should there be a discrepancy, implement changes to redress this and re-audit. The cycle continues.
Patient and public participation	Seeking out and responding to patient feedback about all aspects of the patient journey from booking in to discharge.
Education and training	Ensuring the team is compliant with training needs targeted to their roles within the practice.
Performance management	Implementing processes to raise concerns with underperforming staff or systems relating to organisational culture, conduct, capacity or health.
Risk management	Ensuring processes exist to identify and mitigate risks. When bad things happen to reflect, learn and implement changes to prevent them happening again.
Information governance	Protecting patient sensitive data.

SO, WHAT CONSTITUTES 'GOOD ENOUGH' CLINICAL DENTISTRY?

In principle, it consists of:

- **A robust dental history and examination**

Treating all patients like new patients is a good starting point: it's easy to be complacent with long-standing patients and drop one's guard. Using a template helps to ensure a logical progression through the history and ensures all points are covered. With new BSP guidelines, consideration must be given to full pocket charting on patients with intra-oral evidence of periodontal disease.

Dentists are fortunate that investigations are largely limited to percussion, sensibility, mobility, colour, attachment loss and radiographic examination. Ethyl chloride should be abandoned in favour of the more specific and sensitive colder sprays such as Endo Ice or Endo Frost at -50 degrees. Radiographs should be justified, graded and reported on.

- **Accurate diagnoses**

There can be no treatment plan without a clear list of diagnoses. These can be both general diagnoses, such as periodontal health, and more specific tooth level diagnoses. The diagnoses should be supported with risk assessments to document the likelihood of future disease.

- **Treatment planning – broken into urgent care, primary disease stabilisation and definitive treatment**

This sets out a plan for the patient that prioritises their care, establishes their ownership for oral health and disease prevention, and provides the appropriate treatment at the appropriate time. A patient presenting with quadrant caries is not a patient who should be offered quadrant conservation until they have made changes

that will improve the predictability of restoration and reduce the risk of future restorations. Active caries may be stabilised with provisional restorations and an appropriate preventive regimen established.

- **A conversation about disease aetiology and a management strategy and, where choices present, a reasonable conversation about the risks and benefits of these choices**

This should be inclusive of all core options, with a focus on the likely outcomes of each option. The consent should be tailored to the particular situation, not generic, and it should be an honest reflection of the clinician's ability. When consulting on the likely success of root canal treatment or the likely outcomes of implant surgery, it is becoming less appropriate to reference text books or journals, but rather the focus should be on one's own success rates. If those success rates are lower than that of the specialist, the offer should be made to refer. This may be a more involved process for the new patient who is disease active, or it may be a very simple process for the established, stable patient.

- **Delivery of care**

In principle, this should be painless or made as comfortable as possible. Though the patient may be unaware of the clinical quality delivered, they will be aware of the care and attention dedicated to the process. The importance of the patient's perception in this regard should not be underestimated. Ultimately, however, you should ask yourself how would a colleague judge this standard of care? Would they think it was good enough, even perhaps excellent, or would they find criticism? We should aim to provide a standard of care that we are proud of and that we would be proud to show other clinicians. Nonetheless, there are operating guidelines that can help us work with pride.

- **Discharge and follow-up**

Follow-up regimes should be planned according to risk. That risk should take into account the caries risk, periodontal risk, tooth surface loss risk and oral cancer risk. It's sensible to offer and document shorter follow-ups when treatment plans are more complex or treatment has not progressed as smoothly as anticipated. Patients suffering complications should be more closely monitored, and at the very least, offered an immediate review.

- **Good documentation of all of the above**

Record keeping is key for risk management prevention and good dental practice.

- **Referral for care**

When there is uncertainty about a diagnosis it is important to seek help, be it from a colleague within the team or from the wider referral network. If a decision is made to refer, the patient should be informed of the reason why and any likely time delays and costs for future treatment.³

CONCLUSIONS

It is possible to work in healthcare and offer high quality clinical care, but there will be times when excellence is impossible and compromises are necessary. Nonetheless, there are baseline parameters of clinical care from history and examination to delivery of treatment that, if adhered to, allows good enough dentistry to be provided.

If such core principles are adhered to, excellence will quickly follow.

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The sum of all fears

It is a fact that much of human behaviour is related to maximising rewards and minimising losses. Raj Rattan, Dental Director at Dental Protection, looks at how we can reduce fear and manage risk and uncertainty, so we can stay confident and competent throughout our careers.

The view that success breeds success is explained by neuroscience as the result of a surge in the neurotransmitter dopamine. This reward chemical encourages the brain to carry on doing what it has been doing – it is an example of ‘reward-based learning’. We also learn from failure – so-called ‘avoidance learning’ – where the absence of a stimulus creates a behavioural change. It correlates with the expression of fear.

FEELING THE FEAR

It is a widely expressed view that dentists are now more fearful than ever. We hear it from members, from professional bodies, from those involved in postgraduate education including training programme directors who are in regular contact with foundation dentists.

The fears relate to the consequences of failure, reprimand, and loss of reputation. It impacts self-esteem and may lead to loss of confidence in carrying out clinical procedures, especially when there are pre-existing concerns and self-doubt about clinical competence. These fears are expressed by dentists and the voices have never been louder.

In a bygone age, these voices were heard only by those within earshot. Today, the extended reach of social media means the world can listen and replay. Fears are amplified and this leads to vicarious fear

learning; it appears without any direct contact with the stimulus. An individual learns from another by observing their response to a situation. When one person posts a comment, all readers feel the fear.

Important details are frequently omitted in commentary about dentolegal cases; information and misinformation blended to occupy the same space. Details are a distraction, enforced brevity an asset. This brevity curse has claimed many victims. Incomplete or inaccurate information in bite-sized pieces is easy to exchange and share with the world. It is out there – available to everyone at all times of the day and night.

It leads to availability bias – a type of cognitive bias that distorts the way we see the world. Information that comes to mind quickly and is covered by the media makes us believe that it is very common. Its swift passage through modern communication channels leads inevitably to the bandwagon effect.

Experiments have shown that if a large proportion of people adopt a particular view or stance, then there is a greater probability that others will adopt the same position (regardless of their beliefs). These psychological biases can skew reality, making us feel more vulnerable than we should. In other words, we judge probability by how easily the information comes to mind rather than the mathematical construct it is.

COMPETENCE AND CONFIDENCE

Fears related to competence may also be influenced by self-perception, but many are well supported. Our experience of dentolegal cases tells us much about the factors that contribute to suboptimal outcomes that form the basis of complaints and litigation.

There are situational and systemic predisposing factors. These include time shortage, target-driven payments systems and other related commercial factors. Studies suggest that unfamiliarity with a task significantly increases the likelihood of error. This is a competency issue and we observe this in a significant number of cases.

Competence is a precursor to doing things right. It is a blend of three ingredients that are required in abundance – procedural knowledge, exposure to varying levels of complexity, and experience. Whilst we often stress the importance of comprehensive and contemporaneous record keeping, the outcome of a case built on competence-related issues is unlikely to be successfully defended on the standard of record keeping alone.

Measurement of competence is the key – both at undergraduate and postgraduate level. There have been many developments in educational theory in the last 100 years, but Flexner’s assertion (1910) that “there is only one sort of licensing test that is significant: a test that ascertains the



practical ability of the students confronting a concrete case to collect all the relevant data and to suggest the positive procedures applicable to the conditions disclosed” holds true today.¹ Emotional intelligence, empathy and effective communication may mitigate the consequences of competency-related failures but are not a substitute.

In his thesis, Roudsari (2017) discusses aspects of foundation. He writes that “from the trainers’ point of view and based on a recent qualitative study, however, it has been shown that the majority of the newly qualified dentists are far from being competent, in particular due to lack of experience in a number of key dental procedures; for example, endodontics and extraction of teeth with difficulty levels of moderate to hard”.²

Many foundation dentists that visit our offices in England each year during their foundation training express similar concerns. It compounds the fear. We provide educational programmes to help them overcome these fears and other professional challenges at a critical part of their professional development. We can however do little to increase their clinical competence other than stress its importance as a key risk management principle and suggest solutions to the dilemma.

Literature relating to pre-foundation training competence is scarce because, according to

Roudsari, “most of the publications focus on ‘confidence’ of the graduates and not their ‘competence’”.

This presents another challenge because an over-reliance on confidence is not without its drawbacks. Confidence is a double-edged sword from a dentolegal perspective. David Dunning and Justin Kruger – Nobel Prize winners for their work – demonstrated the overestimation of performance by individuals of low competency levels. It is observed at low levels of experience, because at this stage an individual has little or no insight into their weaknesses. As a result, these individuals are particularly at risk because they don’t know what they don’t know. It is equally true at the beginning of a person’s career as it is at any stage where a person undertakes postgraduate study to learn new skills.

So, how does a dentist ensure they have the appropriate level of training to undertake clinical procedures? Not all postgraduate courses offer the same training opportunities and there may be different levels of clinical supervision available.

SUMMARY

Patients expect us to be competent. Competence-related issues are as important as all other contributory factors to effective risk management. We have an ethical obligation to evaluate outcomes and assess personal competence to avoid

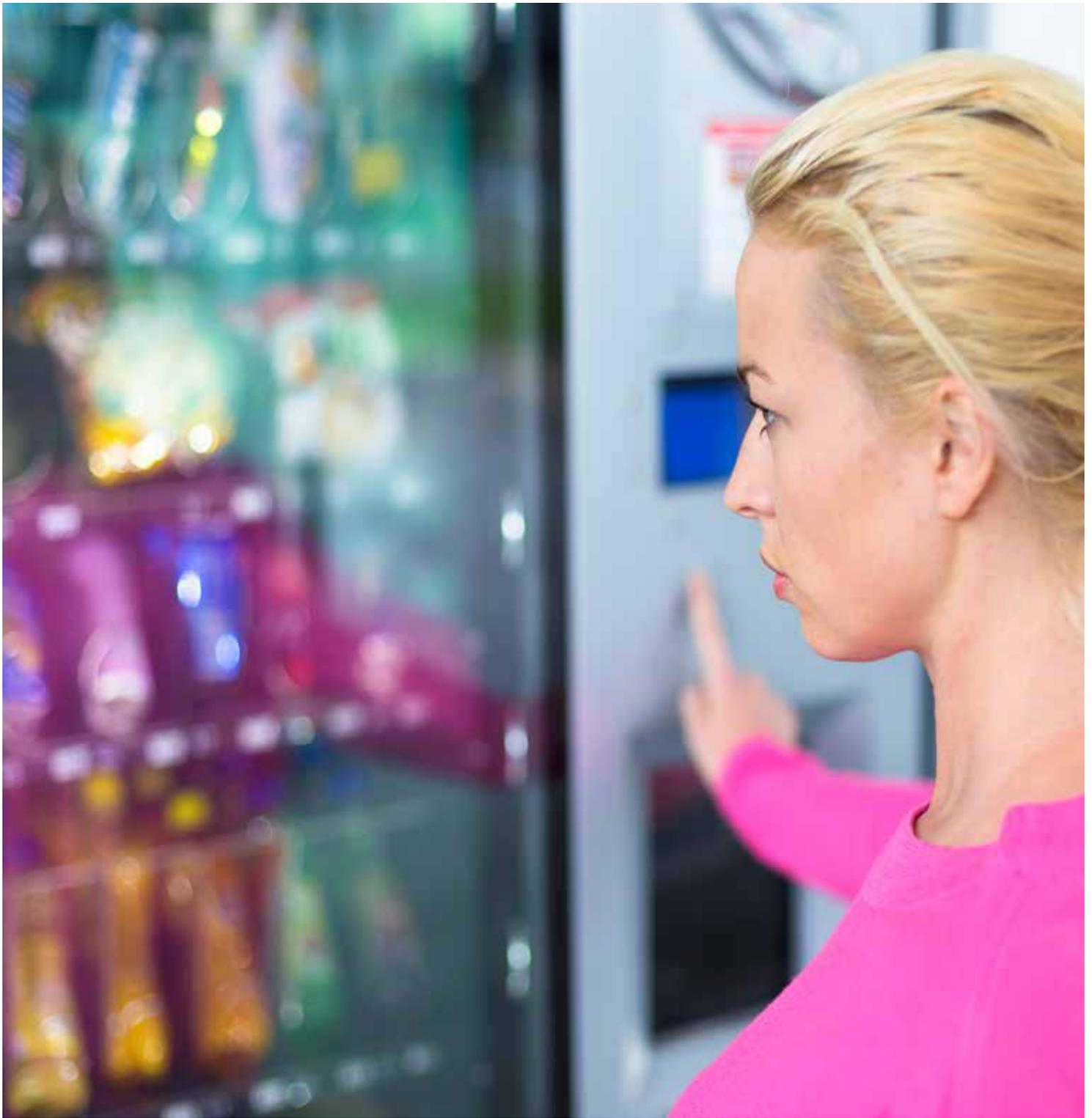
straying – intentionally and unintentionally – beyond our areas of expertise and training, propelled by misplaced confidence and perverse incentives.

Recognising the influence of availability and bandwagon bias is the first step to deal with risk and uncertainty, and estimate probabilities accurately. It’s about being able to gauge the limits of our own knowledge, knowing when we don’t know much, and being confident when we do. This contributes to our risk intelligence.

If we are to reduce the sum of all fears, then individual practitioners, educators, regulators and government agencies have an important role to play to understand and address the root causes. The future depends on it.

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Monitoring erosive tooth wear

Erosive tooth wear is the third most common oral condition in Europe. Professor David Bartlett from King's College London and Dr Soha Dattani of GSK Consumer Healthcare examine the importance of documenting it as part of a standard dental examination.



Despite being the third most commonly observed oral condition after caries and periodontal disease, and affecting up to 30% of European adults, erosive tooth wear is currently not routinely screened or monitored as part of the standard dental examination.

With modern lifestyles resulting in a “snacking” culture, and an ageing population where people are living longer and retaining their teeth into later life, the overall potential tooth wear risk is rapidly increasing. This, coupled with increasing expectations of patients and the public, means that there is an increased potential for litigation in this area.

Managing the consequences of severe erosive tooth wear can be both expensive and time consuming. According to a study by O’Toole et al, costs could be up to £13,000 for private treatment and treatment could take up to 24 months. As with periodontal disease, it is therefore important that examination for erosive tooth wear is part of the routine oral health assessment and clearly documented in the patient’s records.

COMMUNICATING RISK FACTORS

We know that communication is key in the dentist/patient relationship. So if a patient frequently snacks on acidic food or drink, at least twice per day between meals, then it’s a good idea to discuss with your patient the potential need for treatment at a later date.

A patient’s history can reveal a lot about any future treatment they may need. If they suffer from acid reflux or have bad dietary habits, such as swishing or holding drinks in their mouth that may lead to erosive tooth wear, then this should be discussed and noted.

This should be recoded on a 4-point scale (0-3) with 0 indicating no wear; 1 – very early signs such as loss of surface features (perikaymata, softening of the cingular contour); 2 – wear that is visible on a surface but less than 50%; and 3 – over 50%. Like the basic periodontal examination (BPE), all teeth are examined but only the most severe in each sextant are recorded in the notes in the same way as the BPE. A score of three in any sextant or any combined score over

9 should alert the dentist that tooth wear is active and prevention needs to be started. In cases where the teeth become shorter, further advice is needed.

PREVENTION IS BETTER THAN TREATMENT

A patient’s attitude may help direct whether prevention or treatment is advised. They may be fully aware of their tooth wear or be completely surprised when told. It’s important for dentists to broach the subject delicately, especially with patients where the erosive tooth wear could be down to other conditions such as bulimia.

Talk to your patient and explain the examination findings. If they are worried or suffering from pain, poor function or poor appearance then they may ask for treatment. If possible, the dentist should advise looking at prevention or a minimal intervention treatment to prevent symptoms from reoccurring or getting worse.

Patients with severe erosive tooth wear may need extensive treatment. It’s important dentists know when the treatment required is outside their scope of practice and better referred to a specialist.

MAKING A DECISION

It’s key that a patient plays their part in deciding about their teeth and any treatment plan put in place. The dentist must ensure that valid consent has been given by the patient. To secure this, they must have informed the patient what the problem is (including being shown the evidence from the examination) and what treatment options are available (and any risks involved). They also need to talk through the costs that may be associated with a treatment plan.

RECORDING EROSIVE TOOTH WEAR

Unfortunately, little is known about the natural history and progression risks for erosive tooth wear. For some, progression is slow and gradual, but for others rapid hard tissue destruction occurs that can compromise the longevity of the dentition. Even in late stages, the condition is usually painless, and the only clinical feature is

shortened teeth. It should be noted that as erosive tooth wear is not triggered by high levels of plaque, the condition usually affects the ‘committed’ patient. In summary, given there are no clinical guides to identify ‘at risk’ patients, assessment and documentation of erosive tooth wear should occur at every clinical examination.

The Basic Erosive Wear Examination (BEWE) is a well-recognised clinical tool specifically designed for general practice. It has been increasingly adopted internationally and used in 96 peer-reviewed publications in more than 34 countries to date. It follows the same sextant approach as the Basic Periodontal Exam (BPE) and can be conducted at the same time, therefore requiring little additional clinical time. It is not designed to be reproducible but is a straightforward way to record that tooth wear has been examined in the clinical notes.

Keeping accurate, detailed, up-to-date notes including the BEWE results, the joint decision making process and any actions taken or treatments carried out is vital in managing risk. If the patient and dentist together decide to just monitor erosive tooth wear then it’s key to include this in the patient’s notes, to protect against a claim that could be made down the line.

CONCLUSION AND FURTHER RESOURCES

Erosive tooth wear affects 30% of the population, but is not routinely assessed and documented as part of the clinical dental examination. The BEWE provides clinicians with a simple screening tool to efficiently detect and document erosive tooth wear in clinical practice. Its use is advocated to protect the oral healthcare provider and the patient, as the prevalence and awareness of this condition increases. Resources and online training for the BEWE can be found at erosivetoothwear.com and gskhealthpartner.com

Case study

Doing the right thing



The G family had attended Dr P's practice over many years. The four children of Mr and Mrs G had been regularly brought in to see their dentist and they continued to attend the practice as adults. The whole family enjoyed a good relationship with Dr P.

Dr P provided treatment for Mr G that included a root canal treatment for his non-vital 21, which Mr G had finally agreed to have done after having put it off for some time. On completion of the RCT, Dr P recommended restoration of the tooth with a post-retained crown and suggested that the heavily restored and discoloured 11 be crowned at the same time. Despite some reservations about the cost, Mr G agreed to this.

Eight months later, Dr P received a letter from an insurance company. It contained various forms related to Mr G that mentioned "his accident". On closer reading, Dr P noted that he was being asked to confirm the treatment that he had provided for Mr G, including the nature, extent and reason for it. The treatment details were pre-printed within the document, with a signed permission form confirming Mr G's consent for Dr P to disclose treatment details.

Dr P was puzzled, as the information did not coincide with his own records. One glaring inaccuracy was the description of two crowns and two root treatments being carried out as a result of trauma. As the information was so inaccurate, Dr P telephoned the insurance company and it was confirmed to him that the information on the form had been provided by Mr G. Dr P did not say anything to contradict this at that point, but was quite concerned as to what he should do and sought advice from Dental Protection.

The content of the letter from the insurance company seemed to indicate that Mr G had submitted an insurance claim against a

company seeking redress for some accident. Dr P did not wish to say anything that was untrue in relation to the claim put forward by his patient but, at the same time, he was very uncomfortable about the potential implications for Mr G and his relationship in correcting the inaccuracy.

Following advice from Dental Protection, Dr P met Mr G at the practice to help clarify the situation. Mr G explained that he had fallen over in the premises of a major store. Although he had not broken anything, he did have some bruising and had submitted a claim to cover the costs of treatment he had required, including painkillers and physiotherapy. He had thought of including his dental care as a way of defraying the costs of his recent treatment and believed that as Dr P was essentially a family friend, he would be able to back him up. Dr P thanked Mr G for helping him to understand the situation more clearly and, after the meeting, immediately sought further advice from Dental Protection.

Although it would be much more convenient for Dr P simply to accommodate his patient, it was clear that would be deliberately misleading and would make him a knowing party to a fraudulent claim. Aside from this action opening the possibility of criminal charges, there is an ethical obligation on registrants to be honest and respect the law.

Following advice from Dental Protection, Dr P wrote to Mr G to explain that he was sorry but, due to being bound by an ethical code of professional conduct, he was not in a position to support his claim by confirming misleading information. To protect the best interests of his patient, Dr P also suggested that Mr G let the matter of his "dental injuries" drop.

Dr P heard nothing further from Mr G about this. The family, however, continued to attend the practice.

LEARNING POINTS

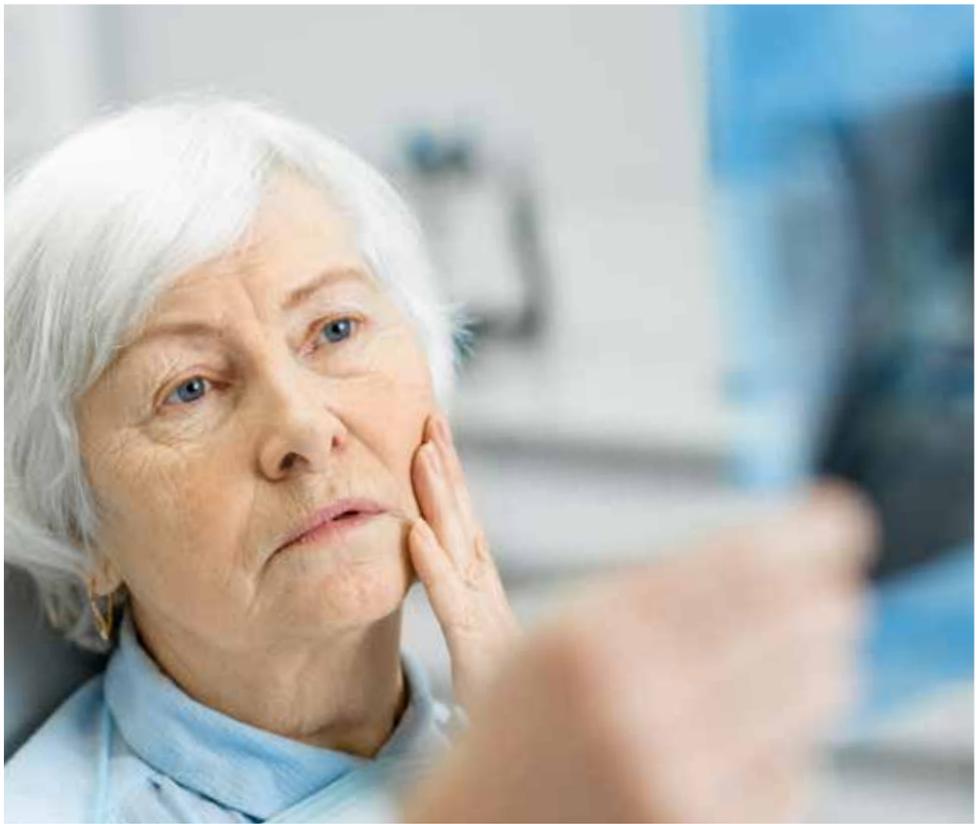
- Dentists can sometimes face situations where it might be tempting to go along with an action to accommodate a particular patient. It is important to remember however that in addition to obeying the law, all registrants are bound by an ethical code and have a duty to uphold the reputation of the profession.

Did you know..?

Membership means **you can always ask for help** from our experienced team of case managers and dentolegal consultants.

Case study

A lucky escape



RossHelen/iStock / Getty Images Plus via Getty Images

Mrs H, who is 69 years old, attended a new dentist as she was struggling with her lower denture that replaced her missing 35, 36 and 37. She had no other missing teeth apart from third molars, and the space at the lower left was very noticeable to her as she had a broad smile that showed her missing teeth on the lower left side.

Dr L established that Mrs H had lost her 37 due to extensive caries when she was in her late teens. The 37 had been extracted and then replaced with a single cantilever bridge with 36 as the abutment. From the information gathered, it sounded like the 36 had lost vitality and a number of endodontic treatments were attempted but unsuccessful. The 36 was eventually extracted when Mrs H was in her early 20s. She requested that Dr L restore the area with implants.

Mrs H had also brought a panoramic x-ray from a few years ago and Dr L noted the reduced bone height, but he considered there was enough to allow for a safety margin beneath the planned implants. Dr L suggested placing two implants at 35 and 36, with a view to providing an implant retained bridge with 37 as the pontic. Dr L had time to do the treatment the same day and, during the surgery, Mrs H felt intense pain as one of the implants was inserted, even though sufficient local anaesthetic had been administered. The following day, a very agitated Mrs H telephoned the surgery and reported numbness on the lower left side of the lip. As a parting comment she remarked that should her symptoms not improve, she would contact the police.

Dr L immediately contacted Dental Protection to request assistance and it was suggested that he immediately arrange a referral to a maxillofacial specialist. Mrs H was seen promptly and a cone-beam computed tomograph (CBCT) scan was taken, which confirmed the implant fixture at 36 had penetrated the inferior dental canal and had probably mechanically traumatised the left inferior dental nerve (IDN). Sensory nerve testing carried out on the lips indicated that Mrs H could not discern directional

stroking or cold stimulus. The specialist removed the implant fixture at 36 without delay, prescribing steroids and NSAIDs, and he was hopeful a prompt intervention might reduce the risk of permanent nerve damage.

After the implant fixture was removed, Mrs H noted an improvement in her symptoms at three months and was kept under review.

LEARNING POINTS

- When Dr L's case was reviewed by his dentolegal consultant it became apparent the assessment and planning fell short of accepted practice. He had not confirmed the date of the panoramic; it was subsequently confirmed he was working from a six-year-old panoramic. On reflection, he now realised that an up-to-date preoperative panoramic should have been taken and a CBCT scan would have been beneficial to further reduce the risk of IDN injury.
- The dentolegal consultant also identified that the treatment records did not show any evidence of a discussion of the risks associated with the treatment. When asked, Dr L could not recall with any certainty whether he had discussed the risks and the potential consequences should that risk materialise.
- Dr L also reflected that it would have been good practice to contact Mrs H following treatment by way of review, so that if any issues arose, steps could be taken to address her concerns or symptoms.
- With hindsight, Dr L recognised that insufficient time had been taken to complete an adequate preoperative assessment and to give Mrs H a cooling off period during which she could think about the treatment and the associated risks.
- She also appreciated the swift recommendation to refer to a specialist, once the nerve injury had been identified, which probably contributed towards the resolution of the IDN damage and perhaps averted any long-lasting damage to his professional reputation.

Case study

Aligning your ethics



RondaKimbrow/E+ via Getty Images

Mr H attended a routine examination appointment and expressed dissatisfaction about the position of his upper anterior incisors and the prominent position of his upper canines. The dentist advised the patient they could provide treatment through a clear aligner system and offered an immediate orthodontic assessment. Mr H agreed and they went on to discuss potential orthodontic treatment within that same appointment.

Mr H informed the dentist that he had received previous orthodontic treatment five years earlier, but had never been completely satisfied with the final aesthetic result. The dentist observed that Mr H's upper incisors were mildly retroclined, which exaggerated the buccal position of the upper left and right canines.

The dentist informed Mr H that he was a suitable case for treatment with clear aligners and provided an estimate of costs. Mr H was very pleased with the proposal and immediately agreed to go ahead with the proposed plan, with an expectation that the treatment would take between 6-12 months to complete.

Treatment commenced and Mr H and the dentist were happy with the progress made during the first six months. However, as the dentist moved into the final set of aligners, Mr H began to express dissatisfaction with the final position of the canines which, in his opinion, were still too prominent. The dentist informed Mr H that the position of his teeth was now anatomically correct and felt no further treatment was needed. Mr H remained dissatisfied and insisted that further treatment be carried out.

Against the dentist's better judgement, he agreed to provide further treatment with the intention of moving the upper anterior incisors to a pronounced buccal position to help disguise the prominent canines.

This refinement phase continued for a further five months, at which point Mr H complained of discomfort and pain from the upper incisors, and he was now concerned that these teeth felt 'slightly loose'.

The dentist noted the mobility and referred the patient to a specialist periodontist. Mr H demanded a referral to a specialist orthodontist to assess the situation. He expressed his concern about the outcome, his disappointment with the aesthetic result, and the discomfort he was now experiencing. He made it clear that he would seek legal advice should his concerns not be dealt with promptly.

The dentist contacted Dental Protection and requested our advice. Dental Protection reviewed all the treatment records and advised a way forward in order to resolve Mr H's concerns. Unfortunately, the treatment records suggested that the orthodontic assessment was inadequate and incomplete. The absence of a lateral cephalometric radiograph, lack of occlusal assessment, discussion of all relevant treatment options based on an appropriate orthodontic diagnosis, along with their advantages and disadvantages, not only compromised the care of the patient but also failed to demonstrate valid consent had been obtained.

The dentist's position was further weakened by the report from the periodontist who noted the poor position of the upper incisor roots, which had resulted in dehiscence and fenestration through the buccal cortical plate, which was likely to have occurred during the refinement phase.

Dental Protection informed the dentist of his vulnerabilities and requested a specialist orthodontic report, along with a remedial treatment plan. The dentist acknowledged he had not given sufficient attention to the orthodontic assessment. He also accepted his

role in causing the complications now evident as a result of agreeing to provide further treatment against his better judgement.

The dentist offered a refund of the failed orthodontic treatment and Dental Protection confirmed that the cost of the remedial orthodontic treatment phase would be paid on behalf of the member.

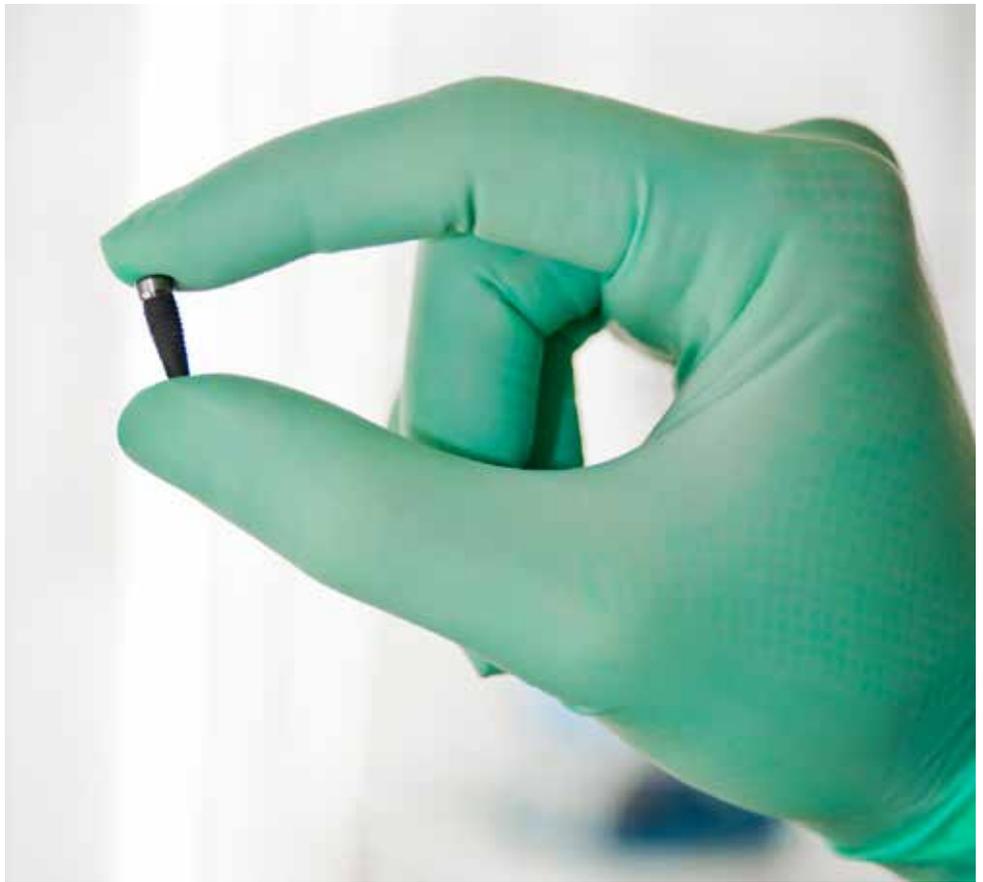
Mr H continued treatment with the specialist orthodontist and was ultimately pleased with the final aesthetic result, which involved fixed upper braces and a further nine months of treatment. Mr H was willing to accept the dentist's offer of a refund and reimbursement of remedial treatment costs, and the case was resolved.

LEARNING POINTS

- Ensure you provide a full orthodontic assessment, including exposure of appropriate radiographs and occlusal assessment, and offer appropriate treatment options, along with the risks and benefits of each.
- Ensure the patient is provided with adequate information and time to fully consider the treatment options – take the opportunity to rebook the patient when necessary.
- Beware of a demanding patient with high aesthetic needs – do not be pushed into providing treatment you do not feel is clinically appropriate or potentially damaging to the patient.
- Always provide an option of referral to a specialist colleague at the outset or in a timely manner, should the treatment not be progressing as you or the patient had intended or as expected.

Case study

Bridging the gap



Mrs R attended Dr A's practice to discuss treatment options to restore her upper arch. She had lost a number of teeth in the buccal segments, as well as the 22, and the remaining anterior teeth were discoloured and heavily restored. The existing partial denture was worn and ill-fitting on account of recent tooth loss.

Options were discussed and a plan was agreed, including placing three upper implants and restoring the arch with a course of treatment involving crowns and bridgework. The patient was pleased with the prospect of being able to replace the partial denture with implant supported bridgework. The treatment was to include six crowns (13 12 11 21 23 26) as well as a further implant-supported crown to replace the 22, a cantilever implant-supported bridge at the 25 with a pontic at the 24, and a four-unit bridge supported by implants at the 17 and 14.

Dr A referred the patient to his colleague Dr B with a request to carry out the necessary assessment and to place implants at 17, 14, 22 and 25. In the meantime, the large restorations in the remaining teeth were investigated and replaced, as required by Dr A, to form a stable basis for the proposed crowns. A temporary denture was constructed, pending the completion of the definitive treatment.

On receiving the referral, Dr B duly saw and assessed the patient. The relevant investigations were carried out to ensure the feasibility of the implants requested and arrangements were made for the patient

to attend for treatment. The four implants were placed, under sedation, at the same appointment. The procedure was uneventful. Aside from some transient discomfort in the immediate postoperative period, the patient reported no major concerns or complications after the surgery.

The patient was discharged back to the care of Dr A to proceed with the restorative phase.

Once the healing was complete, Dr A commenced the crown and bridge treatment. During this, the patient reported problems "with the gum" around the temporary bridge and also occasional, poorly localised pain on the left side. There were plaque accumulations around the implant sites and temporary crowns so Dr A emphasised the need for meticulous oral hygiene. The final bridgework and crowns were eventually fitted by Dr A after some remakes and adjustments were carried out.

The patient experienced ongoing problems with the four-unit bridge and some months later sought a second opinion from Dr C, who advised the patient that the supporting implants were failing and recommended removal. The patient wrote to Dr A to demand a full refund for the treatment she had received from him and Dr B. Dr A then discussed this with Dr B before both dentists sought assistance from Dental Protection.

The patient's records were carefully reviewed to arrive at an accurate understanding of the situation. It was not immediately obvious that there had been any

issue with the original implant placement. However, the records of Dr A and Dr B were sparse in places. There was insufficient information to indicate that valid consent had been obtained, including the discussion of risks associated with the treatment. The findings of Dr C suggested that the occlusion and bridge design may have contributed to the failure.

The patient was clearly disappointed that the bridge had failed and was keen to have this replaced. After seeking advice, both Dr A and Dr B agreed to accommodate the patient's straightforward request for a refund of the cost of the failed implant-retained bridge, to prevent any further escalation.

LEARNING POINTS

- It is not always possible to establish the primary cause of implant failure, which can be multi-factorial. An implant may fail because of issues with the implant itself, the placement technique or factors connected to the restoration. The possible contributory causes need to be assessed before a decision can be made about how to manage the situation. Each case must be judged on its merits.

Case study

What's in a name



Dean Mitchell/E+ via Getty Images

Dr W and her dental nurse Ms S were a formidable team. They had worked together for ten years in a reputable practice renowned for its patient-centric approach to care.

On one particularly busy day, Ms S seemed a little distant. Her lacklustre demeanour reflected her concern for a family member who had been taken ill the day before. By the time the fifth patient of the day was due they were running late and Ms S was setting up the surgery in preparation for the next patient who was attending for completion of endodontic treatment that had been started at a previous appointment.

Dr W reviewed her notes – written at the time of the first visit – and asked her nurse to call the patient, Mr F, from the waiting room.

When Mr F walked into the surgery, Dr W remarked that he was not wearing a suit and tie that day. She recalled that Mr F had been formally dressed on each of the previous visits, but today he was casually dressed. Dr W had noticed that Mr F appeared a little perplexed by her remarks but thought nothing of it.

Dr W advised Mr F that she hoped she would be able to complete his endodontic therapy and indicated that this would take approximately 45 minutes. Mr F was taken

aback by this and Dr W assumed that his reaction was probably related to her comment about the duration of the appointment.

Dr W applied some topical anaesthetic to the injection site with a cotton wool roll and it was only when she examined the tooth, she noticed it was unrestored. This set alarm bells ringing and she realised that the wrong patient was sitting in the chair.

Dr W apologised to Mr F and explained that another patient with the same name had recently undergone the first part of root canal therapy and this had caused the confusion. Mr F was not prepared to accept the apology and said he wished to make a formal complaint.

Dr W contacted one of the dentolegal consultants at Dental Protection who assisted her with a written response. It was explained to Mr F that it was a coincidence that both Mr Fs had been booked in on the same day at similar times and were due to see different dentists. When the nurse had called for Mr F in the waiting room, the 'wrong' Mr F had stood up and the nurse, normally quite vigilant, had not noticed given her preoccupation with a family member's illness.

The written response was accepted as a reasonable explanation and he was content to let the matter drop. He indicated that

he had lingering concerns about what had happened and had interpreted the event as a risk that he might have received someone else's treatment and on this basis said that he would not be returning to the practice.

LEARNING POINTS

- When patients are known to the dentist, this type of error is unlikely to arise. It is more likely when the patient is new or has only seen the dentist a few times and the visual image of the patient has not yet been committed to memory.
- There should be other means of confirming identities in situations where the patient is not known to the dentist.
- Patients in the waiting room may be hard of hearing and may mishear the name that is called.
- Checking and confirming the identity at the outset can save embarrassment later.

Considering CBCT

Cone Beam Computed Tomography (CBCT) has brought significant benefits to the dental profession however its use is not without risk. Dentolegal consultant Jim Lafferty looks at some of the important considerations when using CBCT in practice.



Use of CBCT imaging in dentistry is well established and has led to improvements in assessment, diagnosis and management of patient care. Over the years, use of CBCT in the fields of implant dentistry, oral surgery, orthodontics and endodontics has become more widespread.

The use of such technology to improve patient care and reduce risk will be an attractive proposition to all involved, but there are potential pitfalls. Awareness of these is vital, particularly given the high costs associated with purchases of this type.

There is a considerably higher exposure to ionising radiation that increases the risk of developing a malignancy, so we should all be able to justify why any CBCT is being used, even if you are prescribing the imaging to be taken elsewhere. In some jurisdictions there is now a legal requirement to record this justification in writing. Members in those markets report that this means they are more careful to consider both the benefits and the risks associated with CBCT. As a result, they have reduced the numbers of CBCT images they take, reducing the amount of exposure to ionising radiation.

If you are responsible for assessing the resulting image, you should ensure that you can demonstrate that you have the suitable training, as recommended by the European Commission's guidelines¹ and European Academy of DentoMaxilloFacial Radiology (EADMFR).² A report on the assessment of the image should be recorded in writing. There are enormous amounts of information to be gleaned from these images and

the person reviewing the slices has the responsibility to check for pathology in all those slices – even at sites distant to the area of interest.

In the accompanying case report, you will see that it is very important to establish who will be reporting on the image.

The key points dentists should consider in the area of CBCT are:

- **Arrangements** – who will be responsible for reporting?
- **Assess** – a CBCT without clinical examination is very difficult to defend.
- **Balance** – the risks of ionising radiation against the clinical information gained.
- **Minimise** – can the same information be obtained with a lower dose x-ray?
- **Justification** – record in writing the reason for taking the x-ray.
- **Report** – there should be a written report, leading to the normal recording of diagnosis, treatment options discussion, risk discussion, treatment planning and consent.

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1. European Commission. Radiation protection no. 172: cone beam CT for dental and maxillofacial radiology. Evidence based guidelines. A report prepared by the SEDENTEXCT project. Luxembourg; EC; 2011.
2. Brown J, Jacobs R, Levring J, aghagen E, Lindh C, Baksi G, Schulze D, et al. Basic training requirements for the use of dental CBCT by dentists: a position paper prepared by the European Academy of DentoMaxilloFacial Radiology. *Dentomaxillofac Radiol* 2014; 43: 20130291.

Case study

Mr D was referred to an oral surgeon for pain related to his temporomandibular joint issues. During the early assessments a CBCT was prescribed, carried out in a remote CBCT and imaging centre and a specialist radiologist report ordered. Over a year later, a further CBCT was ordered from the same centre when symptoms had spread.

The patient went on to develop a cancerous neuroma in his tongue, which by now had spread into the lymph nodes, and was considered inoperable.

The family complained to the regulator, and the oral surgeon contacted Dental Protection. He was particularly concerned as his records of the patient's treatment were somewhat brief and generally of a low standard. However, with assistance from Dental Protection, the member was able to show that he had ordered specialist reports and that the developing neuroma had been missed in the original scan. It was put forward that the responsibility for failing to diagnose the tumour was not the oral surgeon's. We then worked closely with the member on developing a CPD programme around record keeping so that, by the time of the hearing, he was able to demonstrate that he had shown insight and taken steps to remediate.

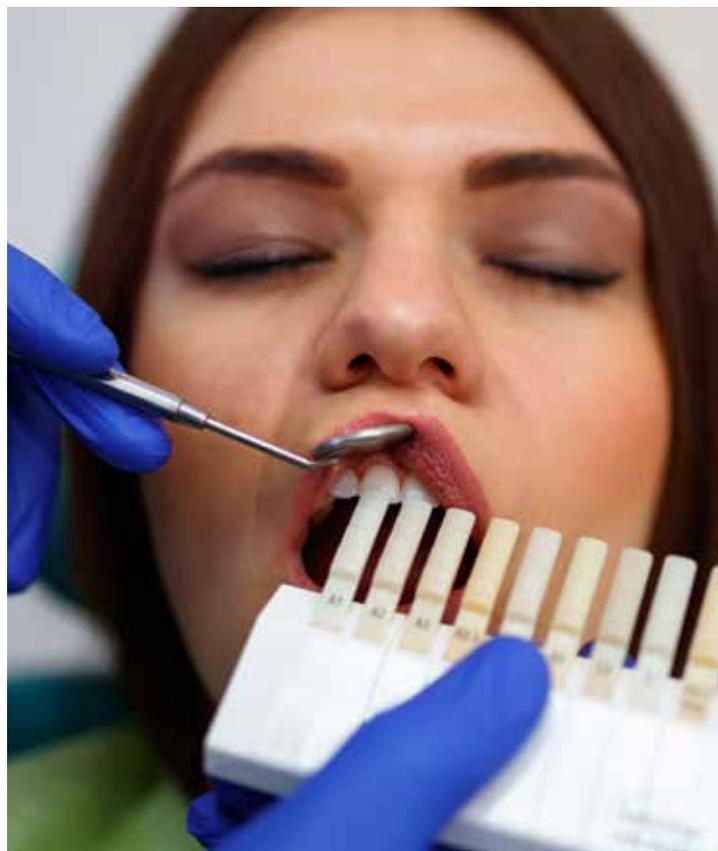
Naturally the member was keen to emphasise in his response to the Dental Council how distraught he was at hearing the news, but he did not consider the complaint showed any wrongdoing on his part. This was recognised by the Dental Council and the case was dismissed.

LEARNING POINTS

- All radiographs should have a written report.
- By having the image reported on by an appropriate specialist, the responsibility for spotting pathology outside the area of interest is not the dentist's.

Case study

An unexpected surprise



MilanEXPO/E+ via Getty Images

Ms C visited her dentist, requesting an improvement on her overall smile and the specific appearance of the upper lateral incisors. They had been restored with porcelain veneers some years previously and the colour match with the natural adjacent teeth was now unsatisfactory.

Ms C, an aspiring actress, who now lived overseas, had been regularly attending this particular dentist since childhood. The dentist had placed the existing veneers more than 12 years earlier to improve the appearance of the peg-shaped lateral incisors. At a previous visit Ms C had obtained some home tooth whitening gel to lighten her teeth, which exaggerated the colour mismatch against the veneers.

She told the dentist she wanted all of her teeth to be a uniform and much lighter colour. When the dentist removed the existing veneers he noted the underlying vital tooth structure was particularly dark. He had recently treated a patient with a similar problem, and so was acutely aware of how challenging it was to replace veneers and achieve the desired result to the satisfaction of the patient.

He made a decision to provide a full coverage zirconium crown on each lateral incisor. At the fit appointment, he failed to check the contact point distally at 22 and failed to notice that this crown was not seated correctly. Ms C returned a few days later complaining of sensitivity and was aware of a deficient margin palatally which she could feel with her fingernail. It was agreed that this crown would be replaced, but it

proved difficult to arrange an appointment to undertake this treatment given the patient's overseas commitments.

The sensitivity continued, so Ms C obtained a second opinion and was advised that both crowns had not been fitted correctly. The report from the new treating practitioner was supported by radiographic evidence confirming a substandard marginal fit – which explained the sensitivity reported. The crowns were replaced by the new dentist and a letter of complaint was sent to the original dentist from the patient. She clearly felt that she had been more involved in the latest treatment decision than she had been when the zirconium crowns had been discussed, stating that she had not been fully informed about how much of the additional tooth would be sacrificed in order to accommodate the crowns, and what impact this might have long-term. She failed to mention that the dentist had been willing to rectify the situation, and that it had been her own diary commitments that had delayed the provision of remedial treatment.

The dentist contacted Dental Protection for advice and assistance on how to manage the complaint. He explained that Ms C was now seeking a refund of fees and a further payment to cover the cost of her remedial treatment. Notwithstanding his offer to replace his faulty work, he felt it was unfair that he should be expected to pay for the remedial treatment as well. Having lost the trust of the patient, the dentist lost the chance to recover the situation, particularly where there was factual evidence of a poor fit. He also accepted that the consent

process had been undermined by his failure to identify how much information the patient needed, specifically around the long-term risks attached to a more aggressive tooth preparation compared with a like-for-like replacement of two veneers.

In her complaint, the patient stated that had she been given the correct information, she would have made a different decision. Our assessment of this particular case was that it was unlikely the patient would settle for a refund of fees and with this in mind Dental Protection made a significant contribution towards the remedial treatment costs in order to prevent the matter escalating to a clinical negligence claim or a regulatory complaint.

LEARNING POINTS

- The law on consent provides a framework that protects patients' rights to make an informed decision about all aspects of their treatment. In this case, the choice of zirconium crowns instead of veneers was not adequately discussed, nor was there anything in the records to defend the dentist's position. Had the patient obtained legal advice, it is likely that she would have been advised that she had good prospects of successfully pursuing a clinical negligence claim. It was therefore sensible to resolve the matter without that occurring.

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