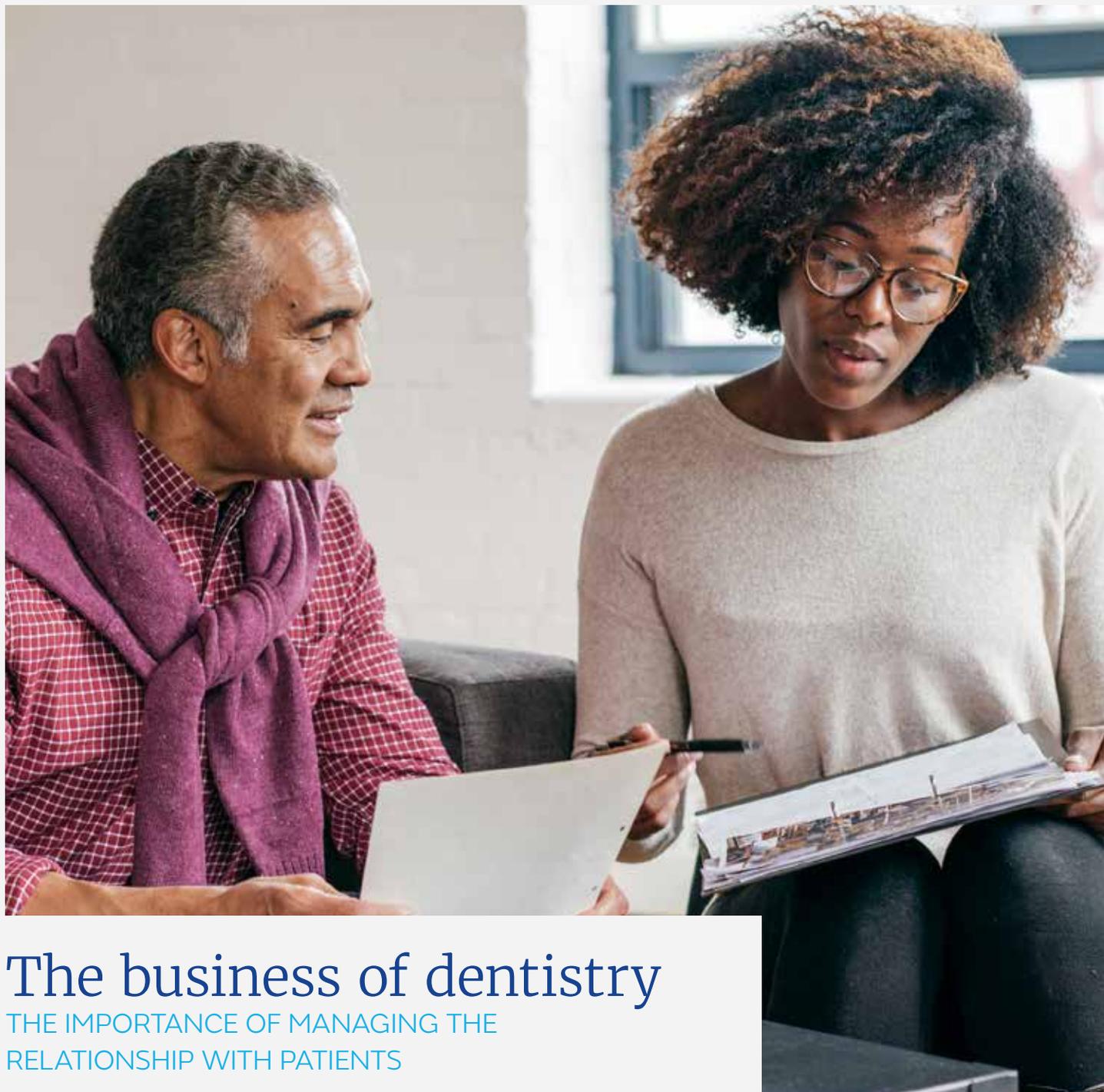


RISKWISE

ISSUE 27 | DECEMBER 2018

SOUTH AFRICA



The business of dentistry

THE IMPORTANCE OF MANAGING THE
RELATIONSHIP WITH PATIENTS

GOOD RECORD KEEPING

The benefits of making and retaining good treatment records

DEALING WITH A DIFFICULT PATIENT

Diffusing a difficult interaction

CASE STUDIES

Practical guidance and learning from real life scenarios

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Editorial



DR ALASDAIR MCKELVIE
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Welcome to this latest edition of *Riskwise*, Dental Protection's flagship publication offering the latest information on dentolegal topics and advice from our dentolegal consultants and professional experts.

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

Elsewhere you will find a selection of keynote case reports which describe some unexpected clinical scenarios leading to patient complaints. The reports also highlight the challenges of resolving some of the issues raised by the complaint and the strategy suggested by Dental Protection for the member to follow when responding to the complaint. The benefits of membership entitle all members to request assistance with complaints and we would encourage you to contact Dental Protection through the usual channels to access this service.

WEBINARS

In believing that prevention is better than the cure, we also provide expert advice, support and education to help protect you from risk. Recent additions to our offerings have included webinars that have been very well received. These live events provide an opportunity for real-time questions and answers during the broadcast, and are an ideal way to have the expertise of Dental Protection brought directly to you. I would refer you to our website for details of when the webinars will be delivered and how to sign up. Recordings of all South African webinars can be accessed through our education platform Prism.

RECORD KEEPING

The key theme for our roadshow events this year has been record keeping and how you can improve this aspect of patient care. We really do appreciate that completing detailed records can often be time consuming. The good news is that digital innovations will, in time, deliver solutions that will reduce the pain and time of completing acceptable records. In the meantime we all need to do what we can to improve our record keeping. Hopefully, the selection of case reports we have included will provide an incentive to critically review the standard of your record keeping, which will in turn improve the prospects of a more robust defence should you need it.

Mention of the roadshows also gives me the opportunity to thank every one of you who has attended – both for your support and your continued membership of Dental Protection.

Thank you for taking the time to read *Riskwise* and I hope there is something useful for every aspect of our profession. Naturally we are always keen to hear feedback from members and if there are other topics you would like us to cover or changes you would like us to make, please let us know.

Best wishes,

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The business of dentistry

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



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

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

WHAT IS TRUST?

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

CAN TRUST BE QUANTIFIED?

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

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

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

CREDENCE MARKETS

In economic terms, dental services fall into the category of credence goods. Patients don’t always know whether they need the suggested treatment, and in some cases even after they receive the treatment, they cannot be sure of its value. This is because the ‘buyer’ does not have the knowledge of the ‘seller’ – a feature of the dentist-patient relationship referred to as ‘information asymmetry’. It is this asymmetry that makes the credence

goods market particularly challenging because it may give rise to aberrant behaviours.

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



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

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

KEY COMPONENTS OF BUILDING TRUST

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

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

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

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1. Graskempner JP. ‘A new perspective on dental malpractice: practice enhancement through risk management’ *J Am Dent Assoc.* 2002 Jun;133 (6): 752-7.
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Good record keeping from Dental Protection

In busy clinical practice, it's easy for record keeping to be viewed as an administrative burden and drop down the priority list. Dental Protection delivered a webinar for dentists across South Africa, which highlighted the benefits of making and retaining good treatment records



Some areas of record keeping continue to present difficulties for dentists. Many of us are aware that our records could be improved, a point brought sharply into focus when we are asked to explain our assessment and management of a patient a long time after the examination and treatment took place.

This, in turn, poses a challenge for Dental Protection when we are responding to complaints or claims against dentists. The quality of record keeping is often the difference between a positive or negative outcome in a case, as demonstrated in this scenario:

A recently qualified dentist decided to remove a maxillary first molar under local anaesthetic and, having explained the procedure to the patient, obtained her consent to proceed with the extraction. The case turned out to be more difficult than had been anticipated, even having the benefit of a good preoperative radiograph.

Unfortunately the dentist displaced the mesio-buccal root into the maxillary antrum after the tooth had been sectioned, creating an oro-antral communication. As soon as the dentist realised what had happened, he explained the situation to the patient and, while she was still in the chair, obtained advice from a maxillofacial surgeon by telephone.

The surgeon advised a primary closure for the socket and the prescription of an appropriate antibiotic, along with the usual local pain management. All these discussions were recorded in the notes.

The dentist lacked experience to complete the surgical closure of the socket and asked a senior dentist in the practice to assist. The patient was then discharged with the appropriate prescriptions and instructions.

A referral letter including the radiograph was immediately written and sent to the maxillofacial surgeon.

COMPLAINT AFTER FOLLOW-UP

The patient was followed up in due course by the specialist and after several weeks of continued symptoms, she eventually recovered. The dentist was shocked to receive a complaint from the patient, alleging that she would not have embarked on the treatment if she had been warned that this complication might have occurred.

She also complained that the young dentist should have recognised the complex nature of the extraction and recommended that a more experienced colleague attempt removal of the tooth. It was her case that the young dentist should be held responsible for her pain, suffering and loss of earnings while away from work.

Dental Protection drafted letters for the dentist to send in response to this complaint and ultimately the patient accepted that he had acted properly and promptly following this rare and unpredictable complication during a routine procedure.

EASY ASSISTANCE

Assisting the clinician in this case was made easy because his record keeping was excellent and he was given support by the maxillofacial surgeon as soon as he requested it. A prompt, accurate and factual response helped to resolve this complaint satisfactorily without attorneys becoming involved.

The case demonstrates the value of keeping good notes and of retaining copies of all correspondence in the file. The more

information that is stored in the records, the easier it is to defend a clinician against an allegation of negligence arising out of a referral.

RECORD YOUR WAY OUT OF TROUBLE

Dental Protection's webinar, The Journey to Better Records, discusses:

- understand the key legal and professional obligations for completion of treatment records
- recognise the key inputs for an acceptable record
- build sufficient knowledge to manage the security of treatment records.

For those who were unable to join the webinar live on 13 November 2018, a recording will be available on our online learning platform, Prism.

OTHER WAYS TO LEARN

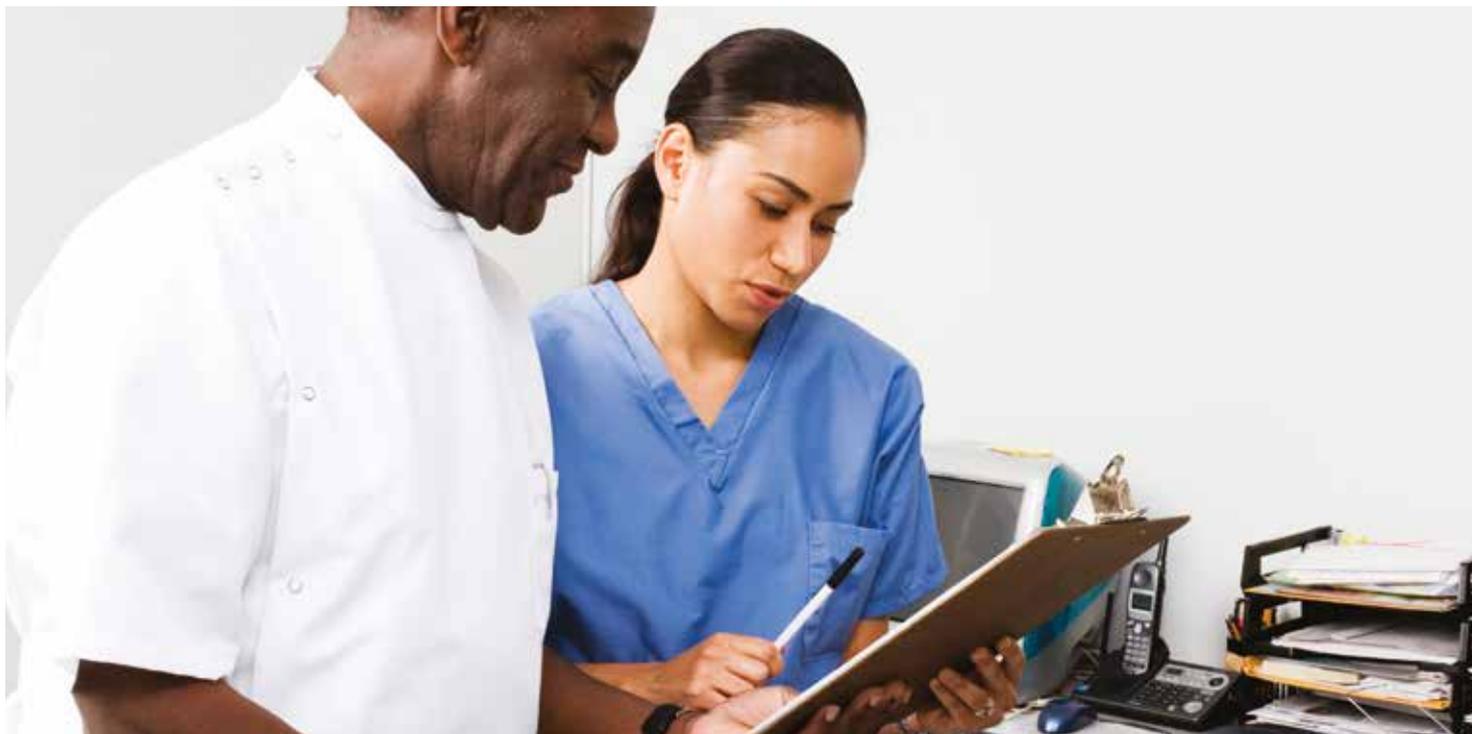
Free as a benefit of your membership, you can access Prism – our online learning platform – on a range of devices and complete modules at your convenience. Take advantage of flexible, interactive learning across a range of professional development modules and workshops – including record keeping.

The Dental Protection website also has a comprehensive overview on the rules and regulations surrounding record keeping.

And, for specific advice on record keeping, dentolegal expert advice is available by contacting Dental Protection on **+27 11 484 5288** or online.



The more information that is stored in the records, the easier it is to defend a clinician against an allegation of negligence arising out of a referral.





Gain adequate consent to avoid claims

As a dentist you always aim to do the best you can, but if you don't effectively manage your patient's expectations and record adequate consent, they might have good grounds for a claim

A claim for compensation due to alleged negligence is often made because the patient has unrealistic expectations about the treatment or outcomes. Even though lengthy discussions may have taken place, unless this is clearly documented in the clinical records that patient may succeed in their claim. Therefore, it is recommended to fully document every discussion in the clinical records to validate the patient's consent. Signed consent forms can be helpful, and sometimes mandatory, but the forms should be specific to the individual treatment planned, rather than an all-encompassing, general consent form.

TIPS TO AVOID A CLAIM

Discuss and fully document in the patient's records:

- the purpose of the procedure
- the nature of the treatment (what it involves and timescales)
- what the treatment will achieve (taking into account the particular concerns of the individual patient)
- any risks, limitations and possible complications (including rare but significant complications)
- alternative treatments and how they compare
- cost
- post-treatment issues including possible time off work or the need for future treatment.

CASE STUDY 1:

UNRECORDED DISCUSSION LEADS TO CLAIM FOR NEGLIGENCE

A clinician examined a patient who asked whether something could be done to replace his upper right second premolar tooth. The patient had browsed through the literature in the waiting room about implants and bridgework and discussed the various options with the dentist.

The dentist recalled fully discussing the concept of an implant-retained prosthesis and the cost for such a procedure. He also advised his patient that a three-unit bridge using both the upper first molar and premolar as abutments was another alternative. The patient decided to go ahead with the bridgework because it would be quicker and less expensive.

The dentist made a three-unit bridge as agreed, but unfortunately the patient found it difficult to tolerate because he was getting food caught underneath it. By mutual agreement the bridge was removed, before making a crown and a porcelain inlay to restore the distal and mesial abutments respectively.

The dentist carried out some further preparation on the molar tooth and fitted the crown at the following visit. Unfortunately the patient experienced pain from the crowned tooth, which subsequently had to be root-treated.

NEGLIGENCE CLAIM

The patient instructed a lawyer to make a claim in negligence against the dentist alleging that he had not warned of the risks of preparing the tooth for a coronal restoration, nor had he fully

explained the advantages of having the space restored with an implant.

Although the dentist recalled discussing the various options and material risks with the patient, there was unfortunately nothing entered in the records to support his claim that the consent process had been carefully completed. Given there is a legal and ethical obligation to create and retain appropriate records, the very absence of a suitable record in the context of a claim is likely to give rise to an overall impression of poor/substandard care and leaves a court or a decision-maker with an unfavourable view of a clinician's practice, whether that is fair or not. Similarly, in the absence of a good record, the decision on the standard of care may well depend upon the reliability and credibility of the parties and their recollection of the incident.

In view of the lack of supportive records, it was decided it would be difficult to defend the claim and a settlement was effected to compensate the patient for the destruction of the abutment teeth and the costs involved for further restorations of these teeth in the future.

LEARNING POINT

Unless conversations and warnings are recorded contemporaneously in the notes, they may well be deemed not to have occurred if a problem subsequently arises and the patient presents a different version of events to that presented by the dentist.

CASE STUDY 2:

OUT OF SHAPE

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

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

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

On investigating the background to the case, it transpired that the patient had been shown several 'before' and 'after' pictures of cases where crowded and badly angulated teeth had been

corrected into normal alignment. In none of these cases had there been any instance where a tooth ended up with excessive buccal to lingual width, and nor had there been any discussion of this possibility in the pre-treatment consultation between dentist and patient.

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

LEARNING POINT

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

Dealing with a difficult patient

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



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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, with both patient and healthcare professional responding 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 THE 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 a referral to a colleague. If patients display violence to any member 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 South African Police Service.

DIFFUSE 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
- a discussion around all options and an offer of explanations
- the patient being involved in the decision-making.

OUTCOMES FROM DIFFICULT INTERACTIONS INCLUDE:

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

Saying 'sorry' could make all the difference

An apology can often go a long way in resolving a complaint or avoiding one in the first place. **Louisa Waite** looks at when you should apologise and why it is so important



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Unfortunately things do go wrong in dental care and sometimes patients are dissatisfied, disappointed or upset with the care that they have received. Dental Protection advises members that an apology is not an admission of liability; rather, it is an acknowledgement that something has gone wrong and a way of expressing empathy.

APOLOGISING CAN AVOID AND RESOLVE COMPLAINTS

Contrary to popular belief, apologies tend to prevent formal complaints rather than actually cause them. An apology and an explanation can provide reassurance to a patient and is often all the patient is looking for. When patients are aggrieved, or feel that they have been harmed by treatment, it is important for the professional person to acknowledge those feelings and to express regret for what has happened – irrespective of where any fault might lie. The lack of an apology in these situations is one of the reasons why patients take complaints further.

Concerns about the consequences of speaking up mean that members of the dental team sometimes hesitate to act when things go wrong. The desire to seem infallible, coupled with a fear of recrimination, can stifle an open approach to errors. As a result, a natural apology and explanation to patients can be lost. However, an apology can reassure your patient that you understand their situation.

WHEN SHOULD AN APOLOGY TYPICALLY BE OFFERED?

An apology should be offered as soon as it becomes apparent that an adverse incident has occurred (regardless of fault) or if the patient is unhappy with their care or some aspect of their account. It is important that patients receive a meaningful and timely apology. It may be some time before all the facts are understood, including perhaps the reasons why and how the events occurred. However, this consideration should not delay a prompt apology.

The culture within a clinical setting should allow dentists the freedom to apologise. It is ethically and professionally the right thing to do – irrespective of the cause.

WHAT IS AN 'APPROPRIATE' APOLOGY?

An apology is appropriate when a patient has suffered harm from their dental care or experienced disappointment. It should be tailored to the situation to reflect the patient's perception of the issue.

For example, 'I am sorry this happened to you' is an expression of empathy, rather than, 'I am sorry I caused this to happen to you and it's my fault...'

Providing context can ensure all parties understand the purpose of the apology. Ownership should also be taken by a senior

clinician. Fundamentally, an apology should be offered willingly, and not perceived to have been given reluctantly.

WIDER BENEFITS

Dental Protection would always advocate a full and objective review of an adverse event, with the patient being informed about any resulting learning points. A commitment should be made to understand and learn from what has happened in a blame-free manner, to reduce the likelihood of it reoccurring and happening to someone else. Most importantly the patient will understand what happened, receive an apology and recognition of the distress they feel.

MASTERING ADVERSE OUTCOMES

The Dental Protection workshop 'Mastering adverse outcomes' gives you the tools to successfully communicate with your patients should they experience an adverse outcome during their care. Find out more at dentalprotection.org



Case study

A failed extraction handled appropriately

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

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

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

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

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

The referral was duly made. Two days later the patient returned in pain and saw another dentist at the practice. A diagnosis of dry socket was made and appropriate treatment provided. At this point the patient questioned why antibiotics had



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.

not been prescribed at the time of extraction and questioned how long they would need to wait for the referral.

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

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

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

LEARNING POINTS

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

Case study

A lacerated cheek



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

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

In his letter of complaint the patient stated that he wanted recompense for negligence and his unpleasant experience. When the letter of complaint was received, as a gesture of goodwill, the dentist decided to refund the cost of the restoration and to waive the charge for his next routine dental examination. The patient was not satisfied with this and stated in his letter that he was considering taking further action with his 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/protected 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 he 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 he write again outlining what he 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 discussing a suboptimal outcome with a patient.

“ ” *the patient was very likely seeking some compensation for what he considered was negligence on the part of the dentist leading to an unpleasant experience.*



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. Tooth 38 was identified to be carious, but was incorrectly recorded as tooth 48.

Tooth 48 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 tooth 38 was unrestorable and needed to be removed.

The patient was aware of the reason for removal of tooth 38 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 dentist 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

- It is important to double-check radiographs with an intra-oral examination and with the clinical records to ensure that there are no discrepancies.
- It is important to have 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

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 tooth 23 and was the abutment for an adhesive cantilever bridge replacing the missing tooth 22. The patient explained that she was keen to have implants provided in the near future as she did not want gaps at the front of her mouth, nor did she want another bridge.

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

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

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

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

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

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

consent had not been obtained when the 23 was extracted.

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

LEARNING POINTS

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



Case study

Incorrect use of reversal agent during sedation

An anxious patient needed extraction of 3, which was deemed to be unrestorable 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.

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Despite the patient not having any untoward reaction after treatment, the surgeon was criticised for not informing the patient of the incident.

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.

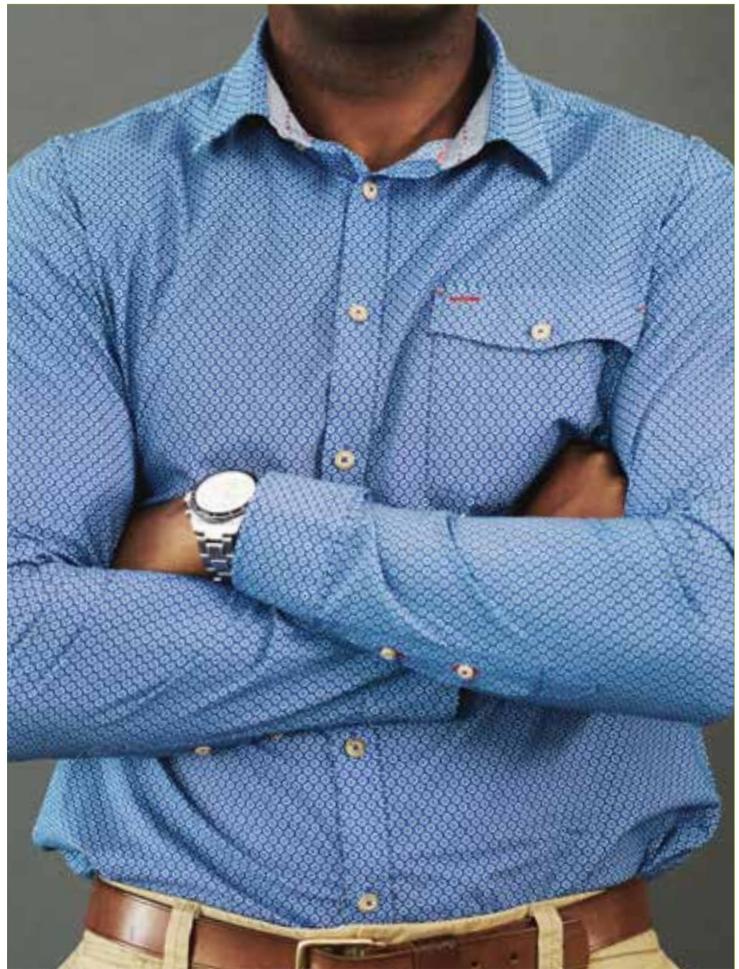
The surgeon completed an incident form one week later, but did not clearly explain that after giving the patient flumazenil, midazolam was then given.

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.

Case study

A request for compensation



A patient had attended a practice on three previous occasions, seeing a different dentist at each appointment. He attended the first dentist with a fractured filling at tooth 36, which had been placed many years earlier at another practice. The dentist placed a temporary dressing and advised that the patient return for a check-up and filling appointment.

At the second appointment, the patient saw the practice owner, who carried out an examination and placed an amalgam DO filling at 36. The dentist also diagnosed the early stages of periodontal disease and recommended a course of periodontal treatment. Non-surgical root surface debridement was completed over two visits and it was advised that the patient return for a three-month follow-up appointment.

The patient did not attend for the follow-up but returned 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 his gum care at the same time. The patient booked in for the treatment as advised and at the appointment he mentioned that he had experienced some food packing in the region of 36, 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 gum care was completed, but the patient expressed dissatisfaction at the time as not all of the stains had been removed. It was explained that if he wanted a full stain removal for cosmetic reasons, an additional hygiene appointment would be necessary.

The patient left and the following week a complaint by email was received. The patient was unhappy that not all of the stains had been removed and explained that this was the prime reason for the appointment. He was also not happy 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 gum care. The patient responded requesting a refund of the filling placed one year earlier at tooth 36, and asked for compensation of R1000 towards his next gum care appointment.

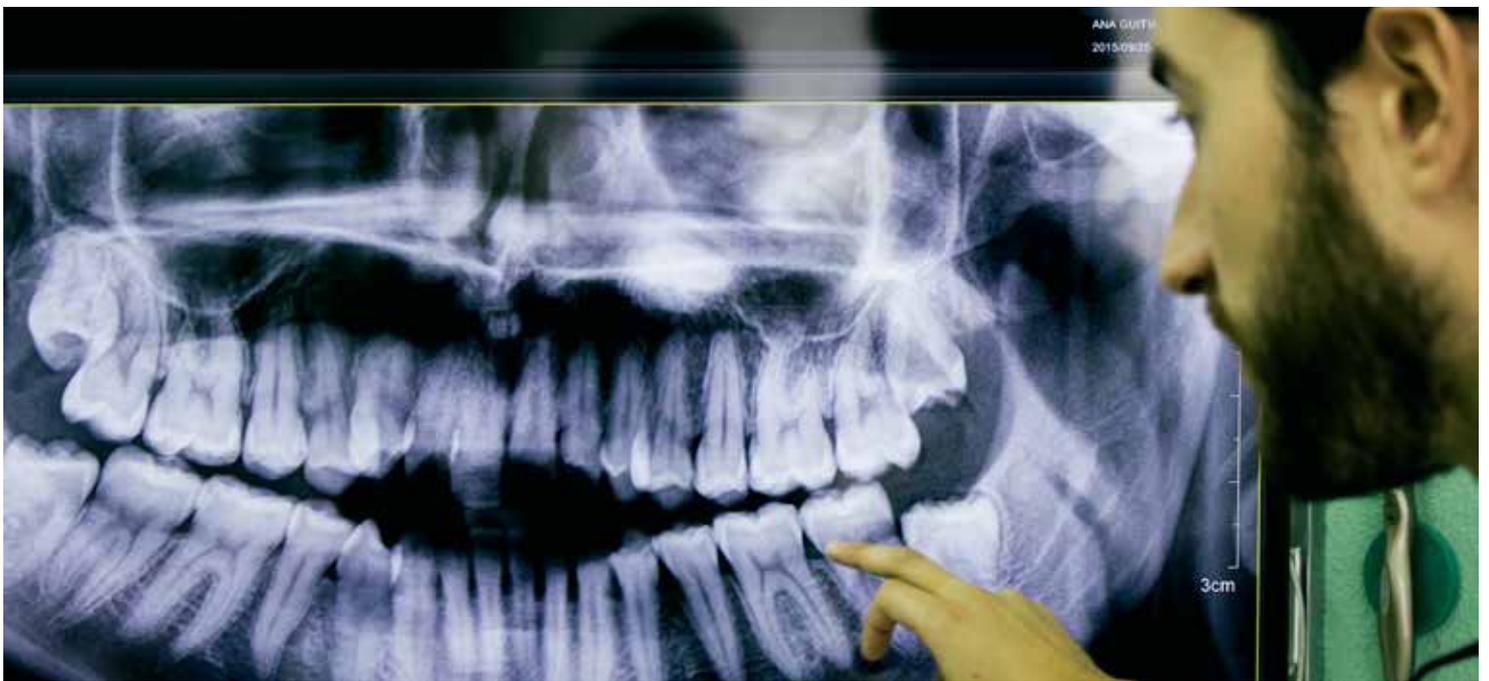
A decision was made to offer the patient a refund of the fees for the filling, as a gesture of goodwill and in an attempt to resolve the complaint swiftly and amicably. It was, however, decided that the offer of R1000 towards a hygiene appointment in addition to the refund

would have been considered to be betterment, and so this was not offered.

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

LEARNING POINT

- This case raises the question of what to do when a patient asks for 'compensation'. The term has a different meaning legally than in common use, and whether it means the case should really be considered in the formal sense of the word as a request for damages arising out of negligent care or more simply for some level of financial remedy where service failure has arisen. Situations like this often arise when a patient writes a letter of complaint to a dentist and mentions that they would like financial compensation. A decision needs to be made as to whether the patient is indeed acting as a Litigant in Person, seeking compensation for pain, suffering and loss of amenity (PSLA) or whether the complaint can be managed in line with the practice complaints handling policy, with the offer of a refund of fees or assistance with remedial treatment costs.



Case study

Minimally invasive management of caries

A patient attended an appointment, where the dentist's examination and bitewing radiograph identified caries beneath a pre-existing amalgam filling. The patient returned two weeks later for an appointment for a filling to be placed at tooth 34. The patient's notes record that the tooth was restored with a distal reinforced glass ionomer cement placed under local anaesthesia. The patient was warned of postoperative sensitivity and occlusion was checked. The patient was advised to return for a review six months later.

The patient subsequently complained to the practice, reporting that they had experienced discomfort the day after the filling was placed. The filling had cracked and so the patient attended another practice and was told there was a dark shadow beneath the filling and that decay was present. The patient was concerned that the filling had failed and that decay had been missed. The dentist was a member of Dental Protection and contacted them for advice.

The member was newly qualified and had been taught techniques of minimal intervention dentistry. This is a recognised, evidence-based approach that preserves tooth structure and allows removal of infected dentine with hand instruments and the placing of fillings over affected dentine. It uses reinforced glass ionomer cement (GIC)

to allow remineralisation of the previously demineralised tooth structure. The approach requires focus on careful case selection, cavity design and control of risk factors.

The member's view was that all soft decay had been removed and clarified that, in circumstances where there was a risk of nerve exposure, it was her practice to use a stepwise technique for the removal of caries and leave a layer of discoloured dentine. The treatment plan was then to review the tooth at a later date once reparative dentine had been laid down, and replace the restoration at that point to reduce the risk of endodontic treatment being required.

The member responded to the complaint, explaining the clinical procedure and advising that the filling would have been replaced free of charge had the patient returned to the practice. The patient responded that the approach taken to treating the tooth had not been explained to her and she was concerned that the filling had failed and required replacement so soon after being placed.

A further response was made to the patient apologising for the lack of clarity in the advice given and the situation was resolved with the patient accepting a refund of the cost of the original restoration. The patient returned to see the dentist six months later and a definitive restoration was placed.

LEARNING POINTS

This case emphasises the need to ensure clear communication with the patient, and to document the information shared in the patient's records, along with the treatment plan and rationale. With a minimal intervention approach the records should document that the patient is made aware of the need for regular review, likely repeat bitewings, and the focus on preventing decay with fluoride, dietary advice and good oral hygiene. Patients should also be made aware that GIC fillings may need replacement and may not be recognised as a permanent restoration.

If the case had progressed to a clinical negligence claim and caries had been identified on the x-ray, and if the patient's records had not demonstrated that a clear discussion had taken place with the treatment approach and the patient's consent to this, then there may have been some vulnerability to an allegation of failure to diagnose and manage caries appropriately.



Case study

The case of double prescribing

Following a 12 year period of non-attendance, a patient visited the dentist due to recurrent pain at tooth 37. His mouth was healthy overall with no existing restorations. There was however a history of recent pain and swelling associated with tooth 37.

Following an examination, a diagnosis was made of cracked tooth syndrome at 37 with irreversible pulpitis. The options for treatment were discussed. These included attempting restoration with root canal treatment and later placing a crown or extracting the tooth. On considering the cost implications and the time involved with restoring the tooth, the patient opted to have the tooth extracted.

The following day tooth 37 was removed under local anaesthetic without complication. Although the extraction was uneventful, the patient was given a prescription for antibiotics by the practitioner on account of the prior history of pain and swelling from the tooth.

The following day, further pain was experienced and the patient reattended with the same practitioner. The dentist thought that he was giving a different, second antibiotic to take in conjunction with the first. Instead the patient was given a further prescription of the same antibiotic.

The dentist based the prescription on the previous day's record, but this was inaccurate. The record entry stated that the first prescription was for amoxicillin, when in fact,



The dentist sought assistance from Dental Protection, and the case was able to be resolved directly with the patient without escalation into a formal legal claim involving solicitors.

metronidazole 400mg had been prescribed. When the patient returned the next day, another course of metronidazole 400mg was prescribed, which he took as he was not aware that he could not take both together.

The patient became increasingly nauseous and dizzy and subsequently attended his local hospital for blood tests. No admittance was required, however the he underwent blood testing with, arguably, associated discomfort and inconvenience.

The patient wrote a letter of complaint and requested compensation for the avoidable pain and suffering that he had experienced. The dentist sought assistance from Dental Protection, and the case was able to be resolved directly with the patient without escalation into a formal legal claim involving attorneys.

LEARNING POINTS

- Based upon the record of the clinical findings, there was no evidence of infection and no clear indication for antibiotics. The patient did report postoperative pain, however there was nothing that would justify the use of antibiotics given the clinical presentation and history. There was therefore a vulnerability in the dentist's position from this.
- No medication should be prescribed in the absence of clear justification. Antibiotics must only be used in accordance with accepted guidance.
- A further issue arose from the inaccurate record entry relating to the original prescription, and this was compounded by the effects of the second course of metronidazole. It was clear that on various levels the position of the dentist was difficult to defend and an early resolution of the case was sought to avoid a potentially problematic escalation.
- It is important to ensure records are accurate. This can best be achieved by completing entries contemporaneously with the treatment to which they relate.

CONTACTS

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