Dental Protection

RISKWISE

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The root of the problem or vice versa...

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Editorial

DR MARTIN **FOSTER**
HEAD OF DENTAL SERVICES, IRELAND

ENVIRONMENTAL CHANGE... OR BUSINESS AS USUAL

Ironically, change is an unchanging feature of the modern age. Although it is true to say that teeth are teeth and patients will always need to have treatment, those are almost the only constant factors in dentistry.

The environment in which the profession operates is shaped by various factors. Some of these can be influenced by clinicians, acting both as individuals and as a profession. Others just come along and we all have to adapt and deal with the new situations created. We are however a resourceful profession of problem solvers and there is usually a suitable treatment option. As all dentists know, there is more than one way to take a tooth out. Although, having said that, it is probably best not to mention A5 claims at this point.

The Ministry of Health's long awaited *Oral Health Policy* has come rumbling into view and of course its implementation will have an impact on clinicians across the profession in different ways. Undoubtedly, the profession will need to be on board to ensure that the policy delivers the aim of better oral health for Ireland. It will be interesting to see what environmental changes this brings about. It will also be interesting to see what changes there are in the way the profession's essential role is recognised and appreciated.

Back to change again. Benjamin Franklin said 230 years ago that nothing in life is certain except "death and taxes". He omitted to mention dental complaints, simply because they hadn't been invented back then.

Dental Protection's experience is that there are recurring themes and situations that routinely crop up, leading to members seeking assistance. Complaints and claims that stem from unmet expectations are a fairly constant element. These are often linked to particular types of treatment where the potential for disappointment is higher. As the possibilities for what modern dental treatment can achieve increase, so do patient expectations. It is called progress, and is obviously a good thing, just maybe not for dental complaints.

In this edition of *Riskwise*, we focus on a number of case studies and look at real life situations that have involved members, to highlight the points that can be learned from these. Of course no two clinicians ever have the same career, but even so, many situations arise that are familiar to all of us, and being aware of the potential pitfalls can help ensure that we don't make the same mistakes. We all learn from mistakes, but the trick is to learn as much as possible from as few mistakes as possible.

Even with the best efforts, dentistry is a tricky business and the seemingly endless introduction of new things — such as new rules, regulations and the steady increase in patient demands — do not make it any easier. However, as already mentioned, ours is a profession of problem solvers and Dental Protection is strongly committed to helping members to navigate a path through the various dentolegal obstacles and challenges that we face – leaving us to get on with the job of dentistry.

So, if we can help in any way, please don't hesitate to get in touch.

Best wishes

Dr Martin Foster
BDS MPH DipHSM
Head of Dental Services, Ireland

casemanagementdental@dentalprotection.org

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Editor
Anna Francis

Design
Conor Walsh

Print
Spellman Walker

Production
Emma Senior

Contributors
Simrit Ryatt
Louise Eggleton

The root of the problem or vice versa...

Endodontic treatment is an area of dentistry that enjoys more than its fair share of dentolegal risk. ***Dr Martin Foster****, dentolegal consultant, looks how this risk can be managed and reduced*

In the league table of treatments giving rise to complaints and claims, endodontics is near the top of the leader board. There are various reasons for this.

First of all, endodontic treatment is inherently tricky. Even a straightforward case can have a variety of built-in risks and pitfalls to get in the way of an ideal outcome.

Another important factor is the operator. Historically, endodontic related cases tended to be associated with more recently qualified dentists. This could lead to an assumption that contributing factors – such as limited experience and over-enthusiasm – were resulting in treatment being embarked upon that had a poor prospect of a successful outcome from the start. However, more recently, there has been a trend that suggests the majority of cases actually involve more experienced dentists, so it is clearly not quite such a simple picture.

As well as frequency of complaints and claims, endodontic cases can potentially be costly to deal with. In many instances the argument is put forward that the dentist was responsible for causing the need for treatment in the first place. From the patient's perspective, the tooth was not painful until the filling was placed. Then, after having RCT, the patient learned that further treatment was necessary (eg a crown, retreatment or even extraction and implant placement), all of which incurred an unexpected and unwelcome cost for the patient.

So how should dentolegal risk be reduced when dealing with endodontic treatment?

> *No two root systems are the same. Nor are two patients. Both can be unpredictable*

PRE-TREATMENT

Some dentolegal risks develop before treatment even starts, so it is important that a thorough assessment of the case is made early on to prevent subsequent surprises for the patient or dentist.

Making a diagnosis and deciding upon root treatment in the absence of appropriate radiographs is asking for trouble. So is embarking upon a heroic quest to "save" a tooth of dubious prognosis, or protecting the patient from a full knowledge of the risks, potential outcomes and costs. Avoiding these common pitfalls makes a lot of sense, as does adopting a structured approach to include appropriate special tests, a definitive diagnosis, restorability assessment and a demonstrable, valid consent process – all of which reflects good practice.

DURING TREATMENT

Some complications can arise despite the best efforts of the clinician. All dentists know that an endodontically-treated tooth is more brittle and liable to fracture. A dentolegal risk associated with this is the possibility of a coronal fracture between visits, which renders the tooth unrestorable. The patient needs to be forewarned of this potential complication to avoid the dentist being blamed for the loss of the tooth. All too many cases arise from the patient forming the view that he/she would still have the tooth if it had not been for the dentist messing up the treatment – particularly if the tooth was symptomless in the first place.

File fractures and perforations should not happen, but they do. Taking a careful approach will certainly lessen the clinical risk. Dentolegal risk can be reduced by warning the patient of the possibility of complications and their practical implications at the outset. Explaining something only after it happens is often seen as an excuse by a patient unexpectedly facing additional treatment costs.

The best dentolegal defence in cases involving hypochlorite accidents or the ingestion/inhalation of instruments or other objects is making sure these don't happen. If they do, defence is... well actually, there is no defence.

POST TREATMENT

After treatment, dentolegal risks still remain. These may originate from a patient disappointed to be having further problems, or surprised by an outcome that was not anticipated. Another source is from "second dentist" syndrome – when another clinician identifies a "problem" about which the patient was completely unaware. This may be an issue that was not picked up by the treating dentist. It may not actually be a problem at all but simply a matter of interpretation of a result. A good post-treatment radiograph can be a helpful defence against this dentolegal risk.

If there is a "sub-optimal" result, it is good to spot this at the time so that the situation can be clarified with the patient. Any appropriate steps can then be taken to remedy the problem or perhaps simply to keep the case under review. The main thing is that the patient is made aware of the situation. If on the other hand, the patient learns of an issue from a third party at a later date, it can be viewed as a more serious fault – or worse, a cover up.

REFERENCES

1. Endodontic Clinical Resources - American Association of Endodontists. American Association of Endodontists. 2019. https://www.aae.org/specialty/clinical-resources/ (accessed 28 Feb 2019).

CASE ASSESSMENT

Assessing any case before starting is the key to managing both clinical and dentolegal risk.

It is important not to take on cases beyond your expertise and to recognise your limitations. Risks can arise from being talked into treatment, wanting to be helpful, feeling sorry for patients, not being able to say no or not being able to admit to having concerns about the case.

Patients may present with a less than ideal root filling on a radiograph, but it is worth pausing before recommending re-treatment. Consider first if you can improve on the clinical outcome. Do you think treatment is necessary? Would the patient actually benefit? The position may be stable and symptomless. Remember, patients measure success as a tooth being retained in a functional condition with no symptoms.

A structured case assessment – taking into account clinical and patient factors – can be a very helpful way to avoid wandering into trouble and questioning what you have undertaken.

One good example of a structured case assessment tool can be found on the website of the American Association of Endodontists.[1]

A structured approach allows the clinician to categorise the difficulty of the case and to advise the patient accordingly. Managing expectations is an important part of reducing dentolegal risk, but you can only manage patients' expectations if you have an idea of what to expect yourself.

SOME TIPS

- **Assess the case and manage patient expectation.**
- **Give a clear explanation of what to expect with regards to outcomes, risks and costs and avoid surprises.**
- **Be realistic and avoid herodontics – know what is possible, when to say no and when to refer.**
- **Avoid too little rubber dam and too little control of hypochlorite.**
- **Check files and canals carefully – if there is a fracture or a perforation, you must be the first to know... and the patient must be told by you. A less than ideal outcome can be made worse if not noticed/acknowledged or appears to have been covered up.**
- **Try to avoid "second dentist syndrome" – know how to judge "success" in the work of others.**

Iatrogenic injuries and what can be done to avoid them

Wherever you are in the world, there is generally a legal obligation in place that sets out duties of employers to ensure appropriate standards of quality and safety in a dental practice. Simrit Ryatt, dentolegal consultant, looks into some iatrogenic injuries and what can be done to avoid them

This legal obligation can include a delegable duty to team members to make sure equipment used in treatment is safe and maintained to be in good working condition in accordance with manufacturers' instructions. It is nevertheless important to emphasise that it remains the responsibility of the clinician who is handling a piece of equipment to ensure a patient is not inadvertently harmed, either by operator carelessness or equipment malfunction.

Experience is generally a good thing, as you become more comfortable dealing with challenging situations throughout your working day. It is also worth bearing in mind that an experienced clinician may subconsciously become complacent about the risk attached to hazards in a dental surgery, particularly where the risk has been identified but not corrected for a while.

No matter how proficient you are, there are some scenarios that are impossible to predict and are not under your direct control, such as sudden movements or the behaviour of a patient. In light of this, it is important that we manage risk by focussing on the variables that we can control, by ensuring that a regular risk assessment of the surgery equipment and operative procedures is carried out.

A good example of how this may be put into practice is to plan procedures in advance and adopt a checklist approach to ensure that the required materials and equipment are readily available and on-hand.

It goes without saying that personal protective equipment at work protects both the members of the dental team and patients. All members of the dental team play a part in identifying hazards and risks and reporting them before they cause injury. Risk assessment and reporting should be discussed at team meetings and follow-up actions should be notified to all team members. It is also important to keep a record of these discussions for future reference.

To help your understanding of how incidents can occur, we have highlighted some examples from our case library. We have also highlighted the learning opportunities each incident provided.

CASE STUDY – A LACERATION FOLLOWING AN EXTRACTION

Mr D attended the dentist and during his examination he expressed his wish to have dental implants to restore the existing space he had from the extraction of teeth 45 and 46 around 20 years previously. The dentist also noted that tooth 47 had fractured beyond repair, but other than that, the patient had maintained a good standard of oral health.

HOW DID THE ACCIDENT HAPPEN?

At a subsequent appointment, the dentist was using a luxator around tooth 47 that slipped and lacerated the adjacent soft tissue. The laceration on the inside of the cheek was severe and extensive.

HOW WAS THIS MANAGED?

The dentist explained what had happened to the patient and offered an immediate apology. The area was sutured and a review appointment was arranged for the following day. The patient was contacted by telephone later in the evening and he explained he was in some discomfort and was aware of some swelling in the area of the wound.

AT THE REVIEW APPOINTMENT

At the review appointment the wound was assessed and the swelling noted. As the injury had been caused by an error in technique, the risk of this type of injury had not been discussed.

The patient subsequently had to take a week off from work and advised the dentist of his intention to claim for compensation for his pain, suffering and loss of earnings.

The dentist called Dental Protection and our team was able to negotiate an early and appropriate settlement, protecting the member's position and avoiding any risk of escalation.

LEARNING POINT

- Although the dentist was very experienced, the error was attributed to a lapse of concentration, which had unfortunate consequences. On reflection, the dentist realised his access to the area could have been improved and his finger rests more stable and sturdy. His reflection and subsequent analysis was recorded and shared with the rest of the team in the expectation that a similar situation may be prevented in the future.

CASE STUDY – A CHEMICAL BURN

Ms C attended a surgery complaining of discomfort at tooth 27 following a dislodged restoration. A radiograph was taken, which showed that the distal-occlusal cavity was in close proximity to the dental pulp and that there was caries present. Ms C was made aware of the radiographic and clinical findings and informed that root canal treatment may be indicated.

As anticipated, during the process of excavating caries, the pulp was exposed and the first stage of endodontic treatment was carried out. During irrigation of the root canal system, the irrigation syringe tip detached from the body of the syringe and a small volume of sodium hypochlorite splashed over the patient's face. Ms C was advised to immediately rinse her face, and the initial stage of the endodontic treatment was completed.

At the subsequent appointment, Ms C reported some soreness in the area impacted by the hypochlorite. The dentist completed the endodontic treatment and was satisfied with the postoperative result. The patient complained and requested compensation for the adverse incident and threatened to escalate her concerns to the Dental Council.

After seeking advice from Dental Protection, it was agreed that the treatment fees should be waived and a contribution was made by Dental Protection towards the cost of treatment provided by a specialist dermatologist.

LEARNING POINTS

- Reflecting upon his treatment, and with the benefit of hindsight, the dentist acknowledged he should have used a rubber dam. The dentist always found accessing the tooth easier without a rubber dam and would generally place it after gaining access. He did not routinely apply a rubber dam at emergency appointments, and the incident reminded him of the need to do so in future.
- Always ensure that the irrigation needle is fully engaged on the body of the syringe and avoid excessive force during the irrigation process.

CASE STUDY – A BURN INJURY TO THE LIP AND CHEEK DURING AN EXTRACTION

During a surgical procedure under sedation, a dentist caused an accidental injury to the lip and cheek of Ms W. The surgical procedure involved making gingival incisions, raising a flap and trimming away bone to remove a partially erupted 48. During the procedure, the right cheek mucosa was burnt by contact with an electro-surgery tip that was being used to trim some soft tissue.

HOW WAS THE SITUATION MANAGED?

The wound was carefully cleansed and closed with sutures.

The patient's fiancé joined her in the recovery room, and although they accepted the explanation at the time, they called later that evening to complain.

A month later the wound had healed fairly well, but there was a residual indentation remaining that was quite apparent. Ms W was concerned the indentation would be present in four months' time, when she was due to get married. The dentist and his clinic agreed to arrange treatment for her with a plastic surgeon and they were informed there was a good chance the wound would heal completely with minor surgery.

Ms W went on to claim for compensation. Although the dentist had expressed his regret at what had happened and arranged for further specialist care, there was still an expectation that the exercise of a reasonable standard of care would have meant that such an injury would not have occurred.

LEARNING POINT

- A team meeting was held following the incident and everyone acknowledged how potentially easy it was to cause such an injury, especially when patients have been locally anaesthetised and also sedated. In recognising the risk the team were in a position to avoid future occurrences.

CASE STUDY – CRUSH INJURY

Mr K was booked in for a routine extraction of tooth 27, which had been causing discomfort and was unrestorable. A mesial-occlusal restoration was planned for 36 at the same appointment.

The dentist completed a composite filling in 36 and then set about extracting the 27. The procedure took longer than expected, but eventually the tooth was extracted in one piece.

Following the extraction, the dentist noticed Mr K had developed some bruising around the lower lip which had been caused by the forceps or elevator trapping the soft tissue. The dentist had not noticed this at the time, presumably because of his focus on the challenge of the extraction itself, and feeling under some stress knowing that a number of other patients were waiting to see him and that he was now running very late.

HOW WAS THE SITUATION MANAGED?

The dentist immediately apologised and also contacted Mr K later on that day. As Mr K was grateful to have had the problematic tooth extracted, he did not take the matter further and accepted the apology.

LEARNING POINTS

- The dentist acknowledged that he had been so focussed on the challenging 27 extraction that he had forgotten the lower lip was also anaesthetised. As they were understaffed, he had been sharing a nurse with another clinician, whereas usually he would have had a nurse on-hand to notice an event such as this. At the next practice meeting this incident was discussed and it was agreed the dentist should always be supported by a dental nurse when carrying out extractions and also to be mindful of the risk of soft tissue injuries to anaesthetised areas.
- Complications often occur when there is time pressure. There should be protocols in place for managing such situations. In this case, a collective team-led decision was made that should a dentist run particularly late, patients would be advised of the delay and given the option to rearrange their appointments or be seen by another dentist if possible.

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CASE STUDY – MECHANICAL INJURIES

A newly qualified dentist mentioned to her principal that the fixation plate that attached the x-ray machine to the wall was not stable and when the arm was fully extended, the pressure on the plate caused some movement. The machine was wall-mounted to the left of the patient chair and had to be extended fully when taking radiographs on the right hand side. The arm was not stable at its full extension and would often drop after it had been aligned to expose the film. As a result, the final images were of limited diagnostic value as they did not capture the teeth and surrounding areas.

The young dentist asked for the fixation mechanism to be repaired or replaced, but the principal resisted this and believed the dentist was over-reacting. He suggested an 'alternative technique' that he thought would remedy the problem. His solution was to forcibly wedge the collimator so it would sit next to the patient and the x-ray arm would not slip down.

The dentist called Dental Protection and a dentolegal consultant suggested the member put her concerns in writing to the principal. It was suggested her concerns could be justified by carrying out a risk assessment of the situation to identify what issues could arise and what harm could flow from a potential incident. It was also pointed out that should the dentist believe the working environment was hazardous, as she was controlling the handling of the equipment, it would be her responsibility to ensure it was safe.

Before the dentist could consider the advice further, she realised her next patient was due and required a radiograph. Unfortunately, the x-ray machine fell off the wall and took the surgery chair-light down with it, striking the patient on the head.

HOW WAS THE SITUATION MANAGED?

The patient was able to have the x-ray in the next room and the principal immediately set about arranging for the x-ray machine and surgery chair-light to be repaired.

LEARNING POINT

- The principal recognised he should have immediately addressed the situation. The patient was not injured but was unsettled, and the practice called later on that day to ensure they were alright.

SUMMARY

These case studies highlight the importance of team work, learning from mistakes and how risk awareness can reduce the number of injuries that are often avoidable.

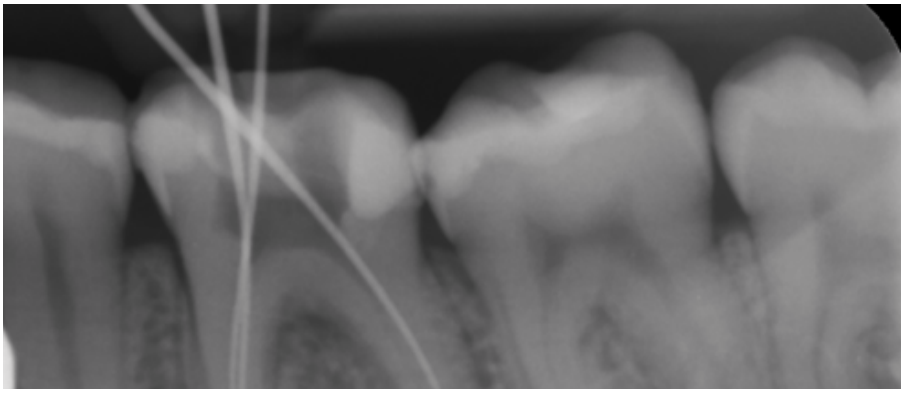
Where risks can be avoided, such as the placement of a well-fitting rubber dam for all endodontic procedures, it is surprising why anyone would risk not doing so. Similarly, when equipment is well maintained this reduces the risk to staff and patients.

These examples demonstrate the value of a sincere and sympathetic apology and the importance of professional support. Although some patient safety incidents may require additional help in order to resolve the situation to the patient's satisfaction, a telephone call following an accident can go a long way to convey care and indicate genuine concern, and can help reduce the chance of a patient taking matters further.

Whether it is in the form of professional advice, help with writing a response to a patient or assistance with arranging formal compensation, Dental Protection is here to protect the careers and reputations of members.

Case Study

Is it vital?



Mr S attended Dr A's practice as a new patient. He reported no symptoms and simply wished to have a check-up, as he had not seen a dentist for two years. Dr A took two bitewing radiographs to check for caries and assess bone levels. The dentist noted the presence of a large, deep composite restoration at UR6 and made an entry in the clinical records to keep this under observation. No mention of this was made to Mr S at the time.

Mr S returned six weeks later, complaining of pain and tenderness on the right side of the upper jaw. On investigating this, Dr A suspected a periapical abscess had developed at UR6 and the diagnosis was confirmed by a periapical radiograph, which clearly showed pathology at the apices of the roots of the UR6.

Mr S was disappointed that pain and tenderness from this tooth had appeared within a short time of his examination appointment, at which he had been advised that his oral health was good and that he did not require treatment.

Dr A sought to explain the situation and the findings regarding tooth UR6. Treatment options were discussed. Extraction was mentioned as a possibility, but as Mr S did not wish to lose the tooth, Dr A reassured him that the tooth could be saved by carrying out root canal treatment.

Dr A extirpated the diseased pulp and a temporary dressing was placed. Mr S's symptoms resolved and he returned for the completion of the endodontic treatment at a later date.

At this appointment Dr A noted the marked curvature of the mesio-buccal root of the UR6. The patient was advised that this may cause difficulties in achieving a successful completion of the root canal treatment, but Dr A assured Mr S that the tooth would be preserved.

During the canal preparation phase of the treatment, a file fractured in the mesio-buccal canal.

A further radiograph confirmed that a fragment of the file approximately 10mm in length remained in the root canal.

The dentist was unable to retrieve the fractured file and informed the patient about what had happened.

Dr A explained to the patient that the breakage of a file was a recognised complication of root treatment, particularly in teeth with curved roots. Mr S was unhappy that this had not been explained to him prior to the treatment and became angry when a referral to an endodontic specialist was suggested, on account of the further treatment costs that would be involved.

He left the surgery without allowing Dr A to place any temporary cover on the tooth.

Dr A had no further contact from Mr S until he received a letter of complaint enclosing a copy of a treatment plan, including costs, from a specialist endodontist who had seen Mr S.

Three weeks later Dr A received a communication from the Dental Complaints Resolution Service (DCRS) seeking a response to a complaint from Mr S. At this point Dr A contacted Dental Protection.

The case was discussed with the dentolegal consultant who was handling the case and providing support for Dr A. On reflection Dr A realised that there was some vulnerability in the treatment and advice provided for the patient.

There had clearly been some concern about the condition of UR6 at the time of the examination, which would have justified further investigation such as vitality testing, and consideration of a periapical radiograph. The findings could have formed the basis for advising the patient of the need for further treatment or warning of the possibility of symptoms developing.

Even if further investigations had not been carried out, the fact that there were concerns about the condition of UR6 could have been flagged up to the patient.

With respect to the endodontic treatment, Dr A had not in fact fully discussed the risks of root canal treatment, and despite the root curvature, had inadvertently raised the patient's expectation that treatment would be straightforward. No mention had been made of the possibility of a file fracture nor that in the event of complications arising and a consequent specialist referral being required, further costs may be incurred. It was noted that in view of the marked root curvature, consideration could have been given to specialist referral.

Although the factor that triggered the complaint was the fractured instrument, this happened against a background lack of understanding on the part of the patient, which was caused by Dr A's oversight in not fully informing the patient.

The fractured file and a specialist referral may not have created such an angry reaction from Mr S if he had been fully informed of this risk, and therefore prepared for it arising, in advance.

It would also have been reduced if advice on the condition of UR6 had been provided at the time of the examination appointment. The weakness in Dr A's position stemmed from a lack of valid consent as the patient had not fully understood the risks of treatment – including cost implications – before proceeding.

Dental Protection provided support and advice for Dr A in dealing with the complaint via the DCRS. This included covering the costs of the remedial treatment with the specialist as a gesture of goodwill. The result was that the matter was resolved successfully and no further action was taken by the patient.

LEARNING POINTS

- **The dentist has a responsibility to ensure a thorough assessment ahead of the provision of treatment, such as the special investigation of a vitality test in this case, which would have prevented the unfortunate sequence of events.**
- **Providing the patient with the necessary information - such as treatment options and the subsequent advantages/disadvantages and consequences - enables the patient to make an informed decision over what approach they wish to take, and contributes to obtaining a valid consent.**

Case Study

Avoiding herodontics

Ms B was suffering from pain that kept her awake at night. An examination by the dentist established tooth 27 was the cause of discomfort. The 27 had extensive dental decay and a missing buccal wall. Ms B had an otherwise intact arch and was keen to save the tooth – she did not want a dental extraction.

The dentist explained that endodontic treatment carried no guarantee of success, especially with the extent of damage to the enamel walls, and extraction was offered as the only realistic alternative.

Ms B was quite persistent in her demands for root treatment, along with a full coverage crown, and was unwilling to be referred to a specialist. The dentist felt pressurised by the patient and embarked upon the endodontic treatment against her better judgement.

Five visits later, only two of the canals had been located and the third may have been perforated as it bled on instrumentation. This was discussed with Ms B and the tooth was dressed.

Whilst the endodontic treatment was becoming more complicated, Ms B was still unwilling to consider an extraction and was forceful in her request for the root treatment to be completed by the practitioner.

Further explanations were provided, but despite this Ms B remained convinced that a crown would solve the problem. She decided to visit a second dentist and was informed that the tooth had an incomplete root canal treatment.

The first dentist received a letter of complaint questioning why the endodontic treatment had not been completed in five visits and why she had been charged for this incomplete and unsuccessful treatment.

The dentist contacted Dental Protection for advice on how best to respond.

Whilst the clinical records were detailed, the practitioner was vulnerable in some areas regarding the clinical care provided. In terms of the pre-operative assessment, the restorability status of the tooth at the outset was questionable. During the procedure the dentist could not place a rubber dam because of insufficient residual coronal tissue, and owing to a lack of anatomical landmarks, a perforation occurred. With hindsight the practitioner realised that the decision to carry out root canal therapy intervention had been a poor one, and she should not have attempted the procedure in the first place.

With Dental Protection's advice and assistance the complaint was resolved by refunding Ms B for the initial endodontic treatment and also contributing towards the cost of the second dentist's assessment.

Had Ms B pursued the matter with a claim for clinical negligence, the solicitors could potentially allege that Ms B had been subjected to an inappropriate procedure with associated pain and suffering.

LEARNING POINTS

- Be alert to patient-led dentistry and the demands of strong-willed patients. Unrealistic expectations should be identified and managed from the outset. The reasons why the treatment is inappropriate should be communicated effectively.
- Avoid being coaxed by persistent patients into carrying out treatments which have a slim to zero chance of success.
- Just because a patient consents to treatment, it doesn't necessarily mean that the treatment is appropriate.
- In this particular case, the complaint was resolved by a detailed letter of explanation and a refund of fees.
- In trying to appease the patient, the dentist had spent over three hours attempting treatment that was essentially doomed to fail, and then had to spend even more time managing the resulting complaint.
- This case highlights the dangers of attempting heroic dentistry; dentists are unlikely to be thanked for lack of success.
- Unrealistic expectations should be managed carefully from the outset.

Case Study

A foreseen fracture

Mr G attended an emergency appointment complaining of acute pain in his upper left quadrant. The dentist identified a carious cavity at tooth 26.

Having undertaken a thorough examination, including vitality testing and exposure of a periapical radiograph, a diagnosis of irreversible pulpitis was made. The dentist noted the curvature of a disto-buccal root which appeared from the radiograph to be in very close proximity to the floor of the maxillary sinus.

Mr G was keen to have this tooth extracted and the dentist, mindful of her obligation to offer all treatment options, also discussed root canal therapy and suggested that given its complexity, there was also the option of a referral to a specialist colleague.

Mr G was informed of the potential risks and complications of an extraction, and in particular, the possibility of a fracture of the curved portion of the disto-buccal root. The risk of a potential oral-antral communication and the possibility of the retained root being displaced into the maxillary sinus were also discussed. The usual general risks – such as bleeding, bruising and postoperative infection – were explained, with the dentist using the radiograph to support her discussions, so the patient had some visual imagery to help his understanding.

Although the dentist felt competent to extract the 26, she also considered extirpation of the pulp to relieve Mr G's symptoms and, as she anticipated a challenging extraction, also discussed the option of a referral to a specialist oral surgeon. However, as Mr G was suffering from acute symptoms, the dentist felt that it was not unreasonable for her to attempt the extraction, and, given the circumstances, it was also an appropriate treatment option.

After taking a short time to consider all the information provided, Mr G requested that the dentist proceed with the extraction. He signed a consent form that included information relating to the shape of the disto-buccal root and all the potential risks and complications as discussed with him.

During the attempted extraction, the 26 did fracture and the disto-buccal root remained in situ. A second radiograph confirmed the position and size of the retained root fragment. The dentist did attempt to remove the retained root but was cautious given the high risk of displacing the root into the antrum. Mr G was informed that the extraction was incomplete and that, as a piece of the root was retained, it would be necessary to refer him to a specialist colleague.

The dentist provided the necessary aftercare and arranged for a review appointment. During this appointment, Mr G mentioned that he was unhappy about the additional costs that would be incurred in order to complete treatment with the oral surgeon, and asked the dentist to reimburse these additional fees.

The dentist contacted Dental Protection and discussed the case with a dentolegal consultant, who acknowledged the dentist had made comprehensive notes and documented all her discussions with Mr G, including the specific risk of fracture of the disto-buccal root. The records also noted that the patient had declined the option of a referral to a specialist colleague before any treatment had commenced.

Dental Protection advised the dentist that her treatment records clearly reflected that valid consent had been obtained, and whilst the outcome was suboptimal, the dentist had provided appropriate treatment, with a reasonable degree of skill, and had discontinued the treatment when she felt the removal of the retained root required specialist intervention.

It was agreed that there were strong grounds for the dentist to decline Mr G's request to reimburse the additional treatment costs, and Dental Protection assisted the dentist in providing an explanation of events in a letter to Mr G. In addition, it was suggested that the dentist may wish to consider refunding the fees for the incomplete extraction, purely as a gesture of goodwill to maintain an amicable dentist-patient relationship.

Mr G acknowledged that he was informed of this possible outcome and had agreed that the immediate referral and standard of aftercare had been to his total satisfaction. He accepted the refund of the treatment fee for the attempted extraction and indicated his appreciation of the gesture of goodwill.

Mr G remained on good terms with the dentist throughout, and later informed her that the retained root had been removed uneventfully by an oral surgeon.

LEARNING POINTS

- By providing the patient with all the treatment options and identifying the advantages and disadvantages of each, along with any associated costs – such as the offer of specialist referral – a dentist can be confident that the choice made by the patient is properly informed.
- Ensuring all discussions with the patient are recorded contemporaneously allows a dentist to rely on their treatment records to defend their position.
- A dentist should always ensure they are working within their clinical competency and be able to recognise when treatment may have progressed beyond their particular expertise or skill set, and provide prompt referral to a specialist colleague when necessary.
- Whilst in this instance the patient accepted the dentist's explanation and appreciated the goodwill gesture, if the patient had chosen to escalate their concerns by pursuing a claim for compensation, Dental Protection would have been in a good position to defend against any attempted litigation because of the dentist's robust treatment records.

Case Study

A delayed postoperative healing following an extraction

Mrs C attended her dentist for an extraction of an unrestorable, fractured 37. The procedure was uneventful and postoperative instructions were provided in the usual way.

She returned the following day in discomfort and the dentist diagnosed alveolar osteitis. The socket was irrigated and the dentist placed a medicated dressing in the socket. The dentist explained the diagnosis, advised Mrs C to take painkillers and offered to book a review appointment the next day.

Mrs C seemed surprised about this and declined the appointment as she had already taken two days off work to attend the clinic for the extraction and the emergency appointment. As there were no signs of infection, antibiotics were not prescribed and she left fairly disgruntled.

Her husband returned to the clinic the next day shouting and being very raucous in his behaviour. He complained to the receptionist that his wife was still in considerable pain following the extraction of her tooth, and stated that this was down to the poor standard of treatment provided by the dentist. He threatened to report the dentist to the press and the Dental Council and said that he had already posted negative comments about the dentist on various social media sites.

The dentist in question was working in another clinic that day, so did not have an opportunity to provide an explanation to Mrs C's husband. He did however contact Dental Protection for urgent advice as he was concerned about the impact of any social media criticism. He discussed the case with his dentolegal consultant and explained that although he was unaware of any press coverage to date, there were a handful of comments on social media attempting to undermine his credibility and professional reputation.

The press team at Dental Protection was asked to assist the member and advised that if the dentist was contacted by a newspaper for a comment, he should find out:

- the journalist's name
- the name of the publication
- the aspects of the care and treatment they were seeking comments on
- the deadline for a response
- the journalist's contact details – phone number and email address.

The press team also provided the following helpful advice:

- Do not respond to any questions immediately – instead take some time to consider a response or to seek advice.
- Maintain your professionalism at all times and do not be tempted to discuss a patient's treatment in a public domain. If you cannot discuss the patient's treatment for confidentiality reasons then you should say so.
- Avoid saying 'no comment' as it sounds defensive. Ensure you come across as co-operative and inform the reporter that you will come back to them.
- Contact the Dental Protection press office for advice and liaise with your employer/practice where appropriate.

The dentist was reassured that the Dental Protection press team could liaise with journalists if necessary and provide a statement on his behalf.

Steps were also taken to address the negative comments made on social media; the administrator of the social media page was contacted and removal of the unfair and inappropriate comments was requested.

Dental Protection recognises that patients increasingly use social media channels to highlight concerns about their treatment and care where previously this would have been privately communicated to the practice. We would encourage members to respond to both positive and negative online feedback. Responding to online comments demonstrates you are listening and care about feedback; however, you should always express a willingness to address any concerns offline where confidentiality can be respected.

The situation was amicably resolved by arranging for another dentist to review Mrs C. This dentist confirmed the diagnosis and explained to the patient that dry socket was a recognised complication and that the pain would subside within a few days and the socket would heal.

It is always advisable to request Dental Protection's assistance from the outset when faced with unexpected clinical outcomes and/or complications that may lead to a patient complaint. In this situation, the dentist was able to identify a strategy to manage the adverse social media coverage and potential harm to his reputation by contacting Dental Protection immediately.

LEARNING POINTS

- **The dentist failed to warn the patient about the possibility of alveolar osteitis at the outset. Consequently, when the patient developed a recognised postoperative complication she became alarmed and blamed the dentist.**
- **An opportunity was also missed when the dentist realised that the patient left the clinic unhappy. It may have been worthwhile considering contacting the patient later on that evening to enquire how she was and provide further support and advice.**

Case Study

Leaving a sour taste in the mouth

Associate dentists leave their current practice for a variety of reasons, and occasionally this can be due to a breakdown in communication and issues surrounding working relationships within the practice. When an associate leaves a practice on bad terms this can be the catalyst for a number of unexpected patient complaints. This scenario can be distressing and difficult to manage if there is no agreement with the practice owner in relation to how to manage post-treatment issues that would otherwise be addressed by the dentist had they remained at the practice.

It is common practice for an agreed sum of money to be withheld by the principal for an agreed period of time when an associate leaves a practice, to allow minor problems to be resolved.

CASE STUDY

The relationship between a principal and an associate had deteriorated to such an extent that the associate had left the practice.

The associate was clinically very competent and experienced, and had completed a number of challenging 'tooth wear' cases. One particular patient, Mr L, had been treated with composite build up restorations on numerous teeth to conservatively manage his tooth wear and the finished result was satisfactory. Whilst the associate's clinical records reflected the merits and limitations of composite resin versus porcelain restorations, there was no mention that further charges would apply for the maintenance and/or repair of these restorations. When Mr L required some fairly minimal general polishing of the composite restorations due to surface staining, he said he had not been informed that additional charges would apply and did not expect the owner of the practice to charge him for this treatment.

Mr L resented being asked to pay for polishing the composites and raised the issue with the principal, who passed the complaint to his former associate. Although the associate had moved over 70 miles away, he offered to review the patient and provide the necessary treatment at no cost, but the patient was understandably unwilling to travel to see him.

This scenario was not an isolated example; it was a recurring story involving a number of patients who required similar maintenance work. Rather than completing this work as a gesture of goodwill to maintain the reputation of the practice, the principal encouraged every minor concern to develop into a complaint that required a formal response from the associate. The fact that the patients felt they were being charged an over-inflated cost for maintenance treatment by the principal only added to their dissatisfaction.

The associate contacted Dental Protection, and with the benefit of hindsight, realised that he had not made it clear to Mr L – or to the other patients – that ongoing maintenance would be chargeable. He recognised that there had been no clarity regarding what aspects of the treatment were covered by the original fee, and as a result, patients had unilaterally made some assumptions.

Dental Protection advised the associate to talk to the principal and to try and come to an agreement so as to avoid further incidents that could be harmful to both their reputations.

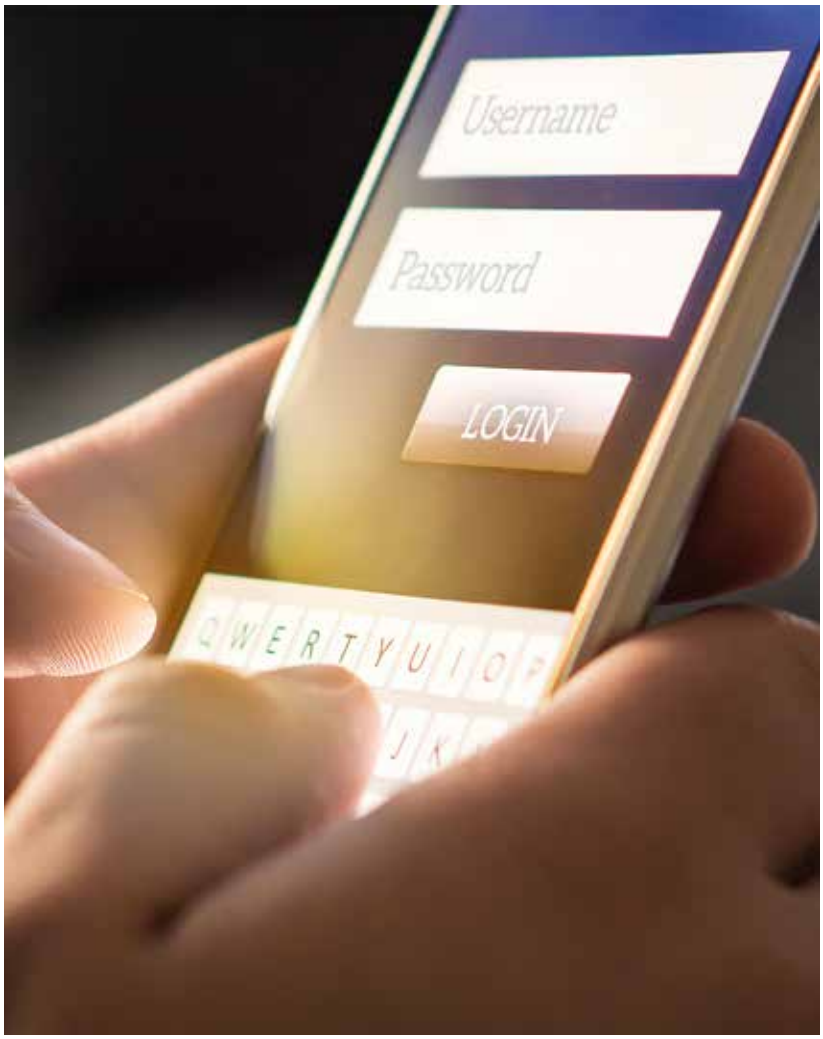
The associate and principal reached an agreement between them to cover the reasonable cost of post-treatment maintenance/polish appointments.

LEARNING POINTS

- This case study illustrates the importance of maintaining professional relationships and taking the time to agree how patient care can, and should, be handed over when a dentist leaves a practice.
- There should be a signed agreement that includes a clause regarding the retention of fees for remedial work when an associate leaves a practice. This avoids disputes and disagreements which may arise after the departure of an associate.
- When planning treatment that requires ongoing maintenance, clear explanations should be given to the patient and documented in the record. This should include an explicit statement as to what the initial fee includes and what charges may apply in the future. This should be set out clearly in writing for the patient and a copy retained in the records, so everyone knows what to expect.
- Financial disputes between the principal and an associate should be resolved between the two parties and not involve the patient.

Case Study

Protecting your reputation



A dentist provided functional orthodontic treatment for a ten-year-old patient.

The treatment did not get off to a good start due to the patient failing to fully comply with advice and instructions on the requirement to wear the appliance.

The mother wished to discontinue treatment so she could seek care elsewhere for her child in the hope they would have better success. The dentist thought he had resolved the situation amicably by providing a copy of the records to facilitate ongoing care and a full refund of fees.

"As well as the defamatory comments published on Google, the patient's mother also sent a number of threatening emails to the dentist"

The patient attended another practitioner and it became apparent that the patient's mother had posted a Google review about the first dentist, alleging he was a terrible dentist, that he caused harm to her and her son, and that his motivation was financial.

As well as the defamatory comments published on Google, the patient's mother also sent a number of threatening emails to the dentist.

The dentist worked in a small, close-knit community and news of these harmful, critcal reviews spread quickly and started to have a negative effect on the popularity of the practice.

Shortly after the dentist contacted Dental Protection, a solicitor was instructed to assist. They prepared a strongly worded letter to the mother to 'cease and desist' her actions, consequent to which the reviews were removed and the persistent, threatening emails ceased.

LEARNING POINTS

- Dental Protection is here to support you and because we have the legal resources on hand to support members when it matters most, we can act quickly to advise and protect your professional reputation.
- Practices should remain vigilant and monitor any comments on websites and social media platforms and seek advice if they have the potential to damage the professional reputation of the practice.
- If you receive a request for clinical records, be aware of any latent and underlying concerns and try and resolve these within the practice. This is an example of risk containment.
- Whilst a refund of fees can de-risk the escalation of a complaint, be aware that patients can seek redress in other ways, including commenting on their experience on websites.
- It is important that patients are fully informed of charges and fees but be aware that information about costs should be presented in a way that does not suggest to the patient that it has primacy over other discussions. This may lead to the perception that a dentist is interested only in the fee.

Case Study

Short term orthodontics

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Miss N attended an examination appointment with a new dentist, unhappy with the appearance of her upper teeth. She informed the dentist that she'd had an assessment with an orthodontist a few years ago and was told fixed appliances were necessary. Miss N wanted a 'quick result' as she was getting married in six months and was aware the dentist provided a clear aligner treatment system. The dentist carried out some checks using the clear aligner system programme and informed her about the costs of the treatment, indicating a good result was possible within six months. Miss N was happy to proceed on this basis.

Treatment continued for four months, with Miss N becoming increasingly frustrated at each review by the lack of progress. The dentist queried whether she was wearing the aligners for the prescribed periods of time. Miss N reassured the dentist she was indeed wearing the aligners for the correct periods of time and was anxious to have the treatment finished due to her wedding drawing near. The dentist continued to reassure her and consulted with the clear aligner programme mentor who advised that additional aligners were now necessary.

The dentist relayed this to Miss N at the following review. Although she was extremely disappointed, she still wanted to continue treatment and accepted this would not be finished by the time of her wedding.

A further five months passed and it became apparent that the case was not progressing how Miss N had expected. She also began to experience occlusal problems and had developed an anterior open bite.

The dentist accepted that progress had been slow and offered to refer her to an orthodontist.

The orthodontist advised that due to Miss N's crowding and the skeletal profile, tooth extraction and fixed appliances were necessary in order to correct the treatment. The patient was extremely upset and complained in writing. She alleged that the dentist had misled and misinformed her at the time of the initial examination about the duration of the treatment to achieve the desired result. She requested the dentist refund the treatment fees and cover the further costs of continuing her care with the specialist orthodontist. Miss N threatened to seek compensation for negligence if she did not receive what she believed to be a fair and satisfactory outcome.

The dentist contacted Dental Protection for advice. A close scrutiny of the patient's clinical records indicated that these were insufficient and incomplete and therefore it could not be shown that an appropriate examination and subsequent diagnosis had been made, or that a suitable treatment plan had been formulated. As a result, the dentist would be vulnerable in the event of an escalation and further inquiry. The records suggested that treatment options – such as fixed appliances and/or referral to a specialist orthodontist – had not been discussed, which amounted to a failure in obtaining valid consent. A specialist orthodontic report concluded that due to Miss N's severe crowding, she would always have needed fixed orthodontic treatment to achieve a satisfactory outcome.

Although the treatment was initially an elective procedure, Miss N's occlusion was now unstable and further treatment was necessary. Dental Protection discussed with the member whether he would be prepared to refund the treatment costs in view of the patient's dissatisfaction, and he agreed.

With Dental Protection's advice and assistance a letter was sent to Miss N. It included an apology for her disappointment. The case was resolved by a refund of treatment fees and a contribution towards the cost of the further treatment with the specialist orthodontic consultant.

LEARNING POINTS

- Ensure all treatment options – and any appropriate referrals – are offered to the patient, along with the advantages and disadvantages of each, in order to demonstrate a valid consent has been achieved.
- Be aware of your professional limitations and work within the limits of your competence.
- Assess each case carefully to avoid attempting treatment beyond your clinical capabilities, even if the patient demands it.
- Do not agree to unrealistic or impracticable treatment times.

CONTACTS

You can contact Dental Protection for assistance **dentalprotection.org**

Membership services

Telephone 1800 509 441
member.help@dentalprotection.org

Dentolegal advice

Telephone (+44) 113 241 0200
enquiries@dentalprotection.org

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