

Riskwise

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Australia



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Editorial

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Dental Team Leader Australia



Welcome

One side of working as a Dentolegal Consultant for Dental Protection is that we are continuously dealing with the unfortunate side of dentistry – the adverse outcomes, the enraged patients (and dental practitioners!), the patients harmed through either bad luck or bad decisions; and last but certainly not least, dental practitioners damaged by the aftermath of an adverse outcome, whether it be a complaint, an AHPRA notification or legal action. The blow to self-confidence, the fear of reputational damage and that burning throat you feel when you have planned to help your patient and it just hasn't worked out. These are the issues that we need to recognise and assist our members with to cope and function.

This emotional toll is balanced by the frequent examples that we witness of practitioners behaving magnanimously in their darkest hour of dental practice, in arranging appropriate care and advice for their patients after an adverse outcome when they are not thinking or feeling their best. Being generous in their offers of care and rehabilitation, and humble in weathering at times loud and unfair criticism.

In short, demonstrating an old-fashioned portrait of professionalism. We tend to think more of the other meaning of being a professional – to be paid for a certain occupation, rather than the traditional sense of being competent and skilled in a certain occupation, with its undertones in

the medical sciences of duty and dedication to a patient. Personally I have always thought of those that I have treated as patients and never as clients or customers. Care for a patient has so much more meaning as it is indicative of a relationship that transcends the attached commercial transaction; and of a duty to see those you are caring for through to a successful outcome.

Both senses of the word “professional” are relevant to dental practice but sometimes there is a feeling of tension between the two as if they were in conflict. This is generally not the case – dental practitioners are entitled to reasonable remuneration for their services and patients are entitled to a reconsideration of this payment if treatment has not worked out, and they have not been adequately warned of this possibility. A refund of fees is not always indicated in the face of failed treatment but it often is, and it often resolves complaints. Some practitioners are worried that this will be seen as an admission of fault – it is not seen this way by our regulators and generally not seen this way by patients. Others are concerned that they may be seen as a ‘soft touch’ by the community and this will trigger further calls for refunds. The reality is that these events are rare in our practising career – rare enough that a refund will not cause harm to our income over the long term or trigger a swarm of complaints.

Refunds, however, are not always appropriate and your Dentolegal Consultant can give you advice in this regard and help you with the decision. We can also give you advice on how to present this decision to a patient, as this can be accepted by a patient almost as an insult on one hand, if expressed carelessly, or as a reasoned decision on the other.

Either way, the commercial side is generally secondary to a patient's perception of the care they have been provided and the professionalism that is exhibited by their dental practitioner. Patients may not necessarily show their appreciation for care in the heat of the moment of an adverse outcome, but it is often appreciated later when the dust has settled. Regardless it is part of our duty of care and responsibility as a true professional.

Very much as a generalisation, in recent times we have seen a decrease in the tolerance for adversity from patients and dental practitioners – no doubt due to the considerably increased stress and uncertainty that many of us have been dealing with over the last two years. Now more than ever is the time for us to reach deep and wear our professionalism with pride.

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Learning from complaints

*In the previous edition of Riskwise we published the article “Reflecting on a complaint” by Zoe Levenson, which was the winning entry in our competition run in partnership with Dental Training Consultants. Here we present the two excellent runners-up in the competition, by **Jenna Shah** and **Priyanka Adatia***

Jenna Shah

It was another early morning start as I walked through the oral surgery doors, unaware of what lay in store for me that day. I called my patient in and began to question him. I think we have all been pushed to carry out a thorough history of our patients so as not to miss out anything of importance, however from the moment I mentioned drugs and alcohol, his whole body tensed up.

I should have paid more attention to his body language and sensed his unease at the topic. The more I probed, the more aggressive he became until he leapt up from the dental chair and queried my abilities as a youthful looking dental student. I explained that I was competent and would be supervised by a tutor. Unsatisfied by my response, he began to storm out of the clinic until a nurse approached him to calm him down and address his complaints.

He dubiously returned and I extracted his tooth with no issue. His demeanour changed drastically from the beginning of the appointment to the end where he thanked me and smiled. Reflecting on this experience, I could have been more empathetic to his issues, and following the example of the dental nurse, explained the reason for asking those questions more effectively. I did not chase after him because of his ‘rude’ comments; however, I should remember not to judge anyone’s actions as they might be warped by personal circumstances or pain; everyone deserves treatment.

Finally, when he returned to the dental chair, I should have apologised for any distress that I might have caused. This case highlighted that although you might be knowledgeable and capable of performing treatment, successful communication is ultimately what leads to patient trust in you as a dentist.

Priyanka Adatia

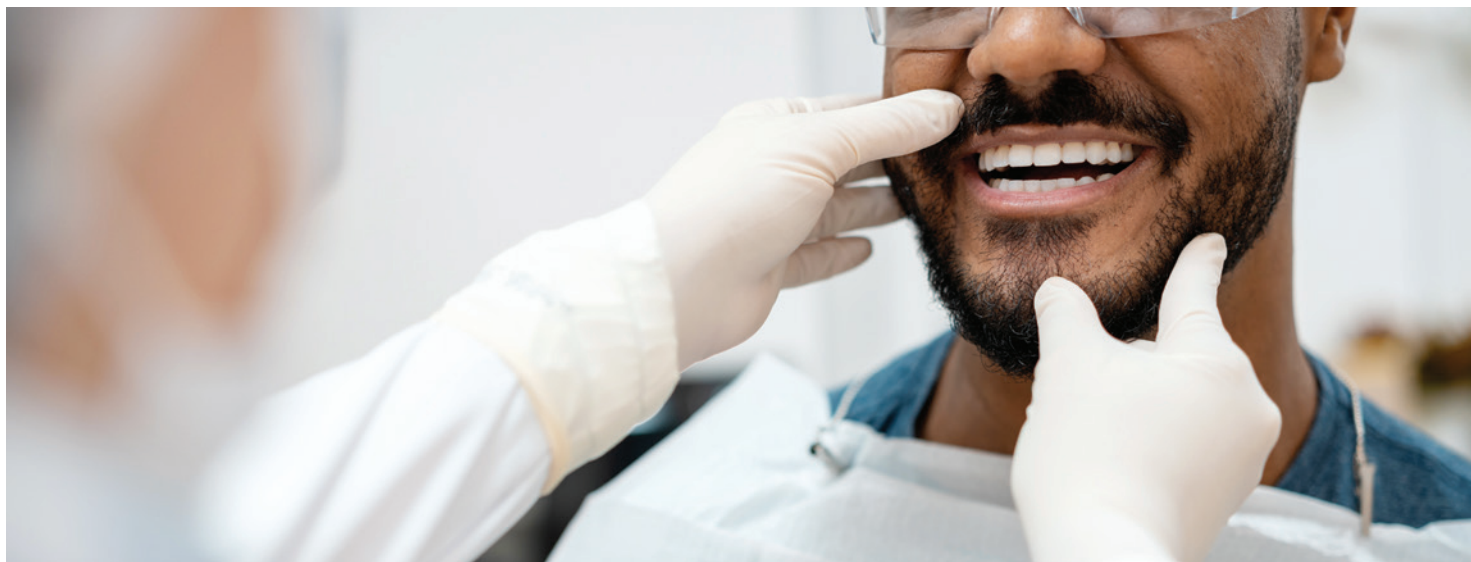
Complaints form an important part of everyday life in many job sectors, be it fast food services, hotels or high street retailers. In an ideal world, complaints wouldn’t exist but without these, self-progression in our fields of work wouldn’t be as pronounced. Complaints are essentially another form of feedback and so revisiting and learning from them is essential.

One complaint I received was while working in a local charity shop, LOROS. At the time, the card payment machine wasn’t working; only cash payments were being accepted. The customer in question complained that she’d spent 30 minutes browsing only to be informed at the till that she wouldn’t be able to purchase the products with her card. At the time, I had apologised for the inconvenience and offered to reserve her products for the remainder of the day, to be picked up later after she had visited a cash machine. Although the customer was unhappy with the situation, she decided this was an appropriate solution.

Throughout the day, having put myself in the customer’s shoes, I empathised with her frustration. So, when discussing the issue with the store manager, we decided actions needed to be taken to avoid reoccurrence. I had suggested measures ranging from a simple sign on the entrance door, to informing customers as they entered onto the shop floor. The next day, even with the non-functioning card machine, with the newly implemented measures no similar issues arose.

Looking retrospectively, the situation is somewhat comparable to the discussion of risks and benefits for dental treatments. A patient wouldn’t want to be given these after consenting or midway through their treatment as this is key information that may influence their decision. Hence, from this complaint I was able to appreciate the importance of delivering influential information in a timely manner.





Cosmetic dentistry: ethics and aesthetics

*Cosmetic dentistry is an increasingly popular undertaking for many dental practitioners but is laced with dentolegal risks. **Dr Martin Foster**, Dentolegal Consultant at Dental Protection, talks through the principal learning points*

It is worth remembering that ever since the earliest days of dentistry patients have sought help with two main issues. The treatment of disease and the improvement of appearance, and not necessarily in that order.

In providing care it is obviously important to ensure patient needs are met and there is shared approach to clinical decision making. This can be tricky if patient wants and expectations are at odds with what is actually required to achieve an improvement in terms of oral health.

One of the biggest ethical challenges in providing dental treatment that is elective and 'wants based' rather than strictly 'needs based' is the necessity to ensure that any intervention proposed will do no harm.

A thorough case assessment

The key factors to take into account in meeting this challenge are firstly ensuring that there is a very careful and thorough case assessment so that there is a very clear record of the starting point. Patients often

have selective memory. Once treatment is underway, they can all too easily forget what the initial position was.

To ensure that there is a complete understanding of the whole picture, the case assessment should take account of the various patient factors, such as history, motivations, expectations and the goals the patient hopes the treatment will achieve. In addition, the full range of occlusal, biological and structural factors that form the clinical environment against which any treatment will be carried out, and the existing smile and facial characteristics, need to be taken into account as these will clearly influence the outcomes which are possible.

As with treating disease, treatment that is primarily intended to improve aesthetics must be based upon a correct diagnosis of what the issue is, if the appropriate options to achieve success are to be correctly identified.

Once treatment options have been identified it is of critical importance that the patient receives comprehensive information and

clear explanations detailing the comparative advantages, disadvantages and costings of each option. It must also be emphasised in all cases where cosmetic treatment is being considered that "no treatment" is always the first option.

In terms of fulfilling the primary ethical duty of doing no harm, whenever there is no disease to address, there is inevitably going to be an inherent risk of doing more harm than good when any intervention is undertaken.

On the subject of risk, it should go without saying that a clinician should not embark upon any procedure unless they have the skills and competence to see it through successfully. It may be worth reflecting on the reality that elective procedures are not about fixing damage but are actually about trying not to damage something that is not broken. You do need to be sure you can do this. If in doubt an onward referral or second opinion may be the best favour you can do your patient and yourself.



Managing expectations

It is clear that social media has played an increasingly influential role in the promotion of dental services to patients. In the same way it can also be used very effectively to manage the expectations of patients with regards to cosmetic treatments. If there is any reluctance among colleagues then it may be helpful to have a conversation with them about why they are reluctant – it might be that they haven't grasped the benefits, or there is a bit of a fear of the unknown – or perhaps they have had previous negative experiences.

Building a social media presence for your practice can be an important tool for you to promote your services and attract new patients, while also strengthening relationships with existing patients – and using these channels to post before and after pictures can be a helpful way to validate any claims made about your competency in cosmetic procedures.

However, you must be careful about what you promise; don't raise unrealistic expectations by showing pictures of perfection. If they are your own examples, get the patient's consent – but if they are stock photos then you must be clear about this.

Cosmetic treatment involves what is going on in the patient's head as well as managing the operative clinical aspects. It is therefore necessary to understand where the patient is

coming from. A experienced dentist should be able to carry out an intra-oral and extra-oral assessment effectively but it can take a fair bit of additional effort to get inside a patient's thought processes and understand where they are coming from in terms of what they see as the problem, and what a successful outcome will look like – for them. It is only when you understand the problem from the patient's perspective that you will be able to consider what solutions, if any, can be offered.

You may feel that the problem is obvious but remember you are seeing the situation as a dentist. A dentist will understandably default to dentist solutions and you may be tempted to suggest a way forward that will not in fact address the patient's problem. So in terms of diagnosis, it is important to spend time actively listening to what the patient is really saying. Assume nothing; ask questions – what are their goals for their teeth/mouth/smile? What will success look like?

Are there any alarm bells ringing for you? If the patient expresses the view that once they have the work done they will get that job/partner/career/success in life that they should have, you may need to think twice about embarking on treatment. You may be able to effect some cosmetic improvement but revolutionising someone's existence is probably not an achievable treatment aim.

The patient may have their own ideas of what the optimum treatment plan is and what

the outcome should be, and it is critically important to ensure that this is in alignment with reality. The important fact to bear in mind with any sort of cosmetic treatment is that even the most technically excellent result can give rise to dissatisfaction if it does not match the patient's perception of what success should look like. If there is any doubt as to what is expected or whether or not you can reach the end result the patient is expecting, it is advisable not to set out on that journey.

A treating clinician has the advantage of understanding the whole process and what is achievable. The duty exists to ensure the patient shares this understanding whatever the treatment provided, and this is all the more so for elective procedures.

No surprises: taking consent

It can be helpful to think of the consent process as a means of avoiding surprises. When obtaining consent for cosmetic treatment it is worth bearing in mind that patients seeking such treatment are motivated by the primary sensory input of vision. It is all about appearance after all so it makes sense to use visual aids, images, models, videos, before and after photos and illustrated information to get the message across.

Remember also that your patients are real human beings, not computer-generated images, so it is wise to use realistic photos of



what can actually be expected rather than images of impossibly perfect teeth radiating from beautifully photogenic faces. And yes, you can use clinical images from your own cases for patient education purposes but you should anonymise these and get the patient's permission.

Having provided the patient with all the information at your disposal you need to check they have retained and understood this. As well as a firm grasp of the treatment itself, the patient should be under no illusions about the fees and the timeframe. It is vitally important that the patient has no unanswered questions so say:

- *Does that make sense?*
- *Would you like more information on this?*
- *There is a lot to consider, I hope that I have explained this clearly.*
- *Please do let me know if you have any questions.*

We know that people process information in different ways. Providing the patient with a detailed written, no-jargon description of what been discussed can be hugely helpful for a number of reasons.

Firstly, it allows the patient to have ready access to the details of the proposed treatment and also allows them to refresh their memory of the discussion and explanations provided. As well as this, there will then be a dated, clear statement of the

information provided as a useful addition to the record of the patient journey. Importantly it can serve as supporting evidence of a consent process being followed.

Given that many cosmetic procedures are elective, there is generally no clinical urgency. Although there may be a patient-generated impatience to get started it is advisable to allow a cooling off period to allow the patient to reflect and confirm that they are in fact happy to proceed. Although more of a time commitment, it can be a good investment to give patients the opportunity to have a second consultation if they wish.

It should be too obvious to state but treatment should not start until you are satisfied that both you and the patient are on the same page in terms of where you are headed, how you are going to get there, how long it will take and what it will cost.

If ever there was a situation to apply the old maxim "make haste slowly", embarking upon cosmetic treatment is definitely an example. Investing time and effort in careful clinical assessment, identifying the patient's wish list, exploring the options and developing a plan that both sides understand and agree is time-consuming. On the other hand, taking shortcuts with any of these will likely be a false economy and will cost more in time, effort and potential disappointment in the long run.

Problems arise when not enough time is given to clear communication at the outset so before reclining the chair and working on what is in the patient's mouth, take the time to draw up a chair and work on what is going on in the patient's head. Above all, remember "first do no harm". If there is a risk of more harm than good then ethical sense should prevail over aesthetic sensitivities.

In summary

Overall, when considering what treatment to offer you should be realistic: under-promise and over-deliver. It's important the patient knows what is realistic – manage their expectations: you can get patients with body dysmorphia who think fixing their teeth will improve their body image.

Make sure the treatment is appropriate and justifiable; don't let patients push you into inappropriate treatment. Consent and record-keeping for elective procedures should be robust, and alternative options should always be offered, including doing nothing at all. Remember to discuss the risks and benefits, including the longevity of the restoration and likely length of treatment.

To view a recording of Dental Protection's webinar on Cosmetic Dentistry, go to dentalprotection.org and log in to your PRISM e-learning account.

Defensive practice – does it really lower our risk?

Dr Simrit Ryatt, Dentolegal Consultant at Dental Protection, looks at why certain approaches to avoiding risk can become self-fulfilling prophecies

The fear of complaints, litigation and a regulatory challenge can sometimes be so overwhelming that it can impact on a clinician's clinical judgement and decision-making to the extent that it causes them to practise what is described as 'defensive dentistry'.

Clinicians will often steer away from procedures that carry a greater risk of failure or avoid patients who have high expectations, in the hope they will have a reduced possibility of facing the risk of a claim or complaint. By practising in this way, clinicians need to be careful what they wish for, as the very risk they are trying to avoid by practising defensively creates a new risk or exposure to a different risk.

In terms of an evidence base supporting the concept of defensive practice, there is a fair amount of literature related to defensive medicine but very little specific to dentistry. When you search for a definition of 'defensive medicine' you will find several results. Oxford languages defines defensive medicine as:

"Medicine practised in such a way as to reduce the risk of malpractice litigation, typically by the use of excess diagnostic testing."

When you search for the definition of defensive dentistry your results will be fruitless as the definition does not exist.

Immediately lots of questions spring to mind such as, does defensive dentistry simply not exist? Is it only a medical phenomenon? The reality is that defensive dentistry does exist, and we often find evidence of defensive practices lurking in the background of complaints we are assisting members with here at Dental Protection.

Does defensive dentistry really exist?

So what would be the definition of defensive dentistry? Could we apply the same definition of defensive medicine to defensive dentistry? The main bread and butter of our diagnostic testing in general practice is the taking of radiographs, vitality tests, tooth percussion and detailed pocket charting, and I am sure you will agree these tests tend not be over-used; therefore the commonly applied medical reference would appear to be inappropriate for dentistry.

In a well-known defensive medicine study in 2013, Ortashi et al defined defensive medicine as: "A doctors' deviation from standard practice to reduce or prevent complaints or criticism."

This definition certainly resonates with defensive dentistry and, in addition, having reviewed many cases related to defensive practice we have also determined other common themes. I have found many practitioners influence their patients to

choose treatments that they are more comfortable with and many dentists avoid certain treatments and certain patients.

The final theme I have noted, and I feel slightly uncomfortable raising this point, is that some dentists lose the primary focus of 'the best interests of their patients' being integral to everything they do and let the focus shift to themselves. This last point is clearly in conflict with the standards of conduct, performance and ethics that govern us as professionals. We should always be providing the best possible treatment for our patients, so how do so many of us find ourselves subconsciously and inadvertently putting ourselves first and not our patients?

Examples of defensive practice

We will often assist dentists with the resolution of complaints arising from patients who are in pain and unhappy following an incomplete extraction and then have had to suffer for a substantial length of time to have their tooth eventually extracted elsewhere. A common scenario is a young dentist attempts to extract the tooth, gets into difficulty and nobody in the practice is willing to help their colleague and supports the referral protocol.

It's not because of the unexpected clinical challenge; it's more a decision taken to avoid being dragged into a potential complaint about poor treatment or service.





Similarly, we review complaints from patients left in discomfort where the dentist was worried about adjusting a denture provided by their colleague for fear of getting blamed for worsening the situation. We also see dentists avoiding molar endodontic treatment as the treatment is perceived as being a potentially litigious procedure. The information presented to the patient includes the available options but is framed in a way that the extraction appears to be a more attractive solution for someone in pain.

Why do some dentists allow their subconscious self-serving nature to influence clinical decision making to the detriment of a patient?

We accept that the significant driver for defensive dentistry is the possibility of facing a complaint, a claim for compensation or a regulatory challenge. This fear is the catalyst for the defensive action, which could almost be attributed to an unconscious form of self-preservation. This action could be described as ethical fading, which occurs when the ethical parts of a decision disappear from view.

It often occurs when people focus heavily on other aspects of the decision such as a certain goal like stress avoidance, profitability or winning. In essence, ethical fading is a form of self-deception that occurs when

we subconsciously avoid or disguise the moral implications of a decision. It allows us to behave immorally while maintaining the belief we are ethical and have integrity. For example, most dentists would say to their colleagues that they would never sacrifice healthy enamel for purely cosmetic reasons, yet our claims experience suggests that some of these dentists do actually destroy healthy enamel when they are the only judge of their own ethical conduct at the time the treatment is discussed and agreed.

A question of ethics

Ethical fading in dentistry is the subconscious bias that drives the self-serving nature so that we stop seeing the ethics in the situation. An example is a dentist coercing the patient or steering the treatment, so they provide the treatment that they are more comfortable with. The more it is repeated and successfully completed, it eventually becomes normalised and people will not even realise the decision is unethical. It is often described as self-deception and is rooted in psychology where ethical aberrations are distorted and disguised as actions with honourable intent. As we can see it is far removed from the famous 'daughter test', which uses the analogy that all patients should be treated as though they were a favourite daughter.

It is accepted that dentistry is a physically and emotionally demanding job where you

need exemplary interpersonal skills and business sense. It can be quite isolating and mentally draining at times, so it comes as no surprise that sometimes people feel compelled to take the easy route, such as avoiding certain stressful treatment choices.

With over 125 years of experience we have a unique insight into why things go wrong and the best ways for our members to avoid them. As we have recognised that defensive dentistry exists, prevention is better than a cure, and having the knowledge to combat potential issues is the best way to stay protected. If the main driver of defensive practice is the fear of complaints or litigation, let's look to see how they can be mitigated with better communication skills and effective complaints identification and management. It can be a team effort so everyone is on the lookout and when it happens they all know how best to handle the situation.

We need to be honest with ourselves, particularly where we face ethical dilemmas, and be prepared to reflect on our decision making and setbacks and positively use them and not fear them; after all, we can only improve when we fail – and how can self-improvement ever be perceived as a negative?

Complaint management – here to help

*Nipping complaints in the bud is always the best approach, where possible – Dental Protection's **Dr Simrit Ryatt**, Dentolegal Consultant, looks at how we can help manage complaints on your behalf*

There will always be patients who are dissatisfied with their treatment, or whose expectations are not met in some way. It is important to appreciate that some dissatisfied patients do not necessarily complain; many of them simply decide never to return to the practice, and some of these patients will tell the tale of their dissatisfaction to anyone who is prepared to listen – for weeks or months to come.

Often, patients want to be heard and provided with an opportunity to let off steam, so they feel their concerns have been acknowledged. Others want an explanation or an apology and some form of appropriate remedial action, whether this involves financial recompense or not. Unless an opportunity is grasped to address the patient's needs and resolve these complaints quickly and effectively at an early stage within the practice, there will always be a risk that the patient will take their complaint to another, perhaps higher, authority outside the practice.

The proactive approach

When they happen, there is often a very small window of opportunity to nip complaints in the bud and Dental Protection has always urged members to be proactive when receiving a complaint. We know from our experience that some members go through a range of emotions when they receive a complaint. The emotion can be the catalyst for an initially defensive reaction and by the time we get involved it's obvious that being

proactive but with the wrong response can easily inflame the situation instead of calming things down.

The strategy is always to find out why the complaint has been made and find a solution that is mutually acceptable. A well-managed complaint lowers the risk of the patient feeling they have to involve anyone else in the process, particularly the Dental Council. By making it difficult for the patient to receive an appropriate response we just make it much easier for them to follow the path of least resistance and vent their frustrations, not only about the cause of their complaint but the way it has been handled. Patients and professional regulators nowadays expect concerns or complaints to be acknowledged, listened to and dealt with promptly. Members should appreciate that complaints, if left unresolved, can proceed on two or more fronts simultaneously.

How we can help

We are here to provide advice for a variety of situations and our dental members are encouraged to contact Dental Protection as soon as a complaint is received, or in the event you anticipate the situation with a patient is beginning to unravel. The earlier you contact us, the more help we can give you in the important early stages. We can also suggest approaches to and assist with suitable responses when speaking to patients or responding to patients via email. We can also help you to realistically manage patients' expectations with respect to turnaround of responses.

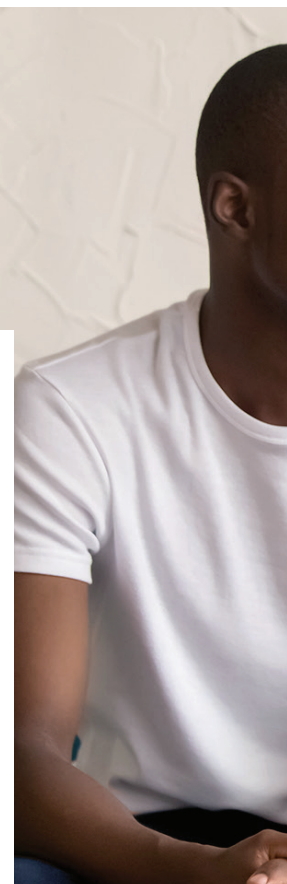
We have an out of hours advice line for urgent situations that cannot wait until the next day and there is always a dentolegal consultant to provide reassurance and immediate general advice. If specific detailed written advice is required, additional details will be obtained before further considered advice is provided. When cases reach the Dental Council, they expect registrants to investigate and provide detailed and professional responses to the complaint. You may prefer to request assistance via email and we can swiftly start the process by seeing how we can best assist you.

Case study – You're not alone

Since normality had resumed after the various outbreaks of COVID-19, Dr W was glad to be back in clinic, although he had been particularly busy recently and he had been working long hours. The outbreaks of COVID-19 had placed additional financial worries on the clinic and this had caused Dr W a considerable amount of anxiety.

Dr W had not taken any significant worry-free time off work since the outbreak started. Tomorrow was Friday, with the weekend break nearly in sight; Dr W was looking forward to spending time with his family and attempting to unwind and de-stress. He was completing a straightforward procedure of a scale and polish for Mr F, a gentleman in his late 50s with a generally healthy mouth. There was minimal calculus to remove, but Dr W could see a fair amount of staining.

Dr W diligently performed the scale and polish, and treatment was completed





15 minutes later. He was just about to leave when he could hear a commotion at reception. He was surprised to see Mr F shouting at his reception team and he was demanding a refund; Dr W immediately tried to defuse the situation. It transpired Mr F felt Dr W hadn't removed all the staining from his teeth. He was angry he had been charged full price for this treatment as he felt it hadn't been completed properly.

Dr W was perplexed by this as he was certain all the stains had been removed, so he attempted to invite Mr F back into the surgery so he could review the patient and understand what the problem was. However, Mr F advised he had lost trust in Dr W and did not want to be seen by him. Before any other suggestions could be made Mr F hurried out of the clinic and as he left, he threatened to contact the Dental Council.

Dr W had a restless evening and he considered contacting Mr F to discuss the matter further, but he reflected that he attempted to resolve matters already and Mr F was adamant he had lost trust in him, so surely any further resolution attempts would be hopeless. Dr W had a sleepless night and struggled to work the next day. He was meant to be attending his daughter's recital on Friday evening but as he was extremely anxious from Thursday's events, he didn't attend and he stayed at home on his own. Dr W spent the rest of the weekend feeling worried about the events on Thursday with Mr F and the issue was on his mind for a number of weeks afterwards.

Almost inevitably, and a bit like a self-fulfilling prophecy, Dr W received correspondence from the Dental Council as Mr F had lodged a formal complaint with them. Dr W contacted Dental Protection and he spoke to a dentolegal consultant, and he broke down. He advised he was already struggling at work due to the stress of COVID-19 and the complaint from Mr F had tipped him over the edge. Immediate reassurance was provided on the phone by the dentolegal consultant and Dr W was advised of the counselling service that is available to members for case related issues at no additional cost.

This really reassured Dr W, and he immediately felt comforted, understood and supported. The dentolegal consultant also requested that Dr W send in all the information relating to the case, including the correspondence from the Dental Council and his treatment records.

The following day, the dentolegal consultant had reviewed the complaint to the Dental Council and the patient had submitted photographs of their teeth, which were supposed to demonstrate the residual staining that had not been removed. Having reviewed the photographs it was clear the patient was referring to the darker dentine that was visible at the incisal edge due to attrition, and Dr W had not left any staining present. Dr W explained to the dentolegal consultant that he felt frustrated he was not provided with an opportunity to explain this to the patient, and this was included in his explanation to the Dental Council that outlined the misunderstanding.

A few weeks later, the Dental Council accepted Dr W's explanation and, although it was an agonising wait, Dr W was grateful for Dental Protection's support and assistance.

Learning points

With hindsight, had Dr W contacted Dental Protection when the patient initially complained, we might have been able to prevent Mr F from progressing his concerns to the Dental Council. Dental Protection would have suggested Dr W take proactive action and assisted him in drafting a conciliatory well-written response, including an explanation about the difference between dentine and staining.

In our experience, calmly written responses can reduce the possibility of a patient raising their concerns elsewhere. Our team are here to provide all levels of support and there is no problem too trivial. It is often helpful to speak to a dentolegal consultant to introduce a level of objectivity to a situation where situations become all-consuming.

Accelerating treatment – accelerating risk?

Dr Annalene Weston, Dentolegal Consultant at Dental Protection, explores whether striving to meet patient demands means our profession is racing to the bottom or rising to the top



The impact of consumerism is evident across many areas of our lives. How we eat, how we access information and how we communicate. Perhaps then it is inevitable that people are now approaching healthcare with the same consumer expectations, wanting their treatment quicker, cheaper, more conveniently than before, definitely pain free and absolutely on their own terms. Naturally, practitioners strive to meet this demand and these expectations.

There is a raft of direct-to-consumer marketing promising to meet exactly all the expectations of the consumer, as stated above. It may be that this is at least partially responsible for the increased inclination of the profession to meet these consumer desires. After all, “the public gets what the public wants”,¹ and if we as a profession don't provide it, then our patients will go and find someone who will. But in doing so, are we placing consumer expectations above clinical parameters, and does meeting this demand come with an unseen price? Or perhaps a cost? And if so, to whom?

Many disciplines of dentistry are evolving at, well, breakneck speed, with procedures having fewer steps (think bonding), quicker time frames (think milled restorations) and the legitimate options for one-stage procedures (think RCT and implants). There can be no doubt that the ability to provide more timely treatments is welcomed by practitioners and patients alike. There can also be no doubt that accelerated treatments are a sensible option for many patients. But they are not without risk.

Convenience dentistry is no longer only available through adverts on Instagram, and is readily seen in everyday practices. Nor is it a new concept. Immediate dentures were in many ways the original ‘accelerated dentistry’ as in this treatment modality, steps were missed in order to reach an end goal more quickly. Can we extrapolate this experience to accelerating treatment always means skipping steps? Not necessarily and if it does, it is important to remember that it does not necessarily mean these steps are skipped in a deleterious way.

For example, the ability to scan a tooth to then mill a crown directly, and skip a physical impression, a potentially unpleasant or unsatisfactory temporary crown, and the delay while the lab construct the definitive restoration would not be grieved by many practitioners or patients. Regretfully, as many practitioners will be aware, immediate dentures do attract a significant amount of patient dissatisfaction. Can we perhaps extrapolate then that accelerated treatments often lead to patient dissatisfaction? This too does not hold true.

Patient expectations about the outcome they can legitimately expect need to be appropriately set as part of the consent process. This is particularly true in accelerated treatment, as the outcome can, in some circumstances, actually be that which has been termed a ‘compromised treatment’. And while compromised care can be acceptable with patient consent, the key to this acceptability is the consent. The patient needs to meaningfully understand what they are getting and why, and what the alternative options applicable in their case are. Failure to obtain valid consent, coupled with the failure to achieve the patient's expectations, is a true recipe for disaster.

Further, poor case selection can lead to unsatisfactory outcomes, dissatisfied patients and patient harm. When selecting to move through treatment more quickly, or bypass stages altogether, a prudent practitioner ensures appropriate case selection at the offset. This means they can avoid finding out later that a one-stage treatment was never going to work for Mrs X, or a compromised outcome was never going to satisfy Mr Y. It also means they can avoid the attention of a critical third party, such as the regulator or a lawyer.

In short, as with all dentistry consent is key, as is reaching a correct diagnosis to create an appropriate treatment plan. Each discipline of dentistry carries with it its own unique risks and, in certain circumstances, accelerating the treatment truly accelerates these risks.

To increase understanding of this, Dental Protection has developed the accelerated risk webinar series, with orthodontics and implants already considered this year. If you missed these, you can access them on PRISM, and we encourage you to keep an eye out for the continuation of this series next year.

References

1. The Jam, *Going Underground*

Case study

An allegation of dishonesty

By **Ravi Gupta**, Lead Legal Adviser, Dental Protection



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Dr S had worked as an associate for Dr N for 12 years. He entered negotiations to purchase a dental practice from Dr N, who was terminally ill. After lengthy negotiations, Dr S decided against buying the practice and Dr N passed away shortly after that. Almost three years later Dr N's widow brought a complaint to AHPRA against Dr S, alleging that he had:

- (i.) represented to act on behalf of Dr N;
- (ii.) claimed on social media that he was the business owner of the practice;
- (iii.) advertised Dr N's practice number on his own website; and
- (iv.) took payment directly from a patient that he was not entitled to.

The complaint alleged that Dr S's conduct was inappropriate, misleading and dishonest.

Dr S contacted Dental Protection and a multidisciplinary team of legal advisers, working alongside the Dentolegal consultant, was put in place to assist. In our response on Dr S's behalf, we admitted some of the allegations on the basis that Dr S had simply failed to update his social media accounts, but the allegations in respect of dishonesty were vehemently denied. Given the seriousness of the allegations and the factual dispute between Dr S and Mrs N, AHPRA referred the matter for a hearing a month later.

After lengthy discussion with Dr S, the hearing found the majority of the facts proved but did not determine that they amounted to misconduct. It determined that overall, Dr S's conduct "whilst unfortunate, inattentive, and careless, cannot be said to reach the threshold for misconduct".

Had the allegations been found proved it was likely that Dr S would have faced significant consequences for his dental registration. We were successful in arguing that he was not dishonest and that misconduct could not be found.

How Dental Protection assisted

Dr S provided us with voluminous documentation and much of the case required a careful forensic analysis of the material to reconstruct the original events, which took place three years before. Due to the passage of time, Dr S could not recall details of many of the key facts that would have assisted in his defence. Further, he was supported by a number of professionals at the time of purchasing the practice whom he relied on heavily and therefore had a lack of understanding of some of the key issues.

This was a particularly emotive matter for all parties in the complaint, revolving as it did, around the declining health and unravelling business relationship with a long-standing colleague (on one side) and a much-loved life partner who passed away in tragic circumstances just as he was to retire (on the other). The Dentolegal Consultant was able to act as a conduit between the cold hard facts of the law, accounts and forensic IT investigations, and the need to acknowledge the difficult and valid emotions on both sides.

This case required multiple meetings with Dr S, the result of which was a lengthy and detailed witness statement to assist him giving evidence. Dr S commented that this provided him with real focus and the ability to provide a response to challenging questions put to him by the panel members. Without the detailed forensic review of all the material in this case, and having to piece together information from a variety of sources, there was a real risk that Dr S could have appeared evasive and, in the worst case, dishonest before the hearing.

Dr S was also immensely reassured that the Dentolegal Consultant who had worked on the matter with him was able to attend the hearing with him as a support person.

Dr S was extremely pleased with the outcome, which in real terms meant he did not have any conditions placed on his registration. There were no restrictions on his practice and he was able to return to his profession without any adverse findings.

Dr S expressed his gratitude to the team at Dental Protection for helping him achieve this outcome and commented that it could not have been achieved without our support

Learning points

- A careful and thorough forensic review of the documents helped reconstruct for Dr S events that occurred some three years prior.
- We were only able to rebut the allegation regarding financial wrongdoing having carefully traced the money payments at the practice. This was made more difficult given that there was no written agreement in place to ascertain the financial split between Dr S and Dr N. Further, the patient at the centre of one of the allegations had attended three different practices for treatment, which made apportioning the fees collected for treatment extremely challenging. Given that this was one of the more serious allegations faced by Dr S, we spent considerable time carrying out this exercise to establish that there was no financial gain and that Dr S was entitled to the money he took directly from the patient.
- An allegation of dishonesty can have significant implications and escalate in scope very rapidly. AHPRA were able to review this particular matter through the lens of many aspects of the Dental Board Code of Conduct, (the document we sign up to adhere to every year when we renew our registration):
 - Professional behaviour and ethical conduct.
 - Advertising a regulated health service (and the crossover with the National Law*)
 - Social media: How to meet your obligations under National Law*

**Health Practitioner Regulation National Law Act 2009*

Case study

An eventful extraction



A patient attended the practice for the first time complaining of bleeding when brushing around the wisdom teeth. This had been occurring for several weeks and the patient also described a bad taste in their mouth. The dentist examined the patient and took an OPG, following which he sent his nurse through to the patient with a form to obtain consent for the extraction of all four wisdom teeth.

The patient agreed to proceed with the extractions under local anaesthesia. Following the administration of the local anaesthetic, a forceps extraction technique was used instead of a surgical approach.

The extractions were completed with some difficulty, but the teeth were removed in their entirety, postoperative instructions were given, and the patient was discharged. No follow-up review was planned but the patient rang the practice two days later, expressing concern over pain from the jaw on the lower left-hand side, together with some numbness.

The patient was not offered an appointment for seven days despite the request for an urgent appointment. When she was examined, a diagnosis of infection and inflammation was made, and antibiotics prescribed. The symptoms persisted but no other treatment or follow-up was offered and, by day 12 after the surgery, the patient sought an appointment elsewhere.

It was at her new practice and following a clinical and radiographic examination that the patient was informed of the presence of a fracture and displacement of the lingual plate. She continued to experience numbness as a result of permanent paraesthesia and a debilitating neuropraxia.

The patient was both angry and frustrated when she was informed of the fracture and the likely nerve damage. She felt she had been treated inappropriately and subsequently abandoned by the original dentist, who had made little effort to address her concerns following the extractions.

Some three weeks after the extractions, she made a formal complaint to the Dental Council (DC) and a claim in negligence was lodged two and a half years later.

Dental Council complaint

The DC complaint was referred through to a full hearing, where it was established that the consent process was not valid and that the clinician lacked the competence to carry out such procedures. It was also determined:

Consent process

There was nothing recorded to demonstrate that the patient was warned of the possible risks and consequences of extracting all four wisdom teeth, in particular 38. In addition, there was no evidence that the patient was offered a specialist referral and both these omissions led to criticism of the consent process.

Competence

The expert instructed by the DC gave evidence that in his opinion, the curved roots of the 38 were lying close to the inferior dental nerve and that by carrying out an extraction with forceps, the procedure forced one or more of the roots against the nerve. He suggested that if a surgical technique had been adopted, and the roots separated, then elevation of the individual roots would not have resulted in an injury to the patient.

The DC determined that the registrant failed to carry out an adequate preoperative assessment to investigate the potential risks before embarking on the removal of four wisdom teeth in one single visit under local anaesthesia. In addition, the registrant failed to properly execute the removal of the lower left third molar, resulting in inferior dental nerve injury.

The DC stated that meticulous attention to preoperative assessment and delivery of necessary skills is essential for the safety of the patient. As a result, the registrant was suspended for a period of three months.

The claim

For a patient to be successful in a claim in negligence, they have to demonstrate that there was a breach of duty and that the patient suffered harm as a result. This claim can be based upon the treatment itself or the consent process.



In this case, the claimant's lawyer was able to demonstrate that there was a breach in the duty of care owed to the patient, both in relation to the treatment provided and the consent process.

It took two and a half years for the claim to follow the DC complaint which is not uncommon, and substantial damages were sought. Unfortunately, obtaining a supportive expert report to defend the claim in its entirety proved unsuccessful and challenges were limited to exploring the appropriate level of damages.

Reflections

Despite support from a highly experienced Dental Protection legal team, the facts of such cases can be indisputable and certain outcomes inevitable. Ensuring fairness and correct procedure together with strong representation are essentials of our service to members but the support for the individual themselves facing such a professional challenge is just as important. DC investigations and claims can have a significant impact upon emotional wellbeing and support from colleagues who understand the implications of these events can be most helpful. Dental Protection also provides a confidential counselling service for members who feel they may benefit from further support.

Learning points

- As set out by dental regulators, registrants have a duty to ensure clinical competency with adequate knowledge and skill. Developing further skills through postgraduate education, mentoring and shared experience is part of our own personal development and taking on complex treatments without appropriate consideration and competency may lead to significant impact upon your own registration.
- In terms of consent, the case demonstrates that a signature on a form does not in itself prove valid consent has been obtained. Detailing that discussion in the records provides the additional support as demonstrated by the findings of the DC, and it should be remembered that consent is an ongoing process of communication.
- It is also worth considering an important point often misunderstood in that consent does not mean protection against poor treatment. If a risk attached to a procedure is described, understood and evidenced, valid consent can be present but this does not mean that any subsequent injury can be accounted for by saying "well I had consent" – for example, if a warning is provided to a patient that endodontic treatment might fail and it does as only two out of four canals have been filled, that does not mean there is a defence provided by a warning – the standard of the treatment has to stand up to scrutiny itself.
- Should an adverse outcome arise, it is imperative that the patient does not perceive that they have been abandoned and efforts should be made to be seen to support the patient in the postoperative period. For more on this, please look into our Risk Prevention Mastering Adverse Outcomes workshops – more information is on our website.

Contacts

You can contact Dental Protection for assistance

Membership services

Telephone 1800 444 542

Dentolegal advice

Telephone 1800 444 542

dentalprotection.org.au

Cost of calls to this number depend on your communication provider. Please check with your provider before you dial.

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