Risk management from Dental Protection

Dental Protection

Riskwise

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Points of view

Why can it be hard to empathise with patients?

Tricky extraction leads to hospital admission

Oroantral and sinus issues are followed by a claim

Introducing the MPS Foundation

An exciting new development in clinical research

Root resorption in child orthodontic patients

We look at the causes of claims in this area

Editorial

Dr Mike **Rutherford** BDSc, FICD, FPFA
Dental Team Leader Australia

Greetings from the lake

As you no doubt saw on the news in March, Southeast Queensland and Northern NSW were both subject to record breaking floods. Just as we had reopened the Dental Protection office after COVID-19, it was closed again due to floodwaters.

My home, an apartment, was thankfully untouched, but the garages and grounds were flooded to a depth of three metres – and our river views were much improved to the point we actually lived on an island for a number of days. We had six days without power and were unable to leave the apartment block except on (wet) foot. No power, no internet.

Calamities such as this brings out the best and worst in people – you often see those you know quite well in a very different light when the chips are down. Some owners in our building moved out immediately when the roads were passable, others hid in their apartments and did not come out. Most, however, chipped in and worked tirelessly to clear the flooded garages and grounds of a stinking six-inch layer of mud. We all have differing abilities to cope and deal with disaster so I try not to judge those that went missing – but gee do I appreciate those that stayed and helped.

And the 20 women from UQ Womens College who turned up to help and worked like troopers. And the actual troopers from 6th Battalion RAR who also worked like the women. And the UQ Evangelical Society who worked like troopers and then baked us choc chip cookies the next day.

All good people.

Triumph over adversity

On a moment's notice our team of Dental Protection advisers was two members down, as another consultant also drove to Sydney to help family.

A hole appeared in the coverage we provide to assist members of Dental Protection, and just as quickly the hole disappeared, as other dentolegal consultants and case managers picked up the slack without hesitation or question. Some staff seemed to be starting the working day before sunrise, and others in the team were sending responses to Dental Protection members long past dinnertime. Membership services, a smaller team, also lost two staff but the service remained the same. No-one hid behind their closed door. Not surprising to me, as we are all professionals and love the role we play in assisting you, our colleagues; but this also came on the back of the last two years of COVID-19 response. COVID-19 brought for us a sustained increase in the assistance required by our members.

It had become almost routine to see advisers and case managers in Zoom meetings talking to kids wandering into frame, as they juggled work and home schooling. Sometimes work hours were whenever it would fit in. Dogs and domesticity became the backdrop to working online. Undoubtedly many of our colleagues in practice have had a far tougher time over the last two years than we have for many reasons, and I do not wish to belittle this in the slightest. We have not had the financial strains, the constant battles with compliance and non-compliance, and the endless explanations to patients about what we can do and can't do, and why.

The message I am trying to convey is that I am proud of our team of professionals and their expertise, commitment and work ethic. I can assure you that no matter what the circumstances, they are here to deliver a world class service to you, our colleagues, in providing advice with complaints and claims, and management of your membership. Our door will always be open.

Dr Michael Rutherford
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Dental Team Leader Australia

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Introducing the MPS Foundation

With research and innovation playing a major role in driving new improvements in patient safety and clinician wellbeing, MPS is proud to launch an exciting new project – the MPS Foundation. ***Adrian Jackson****, Head of the MPS Foundation, looks at why this has been launched and what we hope it will achieve*

In February this year, MPS was very proud to announce the launch of the MPS Foundation – a new, global, not-for-profit research initiative that aims to help shape the future of patient safety and clinician wellbeing through the funding of ambitious research. This will have a particular emphasis on applied research and a focus on alternative state health models, private hospital and outpatient environments and the dental sector.

Using this research to develop an international knowledge base that can be applied locally, the MPS Foundation seeks to help members and other healthcare professionals navigate the challenges of modern practice and find research solutions that enhance patient care, patient safety, patient outcomes and clinician wellbeing, and help to develop expertise in risk reduction and management.

The Foundation will support research in those countries and regions where we have a member base, including the UK, Ireland, South Africa, Australia, New Zealand, Hong Kong, Singapore, Malaysia and the Caribbean.

Background

At Dental Protection, we recognise how important patient care and safety, and clinician wellbeing, are to members and the healthcare profession.

The World Health Organisation has announced that the decade 2021 to 2030 is the "patient safety decade", stating that "improving and ensuring patient safety is a growing challenge to health service delivery globally" and that "unsafe health care causes a significant level of avoidable patient harm and human suffering, places a considerable strain on health system finances and leads to a loss of trust in health systems".[1]

We agree with this statement and want to contribute to improving patient safety globally by funding research that can be used by members and healthcare professionals to improve patient safety locally, in their own work environments.

Dental Protection and the MPS Foundation also recognise that the impact of the changes that are occurring within healthcare systems globally are impacting members' wellbeing, contributing to burnout and loss of resilience. Clinician wellbeing is a growing area of research but one that needs more focus, particularly following the COVID-19 pandemic. Studies in the USA, prior to the pandemic, indicated that "more than half of US physicians are experiencing substantial symptoms of burnout".[2] This is considerably higher than that in the wider workforce. The same study found that there were a large number of factors that contributed to burnout, including work process inefficiencies, excessive workloads and organisation climate factors. Several studies in the USA have also identified that those working in private practice were approximately 20% more likely to suffer burnout.

The strategic goals of the MPS Foundation

The MPS Foundation has five strategic goals:

- To support research that makes a meaningful contribution to reducing risk for patients, Dental Protection members and medical and dental professionals
- To support research that makes a meaningful contribution to improving wellbeing for Dental Protection members and the wider body of medical and dental professionals
- To support research that creates and contributes to the body of knowledge that supports the improvement of patient care, safety and outcomes and clinician wellbeing
- To support the generation of knowledge and understanding that informs and further develops expertise in risk reduction and management to support Dental Protection members
- To support applied research that establishes 'what works' and can be translated into workplaces globally.

Studies have recognised that there are many factors that have a positive and adverse effect upon clinician wellbeing and patient safety, at both an individual and organisational level. The WHO states that "most adverse events can potentially be avoided with effective prevention and mitigation strategies, including, as appropriate, improved policies, data systems, redesigned processes of care (including addressing human factors, including training), environmental hygiene and infrastructure, better organizational culture to improve practices, supportive and effective regulatory systems and improved communication strategies".[3] The MPS Foundation is very keen to explore these areas further with the view to supporting members and will focus its research, in line with its strategic goals, on:

- The impact of human factors on patient care, safety and outcomes
- The impact of processes and delivery models on delivering safe care and better outcomes
- Clinician wellbeing, including the personal and professional wellbeing of clinicians
- Digital integration and technology from the perspective of both the opportunities and risks provided by technology.

Activities of the MPS Foundation

Providing research grants

We will fund an annual research grant programme. Researchers across all MPS countries will be able to submit proposals to receive funding for their research projects. This process will be managed by our online portal.

Funding is restricted both in terms of what we will fund and how much we will fund. We will only fund research proposals that meet our priorities in terms of our scope, focus and geographical interests. We will provide funding through two schemes:

- Small projects – up to a total of £60,000 (or equivalent local currency) and between 3 and 24 months
- Large projects – up to a total of £200,000 (or equivalent local currency) and between 12 and 36 months

Calls for proposals will be undertaken annually and there will be a two-stage process:

- Initial Expression of Interest
- Full application for those shortlisted following the expression of interest

We anticipate the next call for proposals will be open at the beginning of 2023.

Commissioning research

The MPS Foundation will also commission research from research organisations and higher education. Commissioned research will be research that has been identified specifically by Dental Protection colleagues and members. The research proposal, scope and focus will be tightly defined and it will address a specific strategic need, aligned with the Foundation's priorities.

Research competitions

The MPS Foundation proposes to run annual national and international competitions.

In each MPS country a specific patient safety or patient care challenge will be identified and teams will be invited to submit their potential solutions to the challenge, demonstrating how they've researched the issue, identified a solution and how that solution addresses the challenge.

Teams will be judged nationally against their country's challenge and national winners will then be judged against other national winners to determine an international winner.

Teams must consist of three people and be made up of undergraduates and postgraduates. There will be no limitation to the number of teams from any single institution.

Contacting the MPS Foundation

The MPS Foundation Board is chaired by Graham Stokes, a member of MPS Council and the Dental Protection Board. Adrian Jackson is Head of the MPS Foundation and is responsible for the day to day running of the MPS Foundation. The MPS Foundation can be contacted on **info@TheMPSFoundation.org** and more details about our programmes can be found at **www.themprsfoundation.org**.

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1. World Health Assembly, 72. (2019). Global action on patient safety. World Health Organization. https://apps.who.int/iris/handle/10665/329284
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THE MPS FOUNDATION

Root resorption in child orthodontic patients

***Dr Yvonne Shaw**, Underwriting Policy Lead at Dental Protection,*
offers an overview of orthodontic claims received by members in the UK

Dental Protection's philosophy is to support safer practice in dentistry and to help members avoid problems arising in their professional practice. One of the many ways we look to support members in reducing risk is by sharing insights from our cases and claims to help understand how problems may arise and, most importantly, how they can be prevented in the first place.

As part of our ongoing commitment to share learning and insight from cases, Dental Protection has been developing systems to assist in the analysis of unstructured data contained within case files. One of the outputs of this work has been the production of a risk dashboard to support the identification of common themes in the cases we deal with. Further development of these analytical tools will enable us to identify themes and trends in cases more efficiently and, in turn, allow us to share more information with members about risks arising in different areas of practice. This is the first Dental Protection article to be produced that has used unstructured data analysis software to support the claims review.

A review of claims data was undertaken focusing on claims relating to orthodontic care that were opened at Dental Protection during the period 2016-2020. For the purposes of this article, the claims used in the analysis were those involving patients who were aged 18 or under at the time the first alleged failings in care arose. The claims reviewed related to treatment provided by both specialist orthodontists and non-specialist practitioners.

Out of the total claims identified in this data set, approximately 10% had allegations that related to root resorption. Of note, claims involving root resorption feature more strongly in our higher value orthodontic claims.

Root resorption claims

Root resorption is a recognised risk associated with orthodontic treatment, with potentially significant long-term consequences for the patient. It is, therefore, not surprising that a proportion of the higher value orthodontic claims we deal with will involve root resorption. In most of the child root resorption cases reviewed, common factors were noted, which may have made the patient at higher risk of teeth being affected by root resorption:

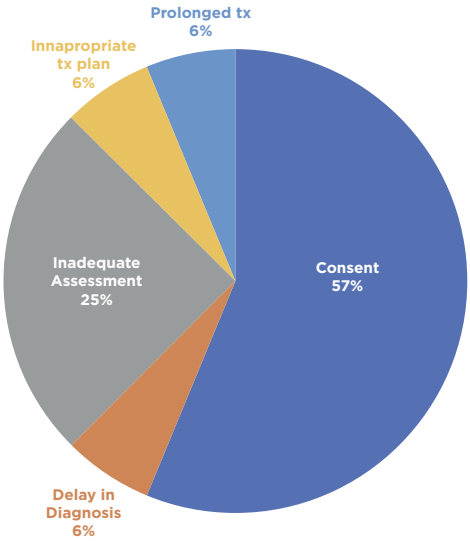
- Ectopic/unerupted canines (47%)
- History of trauma prior to commencing treatment (24%)
- Root shape (eg blunt root apices) (12%)

It should be noted that in the cases involving ectopic/unerupted canines, just over one third of the cases related to alleged delays in referral for orthodontic treatment. In these cases, root resorption had already occurred before any orthodontic treatment was considered or provided. The importance of monitoring the development and eruption of maxillary canines was the subject of a previous Dental Protection article, "Ectopic canines – dentolegal challenges and how to avoid them", which is available at **dentalprotection.org**.

Common themes in claims involving root resorption

As a recognised risk of orthodontic treatment, it is expected that patients for whom orthodontic treatment is being considered should routinely be made aware of the risk of root resorption as part of the consent process. It may therefore be surprising to see that in over 50% of the claims reviewed, alleged failings in the consent process were a dominant factor. Figure 1 below shows the main alleged failings in the claims reviewed.

Fig 1. Common themes identified in child orthodontic claims involving root resorption – Dental Protection data 2016-2020



In many of the cases predisposing factors were present, which may have put the patient at greater risk of root resorption. To defend a claim of this nature, it would be important for the records to demonstrate that:

a) The increased risk had been identified

b) The specific risks that a particular patient faced had been discussed and understood by the patient

c) The treatment plan proposed was appropriate

d) Alternative 'lower risk' alternatives had been considered and communicated to the patient

e) Appropriate monitoring of teeth was undertaken during treatment.

Experts will invariably opine on the above and these are the points on which claims involving root resorption may succeed or fail. Where predisposing factors are present, and the records only provide evidence that a patient had been provided with generic information about the risks, it is unlikely the warnings will be found to be sufficient to demonstrate consent to treatment was valid. Where a patient is successful in their claim, damages can be significant. For a young patient, tooth loss may result in damages to cover a lifetime of implant placement and restoration cycles, as well as reflecting the psychological impact.

The issues displayed in Fig 1 were not the sole issues arising in the cases, with additional allegations relating to inadequate monitoring, prolonged treatment and poor outcome being the most common secondary factors. In around one third of the cases where predisposing factors were noted, secondary allegations were made that there had been inadequate monitoring of the teeth during active treatment. When considering these allegations, experts will comment on whether monitoring was in line with any recognised guidance and teaching. Where there is a lack of consensus, the case will be assessed on whether the approach taken was reasonable at that time. For those treating patients with a known history of trauma, guidance such as that recently published by Sandler et al[1] would be of relevance and may be relied upon by experts in future.

Allegations relating to consent, assessment and monitoring were common themes across both specialist and non-specialist practitioner groups.

Risk prevention

Orthodontic treatment is not without risk and for some patients the risks of treatment may outweigh the benefits. Ultimately the decision whether to proceed with orthodontic treatment rests with the patient, who must make this choice based upon balanced and objective information that has been shared by the treating clinician to help the patient understand the risks.

Identifying that significant root resorption has arisen is not only distressing for the patient, but also generates significant anxiety for the clinician who has treated the patient. It is, however, important to remember that this finding will not necessarily result in a patient making a complaint or claim, and they are less likely to do so if they had understood and accepted the risk of this arising at the outset.

Similarly, being the subject of a claim does not mean that the claim will need to be settled. In most of the cases we see, the successful defence of claims relating to root resorption will rely heavily on the details within the records, to demonstrate that the consent was valid and clinical treatment was appropriate.

As a general guide, the following checklist may help in the defence of a claim but, perhaps more importantly, avoid a patient going down this route in the first place:

- Ensure that any orthodontic assessment routinely includes an assessment of any potential risk factors for root resorption and documents both positive and negative findings.
- Where the assessment identifies a patient may be at a higher risk of root resorption, ensure that the records reflect the specific risk that patient faces and whether alternative treatment options, including no treatment at all, were discussed. Where risks are increased, ensure that any written information provided to the patient is tailored to reflect the identified increased risk.
- If it is proposed to monitor root health during treatment with radiographs, ensure that a clear note is made in the records as part of the treatment plan about when any radiographs should be taken. This is particularly important in settings where a patient may be seen by multiple clinicians or where care is being transferred.
- In the event root resorption is identified, it is important to be open and honest with patients and ensure that not only is the presence of the root resorption discussed but also what steps may be necessary to mitigate any further exacerbation of the problem. Before continuing with further treatment, the consent process should be revisited, and records updated to reflect the discussions and options discussed.
- In the event teeth are subject to trauma after treatment has commenced, ensure any assessment and ongoing treatment reflects contemporary guidance and teaching. It is important to also revisit the consent process to ensure the patient is involved in any further decision making and aware of the risks and alternative options.

References

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Empathy and effort

***Dr Raj Rattan**, Dental Director at Dental Protection, looks at the complexities of empathy in dentistry and potential ways to improve it*

The importance of effective communication in managing the risks in everyday practice cannot be understated. A close scrutiny of many dentolegal cases will highlight failures in communication whether it relates to patient expectations, consent or technical aspects of care. It is because of this that different facets of communication underpin many risk management programmes.

The evidence to support this is strong but we must remember that much of it is derived from medical studies and some of it is open to challenge from a dental viewpoint. We shall return to this in a future article. It is still true to say that the phrase 'breakdown in communication' applies in many dental cases and although it is a convenient, if simplistic, classification of root causes, the term is too broad for any meaningful analysis. It is like 'human error' which was once, and sometimes still is, treated as the culprit in accidents rather than a symptom of a deeper problem.

Communication breakdown

We establish patient rapport and demonstrate compassion through effective communication, and we know that patients judge (in part at least) the quality of care on the basis of the quality of the personal interaction. Other factors also play a part in how the patient feels about their care – the dentist's reputation, previous experiences, and a host of factors that relate to the service quality of the encounter.

The phrase 'breakdown in communication' covers a gamut of scenarios – perhaps even too broad and non-specific to be of any real long-term educational value. For example, failing to obtain valid consent and a complaint from a patient about fees could both fall under the umbrella term of a 'communication failure' but would need to be managed very differently. It comes down to context. If there is one lesson that working in the dentolegal field teaches you, it is not to judge solely on the basis of clinical outcome but to peer into the context and then tease out the root causes of the complaint.

Case study

Consider a recent and interesting example. It involves a patient who attended a practice and suffered injury to her lower lip following the use of a coarse polishing disc.

The laceration unsurprisingly caused some bleeding and it was painful, and there was some localised swelling. On the day of the incident, the patient was very understanding about what had happened and accepted the dentist's reassurance that the wound would heal.

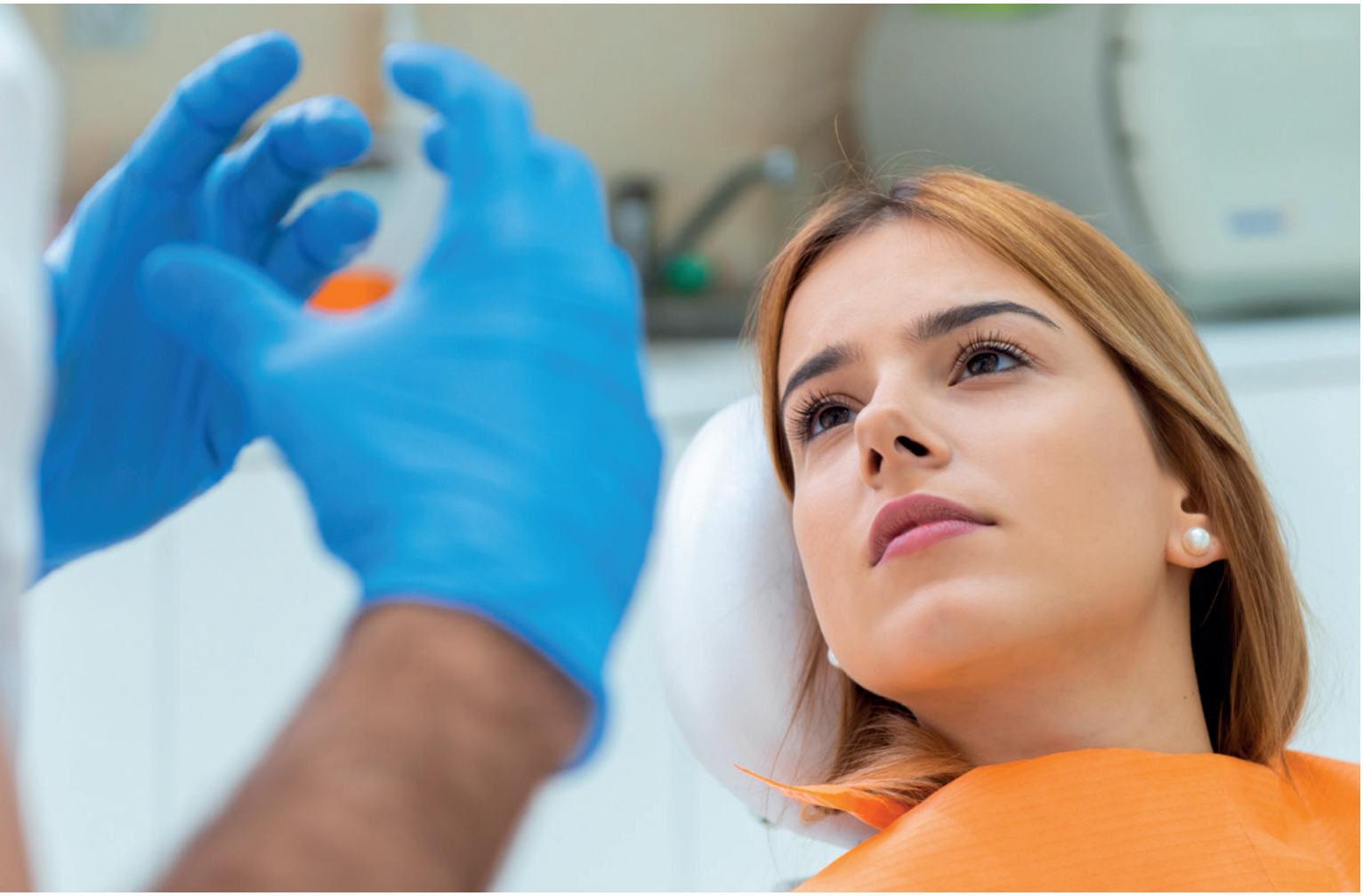
The dentist's recollection of the incident was that it was "minor", and he had explained very clearly what had happened. He had apologised to the patient who, as far as he was concerned, had accepted the situation.

Four weeks later, the dentist received a letter of complaint. The patient stressed that she was not complaining about the injury itself. She accepted that "things sometimes do not go to plan" and thanked the dentist for his very clear explanation of what happened and how it happened. Her complaint, she wrote, was triggered by her "bitter disappointment" that the dentist had not contacted the patient at any time after the injury to check how she was. She had been contacted by the practice to pay her outstanding fees, but nobody had asked how she was. This, in the words of the patient, was "disappointing" – and suggested that the dentist didn't care, and "not caring was unacceptable".

The root cause of the complaint is a very specific aspect of communication; it is the failure to show empathy. One study from CRICO (Controlled Risk Insurance Company) highlighted two ways to improve communication and potentially avoid litigation:

1. Display empathy for the patient's situation.

2. Have an effective consent process.



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Sympathy, empathy, compassion

Sympathy, empathy, and compassion are terms that are often used interchangeably. They are not synonymous, and it is important to understand the subtle differences in meaning.

Sympathy and compassion are reactive responses. Sympathy is a pity-based, sorrowful response towards the misfortune of another person. It is immediate and uncontrolled. Studies have shown that patents regard sympathy as 'superficial' whereas they show a more positive response to empathy. It is more engaging from an emotional perspective and many cases decried as 'communication failures' are in fact cases where there was a failure to show empathy. It is the ability to understand and share the experience of a particular patient.

Compassion refers to the sensitivity to understand another person's suffering. It has two elements:

a) a deep awareness and willingness to gain knowledge about a person's suffering

b) a desire to relieve the suffering.

(The reader is referred to the 2013 report by Sir Robert Francis QC, which revealed severe failings in patient care in the Mid Staffordshire NHS Foundation Trust in the UK – and focused on the importance of compassion. Sir Robert wrote that patients "must receive effective services from caring, compassionate, and committed staff".)

As dentists, we feel we know about and understand empathy. The word is derived from the Greek word *empatheia*, which means "passion or state of emotion". It is about the capacity to enter into the patient's world and vicariously have a sense of what he or she is feeling.

Hodges and Myers in the *Encyclopaedia of Social Psychology* define empathy as "understanding another person's experience by imagining oneself in that other person's situation: one understands the other person's experience as if it were being experienced by the self, but without the self actually experiencing it". A more tailored definition is offered by psychologist Carl Rogers, who defines it as "the ability of healthcare professionals to accurately understand patients, emotionally and mentally, as though they were in the patient's shoes, but without losing their status".

The emotional emphasis is perhaps what is most familiar to us about empathy, but researchers on empathy regard it as a multi-faceted concept. It can be looked at in terms of the emotional (affective) component but also a cognitive and a behavioural element. Whilst the cognitive and affective are two distinct psychological processes, both are essential when discussing empathy.

Figure 1 summarises the different characteristics:

Cognitive empathy

- Conscious process
- Taking another person's perspective
- Imagining what it's like in another person's shoes
- Able to understand someone's thoughts and feelings

Emotional empathy

- Automatic
- Sharing an emotional experience
- Be affected by others' feelings
- Feeling distress in response to someone's plight

Emotional or affective empathy is the automatic response that mirrors someone else's emotions. It has been described as "emotional contagion" because we 'catch' another person's feelings – in much the same way as one might catch another person's cold.

Cognitive empathy refers to the use of reasoning and logic to put ourselves into another's position. It is deliberate and effortful, and refers to how well an individual can perceive and understand the emotions of another, but does not experience any distress themself. It has been described as detached concern.

It has been suggested that cognitive empathy alone creates an impression that someone is 'too cold to care' – a sentiment that was clearly expressed in the case quoted. It was the imbalance of emotional and cognitive empathy that triggered the complaint. To paraphrase the physician William Osler: "The good dentist treats the patient's concerns; the great dentist treats the patient who has the concerns."

Interestingly, some experts have suggested that cognitive empathy is better suited for healthcare because it is important that healthcare workers make rational decisions that should be free from emotional influence.

Behavioural empathy is about taking action to help others, having leveraged emotional and cognitive empathy to help us decide what actions to take. As Helen Riess writes in her book *The Empathy Effect*: "Empathy is produced not only by how we perceive information, but also by how we understand that information [cognitive empathy], are moved by it [emotional empathy], and use it to motivate our behaviour [behavioural empathy]."

Empathy is also the cornerstone of emotional intelligence.

How to improve empathy

Empathy is a spectrum – a continuum – not a binary issue, and being able to express empathy is a skill, but also a trait. Everybody sits somewhere along the empathy continuum.

It can be taught and practised but this is complex because it is a distillation of many different skills, which include:

- Active listening – focus on what is said without interruption. Repeat what has been said to confirm accuracy and understanding.
- Self-awareness – how you perceive yourself and how others perceive you.
- Understanding body language and facial expressions.
- The ability to park your views and not be influenced by them.
- Receiving feedback.
- Drama – literature provides a rich seam of material. Reading fiction where the characters challenge the reader to see the world through a unique character lens is believed to strengthen your empathic responsiveness.

It is a skill that can be taught, but not everyone agrees. Some commentators have the view that (empathic) communication cannot be taught. Either you are born to be a good communicator, or you are not.

The acronym EMPATHY provides some useful insight into empathic communications:

E: eye contact

M: muscles of facial expression

P: posture and body language

A: affect – emotional aspect

T: tone of voice

H: hearing what the patient has to say

Y: your response

Source: Riess H, Kraft-Todd G, Empathy Academic Medicine *(2014)*

Conclusion

The cardinal quality of the professional relationship between dentist and patient is trust and to act in the best interest if the patient requires an empathic disposition. It is as important an attribute as intelligence and perceptual motor skills, and to label it as a 'soft' skill is a misnomer. In a recent article in *Academic Medicine* ("The Practice of Empathy"), Harold Spiro, emeritus professor of medicine at Yale University, writes that "medical students should be selected as much by their character as by their knowledge".

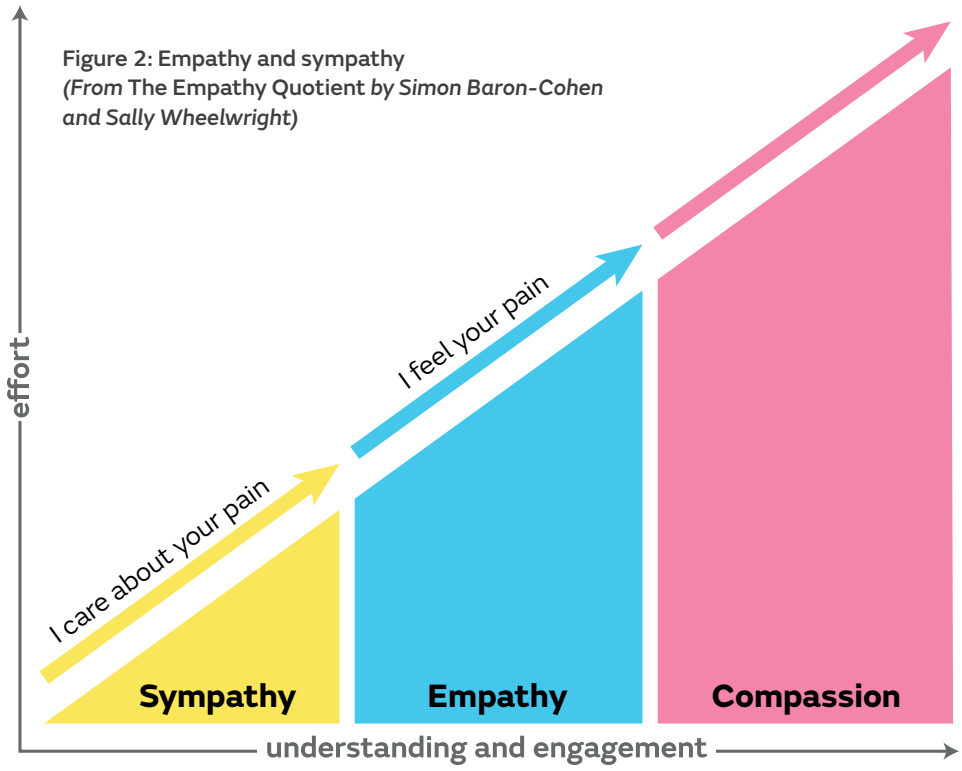
Time spent understanding and investing in developing empathy skills is time well spent.

It has been linked to patient satisfaction, decreasing patient anxiety and a heightened patient experience. Concomitantly, research suggests that doctors (again, the research is medically focused) with high empathy scores have greater job satisfaction and experience less burnout. It also builds trust and rapport and is a key factor in emotional intelligence. Research from the University of Glasgow showed that "empathetic therapeutic encounters are associated with better outcomes".

Situational factors like time are important – lack of time, pressure to reach activity targets, financial pressures are all potentially barriers to empathic communication.

To quote Atticus from Harper Lee's Pulitzer Prize-winning book *To Kill a Mockingbird*: "You never really understand a person until you consider things from his point of view – until you climb into his skin and walk around in it." Unlike compassion or sympathy, it is not automatic. It requires effort. See figure 2.

Figure 2: Empathy and sympathy
(From* The Empathy Quotient *by Simon Baron-Cohen and Sally Wheelwright)



Case study

Adenoma surgery leads to claim

*By **Suzanne Tate**, Litigation Solicitor, Dental Protection*

Dr N, a consultant oral and maxillofacial surgeon, undertook surgery successfully on 12-year-old Miss K's pleomorphic adenoma. Regretfully, 15 years later, Miss K started to suffer numerous recurrences that led to left sided facial palsy, reduced jaw opening, incomplete closing of left eye, loss of taste, Frey's syndrome, ongoing headaches and neck pain. All of these were under investigation, as was the risk of Sjogren's syndrome and the potential future risk to her sight.

A claim was made against Dr N, alleging the surgery was inappropriate because it potentially allowed the spillage of tumour cells and as such had created an increased risk of recurrence. It was alleged the surgery should never have been performed intraorally and if a proper external approach had been utilised then Miss K would not have suffered a recurrence.

How Dental Protection assisted

The significant passage of time led to some difficulty defending this claim. Dr N's account was that Miss K and her mother were properly consented. The risk of a pleomorphic adenoma was exceedingly rare in a child of her age and so an intraoral approach to remove the mass was determined best in order to avoid the certainty of a significant and permanent facial scar for the young girl. Histology indicated clear margins were achieved and Dr N did not consider any increased risk of cell spillage had occurred as a result of the approach taken. Cell seeding, on the other hand, can occur at any time. It cannot be seen or avoided and could have caused the recurrence.

In view of the passage of time and the litigation risk to Dr N due to the factual dispute between Miss K and Dr N, he agreed steps could be taken to resolve the claim. However, this was not possible for some time because of the erratic manner in which it was pursued on Miss K's behalf by her solicitors. The claim was pleaded at various stages throughout the litigation of having a claim value exceeding £1 million (approximately AUD1,850,000), in addition to provisional damages.

At an early Round Table Meeting, Dental Protection made an opening offer, which Miss K's legal team declined to respond to until further expert evidence was obtained. It was alleged Dr N's negligence and the avoidable recurrence had prevented her from receiving her treatment of choice for an unrelated giant cell tumour in her tibia. This was investigated with the help of independent expert evidence and it was determined the radiotherapy given for her recurrences had not impacted in any way on the treatment options for her giant cell tumour, which later led to a below knee amputation.

Once this discreet issue had been investigated with expert evidence, Dental Protection invited a second Round Table Meeting and reasonable opening offers were made. These were forcefully rejected by Miss K's representatives. Miss K's solicitors advised she would recover a substantially higher award at court. The court approved the instruction of ten different independent experts in total to provide advice on Miss K's causation, condition and prognosis.

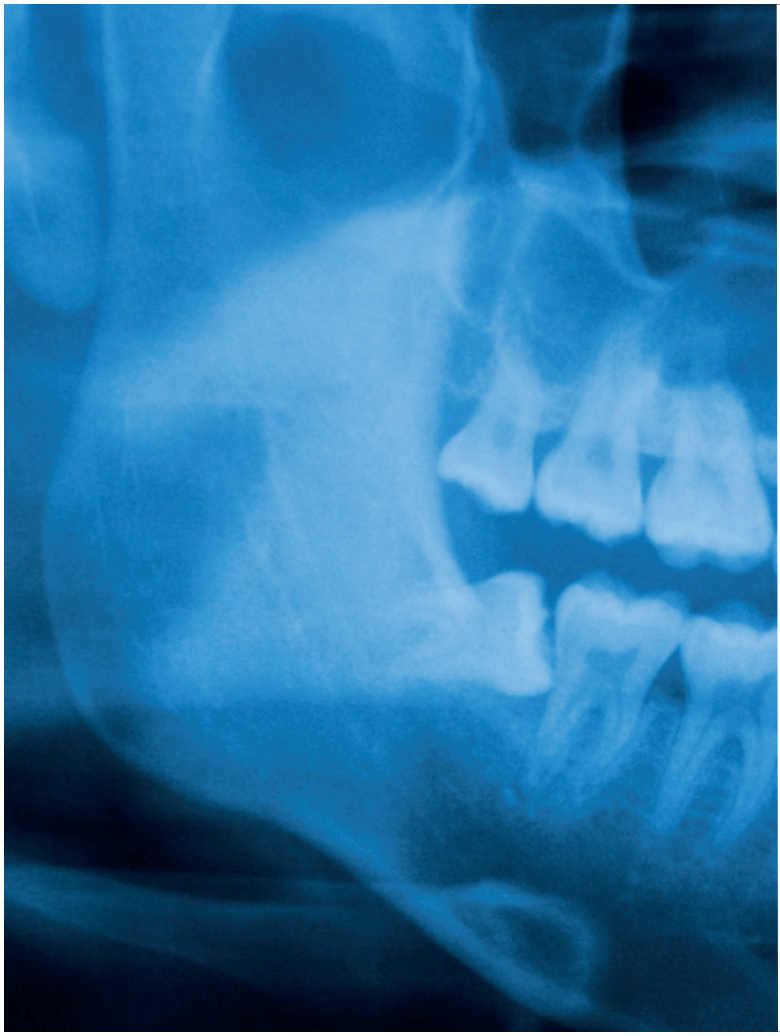
Numerous offers were made and subsequently withdrawn by Miss K's solicitors, who advised our view on a settlement figure was plainly wrong and Miss K would recover an award far in excess of £575,000 (approximately AUD1,065,000), despite an absence of supportive documentary evidence of her pre-incident earnings and a failure to take into account the impact of her unrelated amputation.

A year later, Miss K suffered more recurrences and expert evidence was updated. Dental Protection eventually invited a mediation and finally settled the claim for £450,000 (approximately AUD831,700) plus costs. This is without doubt the best possible outcome we could hope to have achieved.

Case study

Tricky extraction leads to hospital admission

*By **Hashim Talbot**, Litigation Solicitor, Dental Protection*



Mrs R, who was in her late 50s, attended general dental practitioner Dr V complaining of symptoms from tooth 27. Examination revealed that the distal aspect of the amalgam restoration had fractured with no mobility. A periapical radiograph was taken and revealed deep caries towards the pulp. Treatment options were discussed with the patient, including either re-root canal treatment or extraction. The patient opted for extraction.

Dr V also explained that the extraction could be carried out by either himself, or referral to a specialist. The risk of tooth fracture was also discussed. Mrs R opted for extraction with Dr V, however, regretfully the tooth fractured during the procedure.

Dr V had the benefit of having access to a colleague on a surgical specialist training pathway at the same practice. This colleague, Dr G, came into the surgery and took over the procedure with Mrs R's consent. Dr G elevated the roots out and there were signs of a small oroantral communication (OAC). Mrs R was informed of the OAC and this was repaired by Dr G.

Mrs R returned on numerous occasions for review appointments complaining of ongoing symptoms of pain since the extraction of the 27. After three weeks of symptoms, Dr V referred her to see an oral and maxillofacial specialist at the local hospital.

Mrs R subsequently attended the hospital just under a month after the extraction of the 27, with symptoms of a constant ache around the whole side of the face; she was able to eat and drink but with some difficulty due to the pain. She also reported yoghurt running through her nose after eating it, although there were no signs of this when drinking.

Examination revealed an OAC present at the extraction site, and an OPG taken at the hospital revealed a retained mesial root of the 27 in close proximity to the sinus. Consent was obtained for extraction of the retained root under general anaesthetic. Extraction of the retained root was carried out including a buccal flap pad advancement. The OAC was also repaired during the procedure.

Unfortunately, despite the procedure at the hospital, Mrs R continued to experience residual symptoms from the region of the 27. She continued to attend both Dr V's practice and the hospital for regular review appointments.

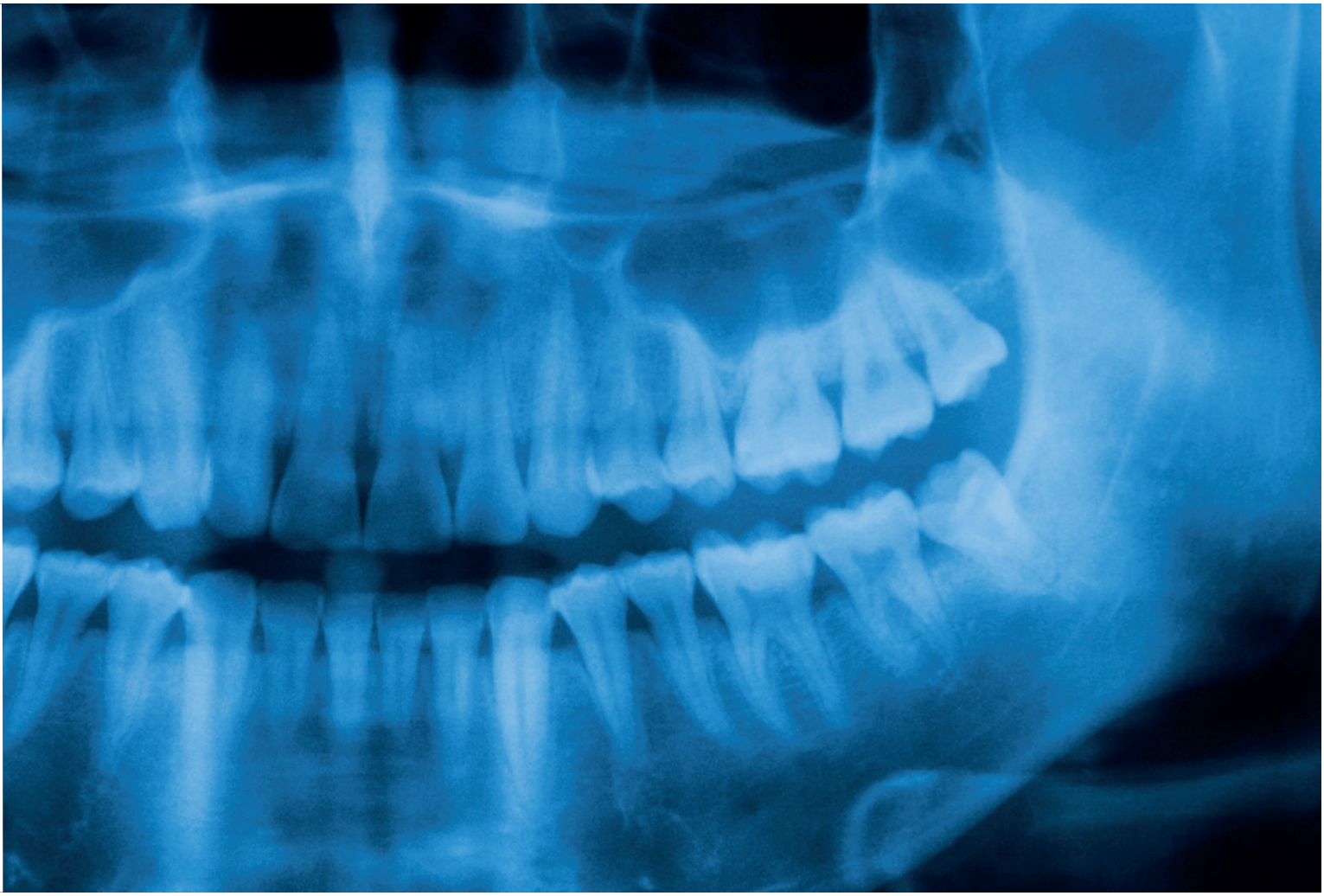
Sometime later at a hospital review, a repeat radiograph was taken which revealed a small bony spicule in the site. This was believed to be a contributing cause of her symptoms and consequently, open debridement was carried out and the piece of bone was removed at the hospital.

Two months later, the area in the upper left quadrant was noted to have healed. However, Mrs R was still experiencing some discomfort from the area. A referral was made to an oral medicine specialist to assess and treat the cause as it was not believed to be dental in origin.

The patient makes a claim

Mrs R instructed solicitors a few months later and a request for her clinical records was made by her solicitor not long afterwards. A formal Letter of Claim was then served, containing allegations of negligence against both Dr V and Dr G.

The allegations against Dr V included an alleged failure to obtain consent for the extraction of the 27 and failing to advise of an OAC developing. The allegations against Dr G related to the alleged failure to remove all of the roots from the 27. Mrs R claimed that had she been informed of the heightened risk of an OAC and retained roots, she would have opted for the procedure to have been carried out by a maxillofacial surgeon at a hospital.



How Dental Protection assisted

Dental Protection swiftly instructed a panel lawyer to correspond with Mrs R's solicitors, relieving Dr V and Dr G from having to respond to the multiple and various requests, required within stipulated timescales.

Dental Protection carried out a full review of the records and provided an assessment of the claim. A Letter of Response was sent, putting forward reasons why we were disputing liability based on our assessment. The claimant's solicitors did not agree with this assessment, and the matter proceeded.

Further investigations were carried out, including the instruction of an independent expert with expertise in oral surgery. A defence was subsequently formally served on behalf of both Dr V and Dr G.

Outcome

After serving a formal defence to the court proceedings, the claim was settled for a modest sum of money on behalf of Dr G, due to a retained root being left in situ and delay in having this extracted at the hospital. Critically, this settlement was made on a non-admission of liability basis.

Learning points

Retrospective review of the radiographs revealed that the extraction of the 27 was always going to be relatively difficult. The radiograph showed that there was not a clear margin of safety in relation to the 27 and the sinus floor, and appropriate warnings would be expected to be discussed with the patient. Neither Dr V or Dr G discussed the risk of an OAC, nor the potential future treatment this may require, and additional costs that this may incur.

Such warnings, including the heightened risk of an OAC developing, tooth fracture and the possibility of retained roots, are always important when extracting teeth, as is giving the patient the option of being referred if it is deemed to be outside the capabilities of a GDP. Critically, these warnings also need to be documented in the patient's clinical records.

Unfortunately, despite the best efforts of both Dr V and Dr G, there was a retained root still in situ, which was found at the subsequent hospital appointment. This is a useful reminder that if a patient continues to have ongoing symptoms from a difficult extraction, regular review appointments are imperative along with regular discussions with the patient to inform them of your treatment methodology and reasons for taking a certain course of action. Ensuring that all retained roots are also removed by assessing the area is also important.

Case study

Losing control – how far can autonomy take us?

Patient autonomy is a pillar of the consent process, but does it ever become problematic? ***Dr Annalene Weston****, Dentolegal Consultant at Dental Protection, considers this in the context of a recent case*

The generation of patients imbued with the mantra of "doctor knows best" are still present in contemporary practice. However, the social movements cultivated and grown by the "flower power" generations of the 60s and 70s were a catalyst for widespread global social change. Following this, the tension between paternalism and autonomy finally gave way, and by the mid-80s patient rights were the winner. This means that we predominantly treat autonomous patients. Patients who are empowered to question us, who can choose and refuse our care, and even review us, and not always kindly.

While paternalism may occasionally feel appealing, as it would seem like a much easier way to practise trouble-free dentistry, there can be no doubt that patient autonomy deserves its place as a cornerstone of medical ethics and critical component of patient care.

However, does autonomy ever go too far? And are we ever at risk of the tail wagging the dog?

Case study

Miss S was unhappy with her smile. She attended a specialist orthodontist for an assessment and was advised surgery would be essential for her to achieve an ideal outcome. However, she could consider a two-year course of fixed orthodontics if she was willing to accept a compromised camouflaged outcome. Unhappy with both these options, Miss S sought an appointment with Dr Z, a GDP who advertised aligner treatments. She expressed that she understood that she needed complex care, but reassured Dr Z that she was not looking for 'perfect'; she was just looking for 'better'. And, as her wedding was rapidly approaching, couldn't he consider providing her with something quick and easy to help?

Despite his reservations, Dr Z agreed to take records and assess what, if anything, he could do. Dr Z proceeded as far as a ClinCheck, and at that stage his reservations outweighed his desire to please. He called Miss S and advised her that he couldn't proceed, as he could not achieve an acceptable outcome for her. Miss S bombarded Dr Z with impassioned pleas, by email and by text. Surely he would help! She understood the risks and limitations – wasn't it her money, her mouth and therefore her choice?

Dr Z agreed to one more consultation to show her the ClinCheck and outline his concerns. Miss S reviewed the proposed treatment and proclaimed it to be everything she wanted. She paid the full fee in advance on leaving the surgery and scheduled all her appointments. Surely, Dr Z couldn't say no now, could he?

Difficult as it may have been to decline to treat Miss S, Dr Z very quickly began to wish he had stood his ground. While the treatment progressed as anticipated from the ClinCheck, the outcome did not meet Miss S's expectations. She became difficult to manage and rude to the staff. Dr Z was pleased to reach retention so this nightmare could be over. Regretfully, although perhaps not unexpectedly, Miss S was unaccepting of her outcome, demanding a refund.

Dr Z had barely had time to consider how he felt about this request when a letter from AHPRA arrived. The notification was accompanied by an expert report from an orthodontist setting out why the aligner treatment wouldn't work in the presence of a gross-skeletal discrepancy, and a complaint from Miss S, alleging she had been unaware of this fact and accusing Dr Z of "misleading her for profit", soon arrived.

Dr Z is not alone in his plight. Patients attend daily demanding specific treatments, researched on Google with a preconceived endpoint and price point. The critical point remains, however, that just because someone wants a specific treatment, it doesn't mean that you have to provide it to them, particularly if – like Dr Z – you are uncomfortable because you do not believe the treatment will be successful, or in the patient's best interests. Fortunately for Dr Z, his records accurately reflected the conversations that had taken place, and critically those indicating Miss S's understanding and acceptance of the treatment and its limitations. AHPRA dismissed the matter.

Learning points

Patient autonomy is one of the four underpinning principles of medical ethics and a vital component of patient consent.

This does not, however, mean that the patient is in the driver's seat – dictating the nature and type of their treatment, and controlling all decisions.

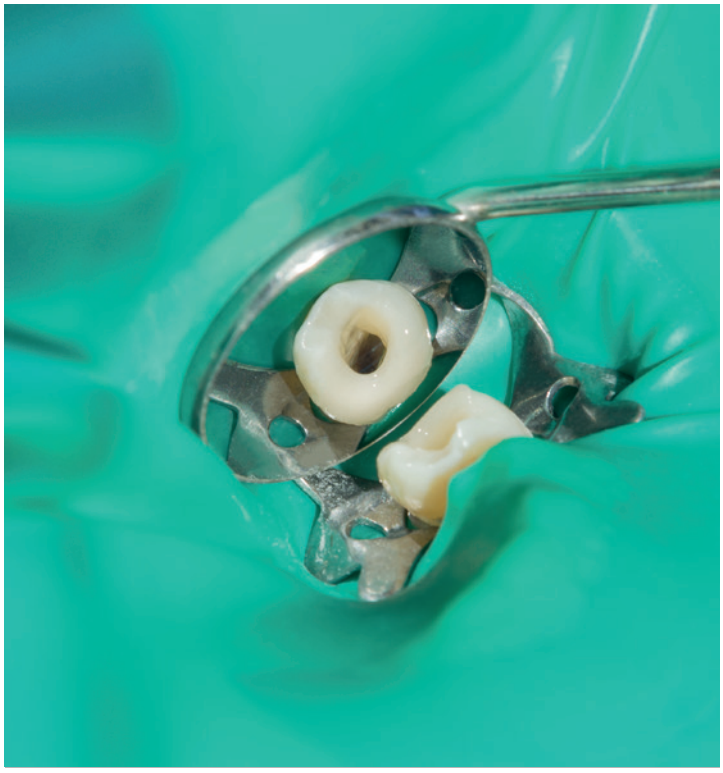
It is important that practitioners are not bullied or coerced into providing treatment they do not wish to – regardless of whether they are uncomfortable because they are out of scope, because they do not believe it to be in the patient's best interests or for any other reason.

The documentation of conversations we have with our patients in their clinical notes is a vital component – both of patient care and, when required, practitioner defence.

Case study

Lost root claim goes to trial

*By **Paula Conwell**, Litigation Solicitor, Dental Protection*



Miss O attended her practice for a routine examination. Radiographs were taken and they revealed the incidental finding of a radiolucency around the roots of tooth 15 and 16. She was diagnosed with an abscess and given antibiotics. Treatment options including root canal treatment and extraction were discussed and Miss O opted for root canal treatment of the premolar and extraction of the molar. Antibiotics were again prescribed five days later.

Nine days later, root canal treatment of the 15 was successfully undertaken. Miss O did not want any treatment for the molar at that time, and she was advised to come back for extraction if she had problems. Almost a year later, Miss O was advised to consider treatment of the 16, which she refused. After a further year, Miss O complained of pain and swelling in the upper left quadrant. Tooth 16 was noted to be tender to percussion and there was some swelling and inflammation in the gum. A periapical radiograph again showed radiolucency around the root apex area and she was again given the option of root canal treatment or extraction.

Due to the potential complexity of the treatment, Miss O was referred to another practitioner within the practice, Dr Q. After reviewing the periapical radiograph Dr Q advised Miss O that the root canals were sclerosed and that root canal treatment could only be completed by a specialist endodontist. Dr Q also noted that the floor of the left maxillary sinus extended over the root of the molar and advised Miss O of the risk of displacement of a root into her sinus during extraction. He advised Miss O that he could refer her to an oral and maxillofacial surgeon for the extraction. Concerned by the potential costs, Miss O declined the referral to either the endodontist or the oral and maxillofacial surgeon and agreed to the extraction with Dr Q on that day. Regretfully, during the extraction procedure the palatal root was indeed lost into the sinus.

Dr Q immediately referred Miss O to an oral and maxillofacial surgeon, who surgically removed the root under general anaesthetic.

After the procedure, Miss O wrote to Dr Q demanding $20,000 compensation for costs incurred, ongoing pain and time off work. She alleged that he had failed to advise her that she could opt for surgical extraction of the 16 at the outset and failed to refer her to a specialist in the first instance.

While Dr Q clearly recalled the conversation of consent, review of his records quickly highlighted that while he had gone through all the risks and warnings with Miss O, and documented those clearly, he had documented that she did not wish to save the tooth by seeing a specialist endodontist, and he had not recorded in her records that she had been offered a referral to a specialist for the extraction.

Dr Q contacted Dental Protection for assistance regarding how to respond to the request for compensation. While his records were good on most aspects, the absence of mention of the potential consequences of a displaced root, including the need to see a specialist for remedial care and additional costs this would incur, coupled with the lack of mention of the offer of referral to a specialist, did leave Dr Q vulnerable to criticism by a third party, if the matter escalated.

Dental Protection assisted Dr Q in a letter of response, offering to assist with the out-of-pocket costs once appropriately evidenced. Initially, Miss O persisted in her demand for $20,000 but quickly came to understand that this amount was unreasonable, and an appropriate agreement to cover her incurred costs only was reached.

Learning points

Record keeping issues and failures can arise when discussing multiple treatment options with a patient as it is easy for one point to be missed. This is fully compounded when something goes wrong during the patient care, as we may be distracted due to our concern for patient wellbeing, or even distressed.

Developing a consistent approach to recording patient conversations in the treatment notes can ensure all relevant information is documented.

Consider involving your staff in writing patient records, as while the responsibility for the content remains with you, the dental practitioner, they can capture detail in real time while you are talking to the patient that you may otherwise omit.

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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