Professional support and expert advice for new dental practitioners

Dental Protection

Young Dental Practitioner

Issue 5 – 2023

Aesthetic dentistry – high risk: high reward

Tips to make aesthetic dentistry more enjoyable and keep patients happy

Page 4

This issue...

Welcome

We really appreciate the time and effort from everyone who has contributed to this publication. Our latest edition of the *Young Dental Practitioner* is yet again another great read, with meaningful tips and guidance for new graduates.

I would first like to congratulate the Class of 2022 graduates who have now settled into working life. I hope you are all enjoying life as dental professionals and making the most of the exciting opportunities coming your way.

For any Class of 2023 graduates we wish you the best of luck for your final months of study and hope you cherish these moments and look back at your years of dental school with fond memories. You should be proud of your achievements and the hard work that you've put in during your time at university.

We know that dentistry can be hard at times so we want to remind you that as a Dental Protection member you have access to many resources that will help you navigate through the tough times. As a member, you also have access to our free confidential counselling service to help you stay on top of your wellbeing and mental health.

Wellbeing hub at **dentalprotection.org/australia/wellbeing**

We also encourage members to check out the Young Practitioner Survival Guide section of our website providing tips and tricks for new graduates. This is a dedicated resource for young practitioners, including articles and information on working abroad, and taking care of your back health.

Visit the Young Practitioner Survival Guide on our website at **dentalprotection.org/au**

If you have any feedback on this latest edition of the magazine or you would like to contribute to future editions, please feel free to reach out to me via email – kara.stokes@dpla.com.au

Warm wishes,

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Aesthetic dentistry – high risk: high reward?

People are more aware of their appearance than ever before, with over 200,000 cosmetic surgeries having taken place in Australia in 2018 (ISAPS). As we know, a major aspect of a person's appearance relates to their smile and, by extension, their teeth. ***Dr Kiran Keshwara***, Dentolegal Consultant at Dental Protection, takes us through some practical tips to ensure that aesthetic dentistry is enjoyable, and you end up with a happy patient at the end of the process.

Patients often ask us what can be done to help improve their smile, saying that they wish their teeth were whiter and/or straighter. The journey of helping a patient to improve their smile can be exciting, while also being a high-risk area of dentistry, with an increasing number of complaints being made about the treatment provided.

It's easy to get caught up in focusing solely on the clinical side of the provision of dentistry, such as taking x-rays and study models, which are crucial to gathering information and aiding with diagnoses and treatment planning. However, there are a number of non-clinical steps that you should take to provide the patient with their desired outcome, and ensure you can sleep peacefully at night.

Communication

There are many avenues to explore with a patient as to how they can achieve their "perfect smile" – from simple stain removal and whitening, to porcelain veneers or crowns with orthodontic treatment thrown in for good measure. Before considering any of the options available, it's important to get an understanding of what the patient wants to achieve.

A detailed discussion should happen with the patient to gauge what they have in mind. As we all know, this can be very difficult with some patients unsure of exactly what they want, and even changing their mind midway through or after treatment. The discussion can be helped by talking to them about aspects of their smile that they're unhappy with, what they would like to improve and how.

Since a picture can be worth a thousand words, it may be useful to ask the patient to provide photos of what they would like to achieve and keep these on file to refer to later and send to any laboratory you may work with.

Another useful aid to the conversation can be mock-ups and wax-ups of the desired outcome. Technology – such as a digital smile design – may also be used to ensure the patient gets a "real-world" idea of the outcome that can be achieved. It's sensible to work with the patient to agree this before any irreversible treatment is provided, and you're both comfortable with exactly what the final outcome should look like.

Sometimes patients have an event, such as a wedding, as a deadline for the treatment to be completed. Knowing this information is critical as it lets you have an honest discussion about what can be done in the time available.

Many patients have family members or friends who can act as a sounding board. If there's someone like this, it's usually a good idea to have them involved in the conversations, with the patient's consent, of course.

Record keeping and consent

The basis of any clinician's defence is the records that are created.

Ideally, these should clearly show what the patient's concerns are, what they would like to achieve, and the options you've discussed with them. This includes any risks and financial considerations. While a consent form can be useful, it doesn't hold the same value as detailed clinical records, which demonstrate the in-depth discussions that you've had together.

Some clinicians have been known to make use of a "standard" consent form for specific treatments, containing information about all the possible risks and warnings that you'd give to a patient. Ideally, the consent form should be personalised to the patient. Crossing the parts of the consent form out that are not relevant and/or highlighting those that are more pertinent to the patient is a good way of demonstrating that a discussion has taken place about the treatment and its possible risks. It's also good practice to leave some sections blank for you to fill in while discussing the issues with the patient.

An aspect which can sometimes be overlooked is financial consent. A patient should be aware of all the treatment options available to them, and their associated costs. There should always be very clear explanations with detailed treatment plans explaining each of the costs involved, whether it's the x-rays, study models, wax-ups or the cost of each crown or veneer proposed.

Giving the patient an overall cost without a detailed breakdown can lead to confusion and can result in them disputing the costs and refusing to pay. For any treatment that requires multiple visits, the patient should be given an approximation of how much each visit would cost, and what they are paying for at that visit.

Expectations

A good adage in any treatment involving elective and/or aesthetic dentistry is "under-promise and over-deliver."

As part of your overall discussion and planning, it's crucial to set out clear expectations. As mentioned earlier, patients don't always know exactly what they want, and some have been known to change their minds once treatment has been completed. This may be due to "buyer's remorse" or because they're underwhelmed with the outcome.

An important factor that can often get missed is talking to a patient about how long they can expect their treatment to last for – this helps with setting the patient's expectations.

At each step, you should check that they're happy to proceed to the next stage and document this in detail so if they change their mind later, you can rely on the clear discussions recorded.

Take your time

Generally, aesthetic dentistry is not urgent treatment.

This allows you the luxury of time to make sure that you have a detailed understanding of what the patient wants to achieve and time to write comprehensive notes. Most importantly, this ensures that the patient has time to consider all the available treatment options (including that of no treatment), the costs and risks involved. This way, they'll never feel pressured into accepting treatment. They also have time to seek a second opinion, and this helps ensure they proceed feeling fully informed and happy.

Don't be afraid

Don't be afraid to say no to treatments that you cannot provide, or to patients who you feel you cannot deliver for.

There are always some people who will simply not be happy, and by talking to them and trying to get to know them, you can hopefully identify them as early as possible, without any treatment having been provided. Some patients may have unrealistic expectations.

It's also important that the patient doesn't push you into providing treatment that you feel is wrong for them.

If you think you cannot help a patient, point them in the direction of a more experienced colleague who will hopefully be able to assist them.

When things go wrong

Despite taking all the above steps and more, ssometimes we get patients who are unhappy with the treatment and demand that it's redone or refunded. In these circumstances, a good first step is calmly talking to them to understand what they're unhappy with, making detailed notes, taking photos and explaining to them what you can and cannot do.

Bringing it all together

Remember, most aesthetic treatment options are elective. It's vitally important that all options are presented to patients, including the option of no treatment. Ensure that you allow them to make the decisions and assist them with knowledge along the way.

Take your time with discussions and treatment planning and ensure that you and the patient have a clear understanding of what can and cannot be achieved. This is crucial in reducing the risk of disappointed patients and stressful complaints.

All at sea

The opportunity to train as a dental officer in the Royal Australian Navy seemed like the ideal way to kickstart an exciting career in dentistry for *Dr Chrishan Fernando*. But when the dream turned sour, the feelings of failure left him unsure which way to turn. Rescue came in the form of friends, family, and a trip to South Korea.

It was at the beginning of my fifth year as a dental school student that I decided I wanted an alternative to a conventional dental career.

For most of my peers, starting work as a dentist was the culmination of five years of hard work and sacrifice, with a pathway that had been meticulously planned and eagerly anticipated.

But I wanted something different. Before graduating from Griffith University, Gold Coast in December 2021, I had participated in a variety of extracurricular activities; I was the Vice President of the school's student association and had taken a variety of leadership roles.

I suppose I was still looking for adventure, so I applied to the Australian Defence Force (ADF) to work as a dentist.

This led to months of difficult tests, forms, interviews, and medicals. And then I heard nothing for several weeks.

I began to lose hope and decided to concentrate on a conventional dental career after all. I applied for several positions in the community dental service and private practices and had many excellent offers. Finally, I accepted a position with QLD Heath at Rockhampton to start in February.

Then, to my surprise, just before Christmas I received an offer from the ADF to join the Royal Australian Naval (RAN) College in Nowra, NSW to train as an officer.

After the shock and elation of receiving this offer – and much soul searching and advice from my friends and family – I decided to undertake training with the RAN in early February. I was proud to be serving my country and enjoyed the positive comments from my peers.

However, the five months of officer cadet training came as somewhat of a shock to me. I didn't get on with the arbitrary rules, regulations and assessments by some instructors. The level of fitness required was very high, despite me passing all the pre-entry fitness tests.

To my mind, the training program is not really suited to medical or dental graduates who join as non-combatants. Certainly, I felt some of my instructors didn't seem to value the role of a dentist in maintaining combat fitness.

I was also concerned that I wouldn't be able to practice any form of dentistry for the five months of training and possibly even post-graduation.

So, after three months of training, and with the support of my parents, I decided that life as a RAN dental officer was not for me and applied for a self-discharge. This in itself was stressful because of the processes, interviews and assessments involved, which took another few weeks.

Once I returned home to Adelaide in late May, I felt exhausted, depressed, and embarrassed. I found it difficult to tell my friends and distant family that I had left the RAN and the reasons for it. I was particularly concerned that my rejection of such a respected Australian institution would be seen as unpatriotic or wasting a good opportunity.

To cheer myself up, I decided to spend a few days in the Gold Coast and reconnect with my peers. Although I consider myself very social and outgoing, I remember trying at all costs to avoid big social situations, with the fear that people would ask the dreaded question of why I left the military and what my plans were for the future. The honest truth was, I had no plans to work – I felt like an imposter and was even considering switching to a career in business leadership or health management.

There was one night when my friend suggested we meet at a university party in Surfers Paradise. I just couldn't do it. I was so scared of being found out and having to pretend to look okay in front of others if they asked me about it. My friend told me

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that the only person who really cared about my past was me. I think that is something to look out for in a support network. The people who are the closest to you and care about you will be honest with you – they won't judge. They'll listen to you, but they'll also bring matters into explicit perspective.

Back home, I half-heartedly applied for some positions in private practice and received an offer from a dentist in the Sunshine Coast with a structured mentoring program, and well-equipped practice. After I visited, the owner called me and wanted to confirm whether I could start work as soon as possible. This triggered an exaggerated emotional response that I had been bottling up and I tearfully had to inform him that I was not yet ready to work. In fact, I didn't have the confidence in myself to start work. I had no experience; how could I touch a handpiece again?

I realised that I had reached rock bottom. Imagine having multiple offers six months before and now having to reapply and almost beg to be employed? I felt so useless, and it was magnified every time I viewed social media. When I read my peers' postings on Instagram or Facebook, my heart would sink and I would think to myself, why isn't that me? Why am I in this position?

My parents became concerned about my lack of confidence and encouraged me to take a month or two off and travel by myself. I had always wanted to go to South Korea, so this was the perfect opportunity to do so. In all honesty, I think that trip changed my life. I never knew how much I loved travelling, planning things or even getting lost in a foreign country! I also met some famous Korean dentists, made new lifelong friends, and reunited with my friends from university there too.

> "Find a good mentor who will help you grow, not just as a clinician but as a whole person

After my return to Australia in July, I was refreshed and keen to restart my job search. I was fortunate enough to be offered a job in private practice in Perth by a kind dentist, who listened to my story and was willing to give me a chance. I now look forward to getting to know my patients and providing them with comprehensive dental care.

I look back on my time with the RAN with some regret, but mostly gratitude for the opportunity to make friends while training, and to serve my country, even if it was briefly – I have a certificate to prove it too!

Finally, what advice would I give a dental student starting year five?

Consider other branches of the dental career pathway such as the ADF but do your research. If you decide to leave a particular job or training scheme, try and make the decision early; the sooner you do it, the less painful it will be.

Find a life outside of dentistry, whether that's going to the gym, learning a new language or finding a hobby. Also, find a good mentor who will help you grow, not just as a clinician but as a whole person. And build a support network of friends and family. In the hardest times, these people will be the ones who'll pull you up and put things into perspective.

Dentistry isn't your life, it just forms a big part of it. Learn how to deal with the challenges and rewards the profession brings you, and remember that ultimately, you're in charge of your own career and the path that you forge.

Tips for surviving your first year of work

By ***Dr Laura Hunter***

The learning curve in the first year as a new graduate is immense and at times overwhelming. Dental school gives you the basic tools to snag your first job, however once you enter the real world of dentistry it's a whole new ball game. No tutors to mark you off at every step, patients are paying good money for your expertise and expecting quality results, not to mention the physical toll of full-time work on your body.

After completing my first year as a qualified dentist, I thought it prudent to share the biggest tips from my journey so far. I've learned the hard way, so you don't have to.

Mentoring

This step begins before you start work and is actually most important when applying for jobs. I cannot emphasise enough how essential it is, firstly to have a mentor and ensure they stick to their agreement to mentor, and secondly to ensure they are a good mentor.

Many jobs will advertise 'Mentorship Programs' to new graduates, but offer little to no support and have you working alone on certain days. Starting out, I would avoid this at all costs. Down the line, when experience levels are higher, a day or two a week working alone isn't so daunting. But the first six months are vital for building confidence and competence.

Can you imagine finding yourself three hours into a surgical extraction with a waiting room full of backed-up patients, the tooth won't budge and you are the only dentist within 100km? That is a sure way to lose all confidence in that procedure and rattle you to your core. Not to mention the patient's less than pleasant experience.

Secondly, make sure they are a decent mentor and human being. Not all practitioners hold themselves to high standards and may have bad habits you don't agree with. If you find yourself doubting their techniques, don't be afraid to stick with your training and remember you have the most up-to-date education. Seek second opinions from a wide range of your colleagues – dentistry is a big community so use it.

If it doesn't sit right with you, walk away. You are not obliged to learn poor techniques from dentists who insist their way is the best or only way. There's an abundance of good quality dental practitioners who will impart valuable knowledge and techniques and set you up for a career in high quality treatment.

In fact, if possible, look for a few mentors you can bounce ideas off, learn tips and tricks from a range of experience and figure out what style of dentistry you gravitate towards.

If you're fortunate enough to have access to specialists as mentors, then capitalise on that! Even though the procedures may be out of your scope it can help you communicate effectively with patients as to why you may be referring them. Specialists also have an abundance of knowledge on how to avoid mistakes commonly made by general dentists as they spend so much time fixing them. Surrounding yourself with specialists can also selfishly help nudge you towards or away from a speciality you may think of embarking on.

Lastly, if you find a good mentor, cherish them! Mentoring can be rewarding but ultimately, they sacrifice time and effort to help. Recognition of this, with a card or a gift, is often greatly appreciated.

Managing patients

Patient communication comes very naturally to some but not all. If you have the gift of the gab then count yourself lucky, as it has been widely reported that patients are less likely to complain or have post procedure complications if they simply 'like' their dental practitioner.

Getting to know your patient on the initial consult appointment is invaluable and can save you a lot of trouble down the line. Always allow more time for that first encounter and take notes at the end of the treatment plan on personal details. Whether they have children, play sport, are going away on holidays. These small details make a world of difference, especially to nervous patients.

Managing patients' expectations is also a huge part of minimising difficult situations. We all strive for an ideal outcome and it can be very tempting to gloss over possible complications of procedures, especially if it's a procedure you're fairly confident in. However, explaining the ideal treatment plan A and alternate treatment plan B and last resort treatment plan C can help a patient understand that complications are a very real risk and despite your best efforts, things can go wrong.

Setting scenarios such as advising the CEREC machine may break mid-mill (happens to us all) and there is a chance they will have to come back for a second appointment for their lab made crown instead, will prepare them for that outcome. If you don't have any issues, fantastic, you look like a whiz.

Lastly, learning to set boundaries with patients from the outset will also save you a world of pain and frustration. Saying 'no' to demands that you think are unrealistic and unreasonable is well within your rights. A wise Periodontist once told me 'Consent goes both ways'.

Time management

Booking long appointments initially is key. It may not be the most cost-effective way to start, but it allows you to treat properly and reduces stress when things inevitably go wrong or take longer than anticipated. Get good first, then get fast. Speed will come with experience but make sure you give yourself ample time to gain experience. This will pay dividends even within a few months.

This can also be one benefit to starting on salary vs commission and it's very common for newly graduated practitioners to negotiate starting on salary for the first six months to a year before transitioning to commission.

One fantastic way to help save time is having 'Fast-note' templates. Treatments and notes as a whole need to be tailored for each persons' situation. However, having certain structures for 'Initial Exams' or 'Composite Restorations' or 'Crown Preps' where you manually add in specifics to that patients' case can save a lot of time, and provide you with a methodology for treatments you are unfamiliar with. Remember though, all records need to be personalised!

Staying active

Exercise may seem like the last thing on your mind at the end of a long day. However, staying strong and fit will not only give you a physical outlet for some of the pent-up stress but also keep your body moving again after long days spent hunching over patients. The difference between periods of activity vs inactivity during work weeks is huge and I find the weeks where I've forced myself to those 7pm gym classes are much more tolerable both mentally and physically. Extra kudos to those who can squeeze in a morning session before work.

This article is just the tip of the iceberg in terms of advice for the first year of working. The most important thing is to enjoy the journey and find pleasure in the small wins just as much as the big.

The Template Trap

As the squeeze to maximise the profitability of our clinical time continues to inflict pressure on us, it's inevitable that savvy practitioners will seek out increased efficiencies in their day-to-day practising lives. When then is the tipping point in record keeping between a useful time saving modality and a harmful short cut?

Dr Annalene Weston, Senior Dentolegal Consultant, considers the Template Trap through the lens of a recent regulatory matter.

Case Study

Dr M worked as a single-handed practitioner in a high dentistry area. Despite the large local population, Dr M had issues attracting and retaining staff, and in a post-COVID landscape, was being crippled by agency fees for DAs.

Dr M offered discounted treatments to certain vulnerable groups within the community, and over time attracted more and more of these patients. Dr M did not have the heart to increase their fees, and found that some days it was best to work unassisted, using the small suction and relying on reception to perform steri so that overheads could be reduced to a manageable level.

Naturally, Dr M had to find efficiencies to be able to work safely unassisted. One step was the development of a comprehensive record pro-forma, with all the details for each procedure already entered in their entirety. The idea was to amend the document, removing what had not been done or discussed from the record, to ensure accuracy. By and large Dr M achieved this, although it did make the record somewhat difficult to follow.

On one such unassisted day, Ms B attended the practice, under the influence of alcohol, and belligerent. While Dr M recognised her intoxication, Ms B had lost an anterior filling and was distressed, and Dr M assessed that it would be a quick fix without the need for LA. Consent was obtained, (although we should all pause for a moment to consider whether we can truly obtain consent from an intoxicated patient) and the procedure to repair the front tooth was uneventful.

On checking the filling in the patient mirror, Ms B became enraged as Dr M had closed her diastomer. She threw the patient mirror at Dr M and pushed the tray of instruments onto the floor, shouting accusations of negligence and assault. So loud and alarming was this interaction that a local business owner in adjacent premises called the police.

The police arrived and escorted Ms B off the premises, as she had been refusing to leave. Dr M was left shocked, bewildered, and running very late.

Two weeks later, a letter from the regulator arrived, advising Dr M that Ms B had made an allegation of assault and treatment without consent, and requesting a copy of the records. Dr M provided this, with a covering submission to explain what had occurred. Two weeks later, Dr M was summoned to attend the regulator who had concerns regarding Dr M's professional conduct. At this point Dr M contacted Dental Protection.

Simply put, as comprehensive as Dr M's records were – as they contained everything – they were in fact completely inaccurate.

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They reflected several things that did not occur, including the provision of risks, and warnings for several treatment modalities not provided to, or discussed with Ms B. For example, the records reflected Ms B had been given LA, a written treatment plan, and that the treatment had been provided under rubber dam. The list of inconsistencies was high and from the context of the complaint, and the explanation Dr M had given, the regulator knew it.

The formal meeting with the regulator was frustrating for all parties as the practitioner felt (understandably) incredibly wronged to be there. Dr M felt that an abusive and reckless patient's point of view was being given priority and that this was profoundly unfair. The delegates of the regulator maintained their line of questioning regarding the veracity of the records, frustrated by Dr M's seeming lack of insight into the fact that the records did not reflect the procedure or events of the day at all.

It became apparent to all that Dr M had fallen into the 'Template Trap'. In the heat of the moment, upset by what had transpired, Dr M had not omitted the irrelevant and unrelated sections of the records. Dr M reassured the regulator that this was a one-off event, and the regulator felt it fair to let Dr M verify this.

Consequently, the regulator attended the practice to audit Dr M's records. Pleasingly, the audit findings were favourable, and Dr M received a caution and a recommendation to make their templates less 'fulsome' and more of a 'framework' to support the collection of and documentation of the relevant information.

The regulator's recommendation highlighted the ease of forgetting to amend a seemingly complete record, and the issues of honesty this raised, as well as the potential impact on the patient's continuity of care.

Learning points

- Some auto templating can be helpful in supporting clinicians in capturing what occurred in an appointment efficiently and consistently.
- Putting too much information in however – for example the complete notes for each procedure – is dangerous. You may not accurately discuss **those risks** as they may not be relevant to **that patient**. Plus, you likely don't use exactly the same materials for every patient you treat.
- Allowing the space and time for personalisation of records increases the likelihood of the record being accurate and of value in ensuring the continuity of patient care.
- With a template, less really is more.
- The regulator is ALWAYS interested in your records, regardless of the underpinning complaint.

What to know more?

We run a virtual workshop that covers this very issue.

Thinking of making changes to your clinical records after a complaint has been made? DON'T!

Helen Harbourne, in-house counsel at Dental Protection, sets out why it's smartest to not give in to this temptation, however innocent or reasonable it may appear.

If you've been diligently keeping up with Dental Protection's regular high-quality educational resources, developed for our members, you'll know the vital importance of keeping detailed, accurate and contemporaneous records. You probably feel quietly confident that your records are of a very high standard. That is, until you receive a complaint from a patient.

As you learn of the complaint, you're probably not overly concerned. Maybe you can remember this particular patient very well, and you know that you discussed that specific issue with them in detail. You're confident that your clinical notes will vindicate you.

However, as you start to read back over your treatment notes, you realise they don't quite reflect everything that you know was discussed. Then you recall it was a particularly busy day, and this was the last patient you saw, it went a little longer than anticipated (which is why you remember it so well!), and you needed to get home in a rush. So, you recorded some basic notes with the intention of elaborating on them the next day you were back in the clinic. That didn't happen.

Although it's been a few months since the treatment, you still remember very clearly everything you discussed with the patient that day. So you think about quickly adding the necessary additional information into the clinical records now.

There's no harm, right? WRONG!

Although poor clinical records may make a claim difficult to defend, altered clinical records will make it virtually impossible to do so, and could in fact be considered fraudulent if not declared.

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Dental Protection are seeing a very sharp rise in the trend of amended records

Dental Protection are seeing a very sharp rise in the trend of amended records. How do we know? Because the lawyers involved in medical negligence claims – and the experts that they engage – are very alive to this and are looking for it, so they can use it to their advantage.

Lawyers are now commonly demanding disclosure of a practitioner's record audit log at the outset of a claim, and they're entitled to request this. It's becoming so frequent that at Dental Protection we've adopted our own protocol of requesting the audit log from our members at the outset of a legal claim so we know, sooner rather than later, whether this has occurred and how best to implement damage control.

Why is this such a big deal?

Every patient complaint made has the potential to become a legal claim. Once it does so, the only thing more important than your clinical records is your credibility. Credibility is everything in a legal claim, for any party. And it will be the key to providing you with the best defence and overall outcome.

Judges can't turn back the clock and be a fly on the wall when the relevant treatment and/or discussions were taking place. The only basis on which a judge can determine what actually occurred – to the greatest extent that they can – is to make an assessment of each parties' credibility and determine who they consider is more likely to be telling the truth.

To the well-meaning practitioner, making changes or additions to their clinical records is done so for the purpose of being helpful and providing further clarity to the situation. However, the picture that will undoubtedly be painted by the patient's lawyer to a judge will be that of a negligent practitioner who is trying to cover their tracks and be deceitful. While the legal team on the practitioner's behalf will of course strongly argue to the contrary, it can be very difficult – and often impossible – to erase this view from a judge's mind, when they see before them a seemingly innocent, vulnerable and allegedly injured individual.

It will often mean that we have to make the decision to pay out a claim where it would otherwise appear to be largely groundless. This in turn is very likely to impact that practitioner's future indemnity premium.

What is the solution?

If there's important additional information that a practitioner would like to document about the patient or their treatment after they've received a complaint, they should do so in a document, separate to the clinical notes and provide a copy to us straight away.

This could be in the form of a Word document or simply an email. We'll then provide a copy of this to our lawyer and it will be kept completely confidential. Our lawyer can then review the additional information and advise the practitioner on the best way to use the information in the defence of their claim, without creating any perception of deception.

Is it ever ok to amend your clinical records?

If you wish to add further notes to a record the day or so after the treatment, and in the absence of any complaint, please ensure you do so in keeping with the Dental Board of Australia's requirements. That means the changes must be clearly identified and dated as having been written subsequent to the treatment, that nothing is deleted (although it can be crossed out but only in a manner so that it can still be read), and ideally including the reason for this later addition to the clinical notes.

So, please remember...

As soon as you become aware of a claim or complaint, no changes of any sort should be made to that patient's clinical records.

Poor clinical records may make a claim difficult to defend, but altered clinical records will make it almost impossible.

Call us at Dental Protection as soon as you receive a complaint or a claim. We can then give you clear and timely advice to allow you the best chance of resolving the complaint or defend the claim at the earliest opportunity.

When should I refer?

Dr Simon Parsons, Dentolegal Consultant at Dental Protection, walks us through the thought processes and provides some helpful guidance in the form of the Smart S referral framework.

It can be difficult to know when to refer a patient to another practitioner, for a variety of reasons. These can include geographical location and the travel involved, financial constraints, a lack of trusted relationships with specialist external practitioners, a desire to build one's own practice and not outsource complex treatment, or even the fear of feeling ridiculous if the issue proves to be nothing.

Yet we all understand our obligation to act in the best interests of our patients, and this may require us to refer them to other practitioners from time to time, even with these factors in mind.

It goes without saying that we can't force a patient to follow through with a referral – to do so would be against their consent. We do have an obligation, however, to strongly encourage them to follow-up on referrals when the reason for this is significant, such as when a potentially sinister condition is suspected.

When might such a referral be required, and when might it be a smart decision even when it isn't absolutely necessary? To answer these questions, it's helpful to remember some of the indications for referral outlined in the Smart S referral framework. Let's take a closer look...

Second opinion

We all encounter patients who may have irregular symptoms or signs of disease. These can manifest, for example, in the form of a surgical site that hasn't healed after an extraction, pain of uncertain aetiology, or random radiographic findings that cannot be easily explained.

Whenever a diagnosis is uncertain, a further opinion is valuable and indicated. That second opinion provides a "fresh set of eyes" and may overcome any cognitive biases or knowledge and skill deficits that we may have, but not realise.

It may also reassure you, as the referring practitioner, that you are clinically sound – sometimes the second opinion will simply confirm what you initially thought. When it doesn't, it becomes a positive learning experience.

Also, consider referral to a patient's medical practitioner(s) whenever you're uncertain about the best approach to ongoing treatment (such as any need for antibiotic cover following joint replacement), or where you suspect an untreated underlying condition. Referral of such a patient back to their GP for further information, investigations or management prior to committing to ongoing care, is wise. This is especially prudent where a patient has co-morbidities or is frail.

Always outline in the referral what your treatment plan involves and why the medical practitioner's input is required, for example:

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Dear Dr

Mrs Jones is scheduled for the surgical removal of three posterior teeth under local anaesthesia in my rooms on (date). I'm mindful that she is currently taking anticoagulant and thrombolytic medications to manage an underlying medical condition.

Could you please forward me a list of all her current medications and advise if you wish her to take any drug "holiday" in the immediate pre-operative or post-operative period? Do you require any additional precautions to be taken to ensure her wellbeing?

I would also be grateful if you could please indicate whether you believe she is medically fit to undergo this procedure.

Thanking you,

Sincerely

Dr Smith BDS

At Dental Protection we regularly deal with cases where there would have been a much better likelihood of a prompt resolution of a complaint or claim had an expert opinion (such as from a specialist dentist or medical practitioner) been sought before treatment.

Unfortunately, obtaining such expert opinion after the patient has experienced an adverse outcome often only confirms an inadequacy in the original assessment and treatment. By then, any helpful window of opportunity to seek more information for the patient has been lost.

Scepticism

Any patient who is reluctant to accept your provisional diagnosis and recommended treatment plan may benefit from another practitioner's insights. If the second practitioner confirms your diagnosis and recommendations, the patient is likely to hold you in higher esteem, be more compliant with the treatment, and be more likely to accept your views in future.

The second practitioner may also be able to offer the patient additional options (for example periapical surgery for a long-standing endodontic issue) that you may be unable to provide yourself. This will ensure that an effective consent process has been followed.

Sinister or suspicious

As noted earlier, where any lesion in the oral cavity or surrounding tissues seems irregular or unusual, it should be investigated further, such as via a biopsy. These situations must be addressed promptly to maximise the chance of early detection and treatment of anything sinister. Timely referral to oral medicine specialists, oral and maxillofacial surgeons or other similarly qualified clinicians, may make a profound difference to the long-term prognosis for a patient.

Clinicians should carefully consider how the need for such a referral is communicated. Some patients may be alarmed by it, while others may be resistant to seeking further information, especially where a lesion has been present for a considerable period. It's best to avoid exaggerating ("this looks like it could be something very serious") or minimising ("I'm sure it's nothing") the issue at hand. Instead, keep your communication factual and straightforward, and be prepared for your patient to ask questions. For example:

"John, it's unusual for a wound to take longer than a week or two to heal. We should get it checked to see what exactly is going on. Why don't I see if I can get you booked in with Dr Smith sometime later this week?"

"Should I be worried about it, doc? Why the hurry?"

"I don't think you should be worried about it for the moment, John. Let's find out why your gum isn't healing. Most of the time it isn't anything serious, but I'd rather be safe than sorry, and I'm sure you would too. The sooner we find out why, the better".

The implications of a missed diagnosis altogether, or a misdiagnosis of a sinister condition as something trivial, are too serious. It's wise to assume that a patient's problem could be a serious or suspicious one until proven otherwise. Thankfully, not every patient we refer with an unusual or rare clinical presentation ends up having a serious issue.

Scope

It goes without saying that a practitioner should only perform treatments for which they've received sufficient training. Our patients expect us to be competent, as do the regulators. If any patient requires care in which you lack sufficient knowledge, skills or experience to manage competently, they should be referred to someone who can.

Indeed, where there are dental manifestations of other disease, such as suggestions of anaemia or immunocompromise, it's appropriate to refer to medical colleagues for the further investigation and management of the underlying conditions. This is because those conditions are outside of the scope of general dentistry to definitively diagnose and then manage.

Very few of us are great at all aspects of dentistry. It can be desirable to broaden one's scope over time, to increase our professional development and what we can offer our patients. Yet a clinician's limited experience in orthodontics can prove to be a risk in managing a patient with complex occlusal issues, such as anterior and posterior crossbites. Even if a treatment is technically within your scope, is it in both your patient's best interests and your own to perform it?

There are times where the treatment outcome may be better, or at least more predictable or faster, when the patient is managed by someone with more experience in that field than you. Carefully evaluate whether you're the best person to manage the patient. If not, consider referral.

Where the likelihood of a better outcome might incur a greater cost for the patient, carefully consider letting the patient bear that cost, rather than you bearing the cost of failure if it arises at your hands. Do not let the notion of additional financial cost sway any decision to provide the best treatment plan for a patient.

Serious harm

Referral is nearly always indicated as an option if the proposed treatment entails an inherent risk of serious harm. Most practitioners would prefer to know that they were not responsible for a permanent lip paraesthesia, serious haemorrhage following surgery, or a life-threatening post-operative infection.

If a procedure involves the risk of a serious adverse outcome, and you're unable or unwilling to manage such an outcome if it were to arise, it's prudent to offer referral. Further, complex dental conditions, such as deeply impacted wisdom teeth positioned in close proximity to neurovascular bundles, or cystic lesions associated with unerupted teeth, demand careful clinical assessment and an ability to (if indicated) change plans during a procedure.

There is a reasonable expectation in most patients that the procedure you start is one you are able to finish. If that expectation can't be met without putting that patient at risk of further harm, referral is indicated.

At Dental Protection, we have certainly encountered cases of such harm at the hands of both inexperienced and experienced non-specialist clinicians. In reviewing the care of the patient prior to formulating a defence, one of the first questions that is always asked is, "Why wasn't this patient referred to a specialist?"

Safety

When considering safety, it can be helpful to look at it more broadly than just trying to avoid any serious harm. Ask yourself, what are the implications to the welfare of yourself and your team if you treat this patient?

If a patient is aggressive, rude, abusive, or otherwise a threat to a harmonious and safe practice, this can pose a risk to the maintenance of a safe workplace. Is that after-hours call-out a safe one to attend for you and your support staff in your practice location, or is it better to refer the patient to a hospital? Provided it's performed with appropriate consultation and handover, referral of these patients elsewhere is wise.

The difficulty that arises is then one of, "Who do I refer this patient to? Do I really want to inflict this patient on my colleagues?"

This is sometimes a dilemma, however, with the exception of the most urgent of situations, it's usually possible to decline to treat someone even if you're unsure who should treat them next. Seek our advice if in doubt about how to do this.

Salvage

If something has gone wrong, such as a molar tooth has fractured during extraction and you're unable to safely remove the remaining roots, it's essential to manage the ongoing welfare of the patient effectively and efficiently. Referral is indicated unless you can confidently salvage the situation yourself.

Strained relationships

Sometimes you can find a patient is just plain hard going and impossible to please. At other times, a patient may not warm towards you and may communicate this in a number of ways, not only doubting your advice but repeatedly failing to attend, querying your fees, quoting "Dr Google" or exhibiting very negative non-verbal cues.

In these cases, an offer of referral may give the patient a sense of "permission" to move on to another practice, or may help to clear the air. You might want to approach the issue delicately, along the lines of:

"Jane, I keep noticing that our interaction seems strained and you seem very tense when you're here in my chair. I'm sorry that this is the case. I just wanted to raise this so we can explore how to manage it. I feel we must trust each other and be comfortable around one another if my care of you is to continue. If you would be more comfortable being treated by another dentist, then I'd be very happy to organise for your records to be transferred to that person. What are your thoughts?"

In summary, the decision to refer may be based on one or more of the above factors. It's difficult to be criticised for referring a patient whenever reasonable grounds exist to do so. Of course, a patient may also desire to seek referral in the absence of any of these indications, in which case that request should be respected and complied with. We must respect a patient's autonomy in the decisions made about their care.

Whatever the basis for referral, be sure to act on it promptly and document it in the clinical record.

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Hindered by the decisions of others

Receiving a complaint from a patient can be a worrying and stressful time. Navigating the road to resolution can be inherently difficult, and this is compounded when hindered by the decisions of others.

Staying the course and achieving an amicable outcome can require both professional and personal fortitude. ***Mrs Anita Kemp***, Case Manager at Dental Protection, considers this through the lens of a recently reported matter.

Dr B had taken over the care of Mr M's dental health, from his practice principal, Dr A. Mr M had become unhappy with the appearance of his current implant retained upper denture, and requested that Dr B make him a new one, to which Dr B agreed.

The new denture was fabricated, and Mr M was happy with the final result. At a routine check-up and clean appointment, when replacing the denture after cleaning, one of the implant screws fractured. Dr B explained to Mr M what had happened and made the appropriate referral – after recommendations from colleagues – to the periodontal specialist to assist with its retrieval. He had also called the specialist and confirmed that the screw could be removed.

Dr B assured Mr M of his assistance and support throughout this time and Mr M advised Dr B that he was not concerned at all, adding he was happy to use his health fund benefits if needed.

Mr M attended his appointment with the specialist and while there, the denture and bite were adjusted and his periodontal condition was treated, but the screw was not removed. Later that month, Mr M returned to Dr B, as he noticed that another of his lower implant crowns (44) had felt loose. Dr B completed the necessary treatment to tighten the implant. Mr M was charged for this appointment and when leaving the practice disputed the fee. In his mind, 44 crown had become loose as a direct result of bite, which he now believed had changed since the screw fractured.

A few weeks later a letter of complaint was received, and it was addressed to Dr B's principal dentist, Dr A. The letter outlined Mr M's discontent with his treatment and the fit of his denture and bite. He attributed the cause of these concerns to Dr B, and the fractured screw. He mentioned that he had been sent to the specialist to have the screw retrieved, which hadn't happened, and he had incurred further costs when the lower implant became loose, which he found completely unacceptable.

He was of the belief that the fractured screw had changed the fit of his denture and bite and caused the lower implant 44 to become loose. Furthermore, after his recent appointment with Dr B, Mr M had returned to the specialist and was told they were unable to remove

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the screw and referred him to 'another specialist' for further care. He advised that in order to avoid escalation of his complaint or legal recourse, he did not want to see Dr B again. He requested that he return to the care of the practice principal Dr A, for remediation and all future treatment and care, because Mr M held Dr A in very high regard. Unbeknown to Mr M, Dr A had made it very clear to Dr B, that he would not manage Mr M's care and that it was up to Dr B to facilitate and manage his complaint.

In reality, Mr M felt abandoned. Through no fault of his own he had been bouncing between practitioners and began to scrutinise and question all treatment that had been provided to him both past and present.

Mr M's perception of Dr B also changed. Mr M felt that Dr B was the sole cause of his dental concerns and he was very angry. Dr B reached out to Mr M, acknowledging his feelings and concerns, and offering an apology and advising that he was under the impression that the fractured screw would be removed by the periodontal specialist. He then reextended his offer to assist with the retrieval costs with the prosthodontist specialist, and explained that Mr M's treatment and care remained his priority and that he was not alone.

Mr M was still very upset and requested a copy of his records, from Dr B and the periodontal specialist practice. Dr B naturally agreed, but when he attempted to organise the transfer of Mr M's records he was told by the practice principal that these full records would not be released.

Although Dr B was aware that Mr M was entitled to a copy of his records on request, he felt helpless. He had Mr M contacting him and demanding his records and he had his practice refusing to release them. Unsurprisingly, the decision by the practice to not release the records did not bode well with Mr M, nor did it help Mr M and Dr B's already strained relationship. Mr M believed it to be Dr B who was obstructing access to his records and began to question Dr B's transparency with his treatment.

Despite all of Dr B's good intentions to assist Mr M, it seemed at every turn, decisions outside of his control were making matters worse.

Nevertheless, Dr B continued to correspond with Mr M politely and respectfully, offering his assistance and support where he was able, reminding himself that there was a person attached to this matter and taking time to reflect on the events that had occurred from Mr M's perspective.

Dr B continued to follow Mr M's care with the prosthodontist and was able to achieve an amicable agreement and resolution with Mr M when the screw was finally removed.

Learning points

- In this situation, the complaint and Mr M's perception of Dr B's treatment and care – or lack of it – was escalated by outside influences from staff and colleagues. When treatment didn't go to plan, Mr M looked for someone to blame and unfortunately and unfairly, Dr B bore this brunt.
- While unfair and very difficult at times, Dr B was able to weather this storm, dispatch his duty of care and reach an amicable agreement with Mr M.
- This inherent professionalism protected Dr B from a formal complaint to the regulator, and ultimately enabled the resolution of the matter.

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