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Dental Protection

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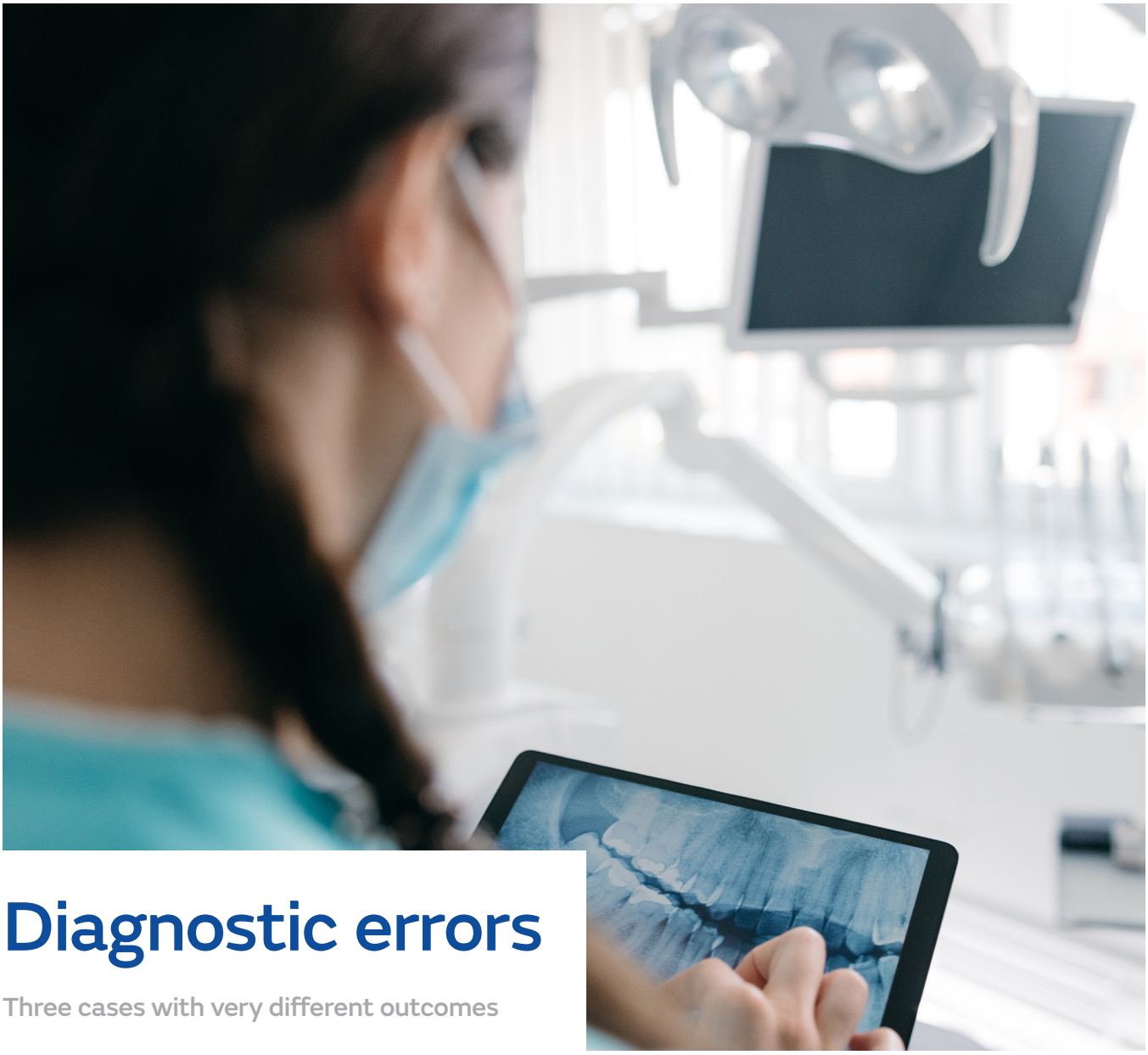

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Editorial

Dr Annalene Weston
Dental Team Lead – Australia

It is a great honour and privilege to be writing my first editorial for *Riskwise*. This honour comes as Dr Mike Rutherford has handed over the mantle of leadership to me, as he moves towards a happy retirement. I wanted to take this opportunity to thank Mike for his unceasing dedication to our members, and his calm and clear leadership of our team through not only the day-to-day challenges any work brings but also a global pandemic. Mike rallied the team as we pivoted from office to home and he empowered us to continue to provide the seamless world-class service our members have come to enjoy, regardless of what was going on around us. I am very grateful that Mike will continue to work in the team for many months to come, and please do join me in wishing him well and thanking him for his service to our profession. I am humbled to be following him into this role, and I pledge to continue his great work for our profession.

As many readers will be aware, Dental Protection and the Medical Protection Society at large are deeply committed to developing, enhancing and supporting practitioner wellness. We provide resources to our members in many forms, including podcasts, articles and our confidential counselling service, and we even support wellness by providing access to two targeted apps for our membership. Pleasingly, the uptake and access of all of these resources has grown, and I feel it will surprise no-one that this uptake leapt in 2020. I am grateful that we had these resources at hand when our colleagues needed them most, and I applaud our colleagues who work tirelessly to create them.

As part of our work in wellness we consider how to become more resilient, as individuals, organisations and communities. This has never been more necessary in contemporary times as it has been over the past few years.

I read a great deal to learn and grow as a Dentolegal Consultant. I read about dentolegal risk and human error, about burnout and resilience; and through the course of this reading, I stumbled across a term that immediately made me think of us as a profession at large, and I wanted to share it with you. The term is *bricolage*.

Bricolage is derived from the French verb *bricoleur* and essentially means making do with what you have at hand to solve a problem. This struck a chord with me as I believe a great deal of day-to-day dental practice relies on bricolage, whether it be related to equipment, materials or the biological structure we are striving to maintain. Critically, bricolage as a trait is thought to be an inherent component of a resilient individual. We are all highly resilient individuals and have demonstrated this through our successful completion of arduous studies, and the successful application of our learnt skill, day after day, patient after patient.

However, even for the most resilient of us, it can be too easy to focus on our failure, or those times when we found ourselves lacking. Today I would like to challenge you to instead reflect on and revel in your ability to bricolage and celebrate all the times that you have successfully solved a problem with what you had at hand, especially when what you had wasn't want you wanted or needed.

Our natural tendency of bricolage sits at the foundations of our success and deepens our resilience. I truly believe that this is something we as a profession should take great pride in.

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Managing difficult interactions

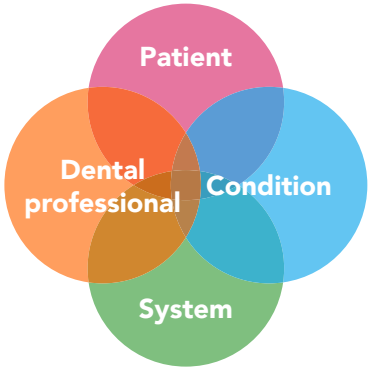
***Dr George Wright**, Deputy Dental Director at Dental Protection, explores some causes of difficult interactions and basic strategies for handling them*

For many, difficult interactions with patients remain an unattractive occupational hazard and one that can challenge even the most experienced of practitioners. Dental Protection regularly receives calls from members seeking advice on either preparing for an expected difficult interaction or dealing with the fallout from one. It will come as no surprise that the way in which a difficult interaction is handled can prove pivotal in how the patient responds.

A well-managed interaction, even following a significant disagreement or conflict, can strengthen the professional relationship. However, without careful navigation, a difficult interaction can easily escalate and precipitate a patient complaint, while also increasing the risk to the dental professional of aggression or violence from the patient.

However, it is important to recognise that with all the will in the world, some dentist-patient relationships may break down irrevocably and will require careful management to ensure a transition of care that is in the patient's best interests.

What makes an interaction "difficult"



The literature, along with our own experiences, tell us that generally, the source of any difficulty lies in one or more of four interrelating domains: the patient, the dental professional, the patient's clinical condition and the systems in which we work.

On any normal day, we may be able to take difficulties arising in one or even two of these domains within our stride. But the more domains that come into play, the more difficult it is to manage the interaction effectively – partly because we may have fewer positives to draw on to provide a counterbalance. Consider, for example, the 'perfect storm' of having a patient with high treatment needs, presenting with dental anxiety, being 20 minutes late for a 30-minute new patient examination on a day when you are short-staffed, the computers are malfunctioning, and you

didn't sleep well the previous night as your young child was unwell. Taken in isolation, many of us would be able to work unaffected by any one of these factors. However, the cumulative effect of these when they all come into play can create an entirely different context for the patient's appointment.

Patient factors

Patient factors can include unrealistic expectations, differing interpretations of the same situation, extreme emotion (for example, dental phobia), or the patient's inflexibility in relation to alternative treatment options. I recall from my own clinical practice a patient, presenting with multiple missing anterior teeth and severe periodontal disease, who wished to have their teeth replaced with a 7-unit bridge. Careful discussion with the patient yielded nothing in terms of their acceptance of the situation or what in my view were the available options (none of which were a lengthy bridge supported by two grade 3 mobile premolars).

Condition

A patient's clinical presentation and condition can also add a layer of unwelcome complexity, which might leave us feeling uncomfortable. Anecdotally at least, dentists report difficulty interacting with patients when they feel the patient's pain is non-dental in origin or, for example, those patients with complex medical histories taking multiple medications.

System factors

System factors play a significant role in modern healthcare and are a source of frustration to many. Unfortunately, many of these factors sit outside our immediate sphere of influence and it is important to focus on the factors that can be controlled.

Research has shown in medicine that dentists are often less empathic with patients when there are system factors causing difficulties rather than other factors,[1] and work on human factors in other industries such as aviation has also reached similar conclusions. For those not working in private practice, there are additional systems and process considerations that can further challenge even the most resilient practitioner. Members contacting Dental Protection for advice following a difficult interaction with a patient will often refer to systems and process factors as contributing to why an interaction evolved as it did. These might include factors such as time pressures, interruptions, availability of resources, and equipment issues.

Dental professional

It is interesting to note that although all dentists recognise difficult patients, individual dentists are likely to vary as to which patients they would identify as such, or the degree to which they would rate them as difficult. So, identifying and rating the difficulty is not objective, and as dentists, we ourselves form part of the equation.

An interesting study conducted in Australia[2] identified that when asked, dentists believe that they are practising good patient-centred consultations "all the time". Any failure or difficulty in the consultation is thus seen as an external or an 'other'-related problem, rather than it being directly dentist related.

Dentists had no difficulty in identifying barriers to patient-centred care that arise due to systems or processes. What was less obvious to them were the behavioural factors in themselves, the patients, or the dental team that also could give rise to difficult interactions. Yet it is easier to influence the behavioural factors than it is to influence systems and processes. So, it is worth focusing on the factors that are under our control and that can be improved to reduce the risk of complaint or claim.

Sometimes it can be just a personality clash, but often it's something in the situation that triggers our 'hot buttons', which may activate our prejudices, stereotyping, and assumptions. We may also have been profoundly affected in a negative way by our interactions with patients who have presented or behaved in a similar way to the patient before, and this may significantly influence our attitude and ability to handle the interaction.

Examples include the patient who is always cancelling appointments, the patient who does not pay on time, or the patient who only uses you in an emergency. Our degree of training in handling difficult interactions is also a major factor.

It is interesting that people in service industries receive a lot of training around handling difficult situations. Do we, as healthcare professionals, receive the same level of training?

Our own resilience can be affected by our own emotional baggage and a patient that might not otherwise have created a problem becomes a 'difficult' patient. This might also explain why difficult patients to one person might be easy-to-manage patients to another. All of this is harder when we are hungry, angry, late, tired, energy depleted, distracted.

Choosing your response

Dental research has shown that the impact of difficult interactions contributes to stress, and this creates long-term physiological and psychological phenomena if not managed correctly.[3] Difficult interactions tend to create a feeling of discomfort. The original work of Corah and O'Shea on dentists' perception of problem behaviours in patients listed various behaviours that can be very annoying for dentists. These included patients devaluing, being critical of, or questioning a dentist's performance. Because such behaviours are likely to result in feelings of personal assault on the dentist's part, they are likely to have a deleterious effect on the patient-dentist relationship.

It is helpful to be aware of your own warning signs – signs that your emotions are starting to affect your behaviours. For example, what do you do when you get angry? The consultation is a dynamic interactive process, and patients and dentists will respond to each other's behaviour in ways that will either help or hinder the interaction.[4]

An interesting study by Thierer, Handleman and Black in 2001 assessed the relationship between dentist communication behaviour and their perception of patient attributes such as likeability, manageability, and prognosis. The result suggested that dentists alter their communication behaviour depending on their assessment of various patient qualities.

There are already branches of communication that look specifically at these situations, for example neurolinguistic programming, which recognises that people have different filters through which they see the same situation, which predetermines their reaction. Is your reaction different when you like or dislike a patient or with someone who fails to attend an appointment? It is an innate human trait that if you don't like someone, you will often show it.

Effective skills and strategies

Making a careful and considered diagnosis of the difficulty is a critical step in having an effective response. One of the most effective strategies in managing a difficult interaction is to recognise our own reaction. Our automatic reaction may be telling us things like "this person is a nuisance" or "this person is uninterested in their oral health". Such reactions may be correct or incorrect, however, they are not helping us to manage the situation. On the contrary they may be interfering with our self-control and self-confidence, and our ability to demonstrate the necessary support skills.

Various support skills can help to effectively manage a difficult patient interaction. The first of these is active listening, which involves two key components: open-ended questions to encourage the patient to tell their story, and reflection of content back to the patient, including short summaries and acknowledgement of emotions. We try to give a considered response. This may take some time but trying to objectively define the problem, name it, and externalise it from the patient and the dental professional can provide the backdrop to managing it effectively. It may be useful for the dental professional to take time out by, for example, reviewing radiographs or records while quietly going through this analysis of the difficulty.

One of the problems in a difficult interaction is that there might be a tendency to plan your response while listening to the patient. It is important to listen without distraction and to concentrate on demonstrating to the patient that you are listening. It can be particularly difficult to actively listen to a patient when you feel the patient is wrong, because there is a tendency to immediately react and put the patient right.

Active listening allows us to move past assumptions and stereotypes to what is the reality for our patients. A patient who feels listened to is much more likely to engage.

The second of the key support skills is empathy. Empathy is the patient's perception of being heard and understood and is inferred by the clinician's good listening behaviour, body language, summarising of the story, and reflecting of their emotion. It is also based on working on the agenda that is important to the patient. Active listening is a critical component of conveying empathy.

It is possible to be empathic with a patient even if you disagree with what the patient is saying or find it difficult to be sympathetic to their plight. The beauty of empathy is that it can be applied to situations even where you are uncomfortable. Conveying empathy is a powerful way to increase the feelings of support of patient experiences.

Another key support skill is reframing. This is a technique used in psychology, where a therapist might ask a patient to consider a different explanation for their concern, knowing that doing so may well reduce their distress. To consider alternative explanations for a patient's behaviour or attitude might allow us to approach that patient in a more objective or neutral manner. The interesting thing about reframing is that the alternative explanation does not have to be true, just as our immediate autonomic reaction to the patient may not be based on truth either. All we are trying to do in this situation is to open ourselves to the patient and in particular the patient's needs.

An example of this is the patient who is quite hostile at your inability to find the source of pain, and where you label the patient simply as a 'difficult and impatient' person. The reality is that by reframing, that patient may be dealing with anxiety, but also a more serious disease that they have not been able to articulate to you.

Practical tips

When faced with a patient with whom you anticipate a difficult interaction, the above 'theory' can very quickly be forgotten, and we can default into 'defence' or 'attack' mode. A simple step to take towards de-escalating conflict is to first acknowledge how the patient is feeling. By doing so, you can demonstrate to the patient that you have actively listened to their concerns, and it allows you to check understanding. From here, it may be helpful to inform the patient of your position, clearly stating the reasons, and respectfully explaining any boundaries. Finally, if done effectively, you will be able to move with the patient to discussing a way forward. At this point, it can prove invaluable to empower the patient to propose possible options, albeit with some gentle encouragement. By taking this approach, patients are more likely to feel they are in control of the situation and are more accepting of the resolution they have jointly reached.

Conclusion

When preparing for a recent Dental Protection event, I was reminded that with only a few seemingly minor alterations to the course of an appointment, a situation can rapidly become disproportionately difficult and escalate beyond our control. While such a day is thankfully extremely rare in practice, we will all come across difficult interactions from time to time.

Every patient is different, just as every dental professional is different, and many will have found a process that works for them – often through trial and error – for dealing with a difficult interaction. Hopefully with a few tools, both to reflect on why a situation is apparently difficult and to provide some basic steps to follow when approaching a difficult interaction, dental professionals need not fear these interactions and can be empowered to resolve them amicably.

REFERENCES

1. Weingarten et al 2009.
2. Asimakopoulou K 2014.
3. Bodner S. Stress management in the difficult patientencounter. Dental Clinics of North America 2008;52:579 – 603.
4. Krebs et al 2006.

The pursuit of happiness

***Dr Raj Rattan**, Dental Director at Dental Protection, looks at the science behind wellbeing*

Happiness has been described as "the experience of joy, contentment, or positive wellbeing, combined with a sense that one's life is good, meaningful, and worthwhile". It is a complex, abstract social construct and because it is subjective in nature, it is difficult to measure, and desirable but often elusive. There is supporting evidence for the primacy of happiness and other goals are valued because it is believed that they add to human happiness.

References to the pursuit of happiness can be traced back nearly 2,500 years ago. Confucius, Buddha, Socrates, and Aristotle have all tackled some aspect of happiness and have many things in common. The Greek word that usually gets translated as 'happiness' is 'eudaimonia'. It was Aristotle's view that happiness was the ultimate purpose of human existence, and to lead a virtuous life and do what is worth doing. This is the exercise of virtue.

It is also important to distinguish between pleasure and happiness. Pleasure relies on external stimuli, which is why it is transitory, whereas happiness comes from within.

Professional mood

Our surveys suggest that our profession is not happy.[1] Professional morale – how people are feeling as a collective whole – is low, work-related stress levels are high, and burnout is a growing concern.

The British Dental Association (BDA) reported that almost half of dentists surveyed experience burnout, and more than one in three reported symptoms of depression. The most stressful aspects are shown in Figure 1.

In contrast, people who report higher levels of happiness find their work satisfying, less stressful, and enjoyable. They are less likely to make mistakes, are characterised by a growth mindset, and are also likely to be more successful. The quest for happiness should therefore remain a high priority.

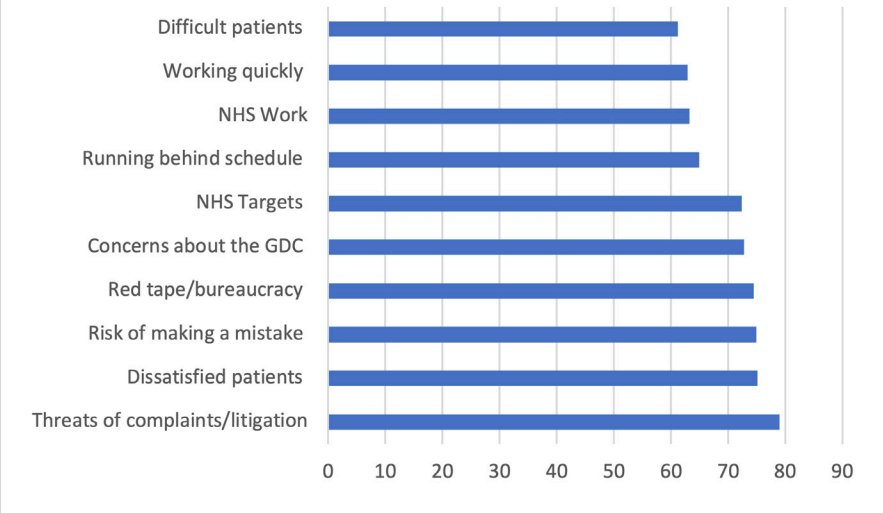


Figure 1: Reasons for stress (UK data)

Science of happiness

The science of happiness is the study of the factors that contribute to wellbeing. It is a relatively new field of research that focuses on the biological/chemical processes that contribute to feelings of wellbeing and happiness.

The psychological, social, and biological factors that contribute to wellbeing include positive emotions and experiences, a sense of purpose and meaning in life, a sense of self-worth and autonomy, and control of one's life.

The chemicals and neurotransmitters that affect mood and happiness include:

Serotonin – mood regulation and positive emotions.

Dopamine – motivation, pleasure, and reward

Endorphins – pain relief and positive emotions – so called 'feel-good' chemicals.

Oxytocin – associated with social bonding and positive emotions.

Physical and environmental factors such as sunlight, exercise, and diet also affect neurotransmitter levels, which determine our mood and happiness. Additionally, researchers have identified some personality traits that are associated with greater happiness such as extroversion, conscientiousness, and emotional stability. It is a complex area of research, details of which are beyond the scope of this article.

Measuring subjective happiness

The Subjective Happiness Scale (SHS) was one of the first developed by Lyubomirsky and Lepper to measure subjective happiness.[2] It is short and reliable, and consists of four items indicating the degree of happiness scored on a 7-point Likert scale.

The SHS is a 4-item measure (Table 1) that asks respondents first to rate on 7-point Likert-type scales how generally happy they are (1 = not a very happy person, 7 = a very happy person) and how happy they are relative to their peers (1 = less happy, 7 = happier). The remaining two questions require participants to indicate the extent to which a description of a "very happy" and a "very unhappy" person, respectively, characterises them (1 = not at all, 7 = a great deal).

To score the SHS, the values from the first three items are scored between 1-7, while the fourth item is reverse scored (ie, 7 is turned into 1, 6 into 2, 5 into 3, 3 into 5, 2 into 6 and 1 into 7). Then the scores for all four items are added together and averaged, to give the final score.

Most people score between 4.5 and 5.5.

A formula

In their model of happiness, Lyubomirsky, Sheldon, and Schkade proposed a framework in which three factors contribute to people's sense of wellbeing and happiness.[3] They suggest that genetics account for approximately 50% of the happiness equation, circumstances for approximately 10%, and intentional or volitional activity for the remaining 40% (see Figure 2). The strong association between happiness and personality may limit volitional activity, because personality traits are fixed and unlikely to change.

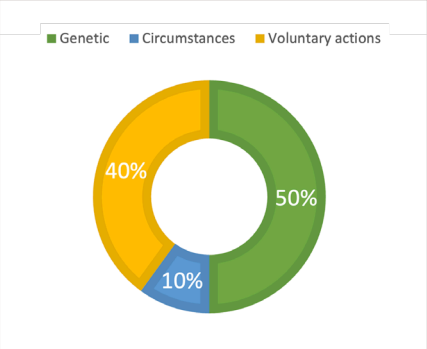


Figure 2: Determinants of happiness

Happiness is the sum of three factors. The formula that is often quoted is H = S + C + V where:

H stands for Happiness

S stands for Set Point (genetic predisposition)

C stands for Conditions of living, and

V stands for Voluntary actions and activities.

The key message in this model is that by focusing on the voluntary 40% a person can significantly improve their happiness. It is not that simple though because the three factors are not independent and exert an influence on each other.

Table 1: The SHS scale

In general, I consider myself ...	Not a happy person						A very happy person
	1	2	3	4	5	6	7
Compared with my peers, I consider myself ...	Less happy						More happy
	1	2	3	4	5	6	7
Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this characterisation describe you?	Not at all						A great deal
	1	2	3	4	5	6	7
Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this characterisation describe you?	Not at all						A great deal
	1	2	3	4	5	6	7

The temptation is to accept this as a mathematical certainty when it is not.

In our member surveys, the 10% attributed to 'circumstances and conditions' seems a very low percentage. Our analysis of the responses to some questions would suggest that the true figure could be double or more than in the base formula. Sonja Lyubomirsky herself refers to the numbers as 'averages and approximations' in one of her presentations. In 2019, she reflected on her and her colleagues' earlier research and acknowledges that "the pie chart diagram appears to have outlived its usefulness". She suggests that volitional activities may influence happiness less than they thought – perhaps as low as 15% – and that "happiness can be successfully pursued, but it is not 'easy'".[4]

Policy makers have an important role to play when it comes to promoting happiness, particularly when it comes to the 'circumstances' element of the happiness formula. Much of the angst and stress reported by our members can be attributed to work conditions, targets, and clinical pressures – all of which are creations of policy makers or unintended consequences of failing systems. If we want to improve the professional mood and enjoy the benefits (for patients and practitioners alike), we must lessen the impact of the stressors.

In the first chapter of the 2023 World Happiness Report, it states: "Once happiness is accepted as the goal of government, this has other profound effects on institutional practices. Health, especially mental health, assumes even more priority, as does the quality of work, family life and community."[5]

Summary

Happiness, wellbeing, and the quality of professional life are closely related concepts. There is a positive relationship between happiness and altruistic behaviours where the wellbeing of the helper and the helped is improved. It has been shown that those who receive altruistic help are themselves more likely to help others. We need to be clear that feeling happy and being happy are not the same thing – there is a difference between a momentary level of happiness and the enduring level of happiness. In the words of Professor Lord Richard Layard: "By providing evidence of what's going to make a difference to people's happiness, then the policymakers can't make good policy." There is now ample evidence of what will make a difference to people's lives, and so the profession can be forgiven for saying "over to you" without it sounding like a dereliction of responsibility.

REFERENCES

1. Collin V, Toon M, O'Selmo E, Reynolds L, Whitehead P. A survey of stress, burnout, and well-being in UK dentists. Br Dent J. 2019; 226: 40-49.
2. Lyubomirsky, S., & Lepper, H. A measure of subjective happiness: Preliminary reliability and construct validation. Social Indicators Research. 1999;46, 137-155.
3. Lyubomirsky S, Sheldon KM & Schkade D. Pursuing happiness: The architecture of sustainable change. Review of General Psychology. 2005; 9(2): 111131.
4. Sheldon KM, Lyubomirsky S. Revisiting the sustainable happiness model and pie chart: can happiness be successfully pursued? The Journal of Positive Psychology. 2019; 1743-9779.
5. Helliwell, J. F., Layard, R., Sachs, J. D., Aknin, L. B., De Neve, J.-E., & Wang, S. (Eds.). World Happiness Report 2023 (11th ed.). Sustainable Development Solutions Network, 2023.

FURTHER READING

Layard R, De Neve J-E. Wellbeing: Science and Policy. Cambridge: Cambridge University Press; 2023.

Ethical fingerprints

***Dr Martin Foster,** Dentolegal Consultant at Dental Protection, looks at how ethics shape the traces dental practitioners leave in their patient care*

We leave traces on the things we touch. As a result of a range of popular television crime dramas, we are no strangers to the concept of fingerprint identification as a means of establishing who was where and what they did.

Fingerprinting has a surprisingly long history. The Ancient Babylonians recorded in clay the 'prints' of arrested felons. In the modern era, from the 1890s, fingerprints have been used in evidence to tie an individual to a place or an action. Interestingly, one of the first cases that used fingerprint evidence, that of Henri Scheffer in France in 1902, involved a murder on the premises of a dentist. The point is, the marks we leave can cause us trouble.

Our 'ethical fingerprints' also leave marks on what we touch. As well as for us as individuals, they can cause trouble for our patients too.

What are 'ethics'?

'Ethics' can be thought of as the framework of principles accepted by an individual or a group as guiding acceptable, expected conduct. It is a complex area involving the concepts of conscience, belief systems, right and wrong, and codes of behaviour. We may do our best to behave ethically, but we are all human. Sometimes people do the 'wrong' thing through self-interest, convenience, pressure, or succumbing to temptation. Circumstances can also lead to an individual doing a bad thing but for what seems like a good reason. We have all seen (and enjoyed) films where the 'baddies' get their comeuppance as a result of the 'goodie' doing something that is not merely ethically questionable but is just downright bad – but somehow, we don't mind this because it seems ok in the circumstances.

So, it is possible to recognise something as 'bad', while at the same time excusing or even condoning it. From this, it is not too much of a stretch to suggest that given the right circumstances we are all capable of straying? Is it more moral to observe the rules or to help a loved one in need? This is the stuff of ethical dilemmas that often involve choices that are not simple.

Whose interests matter most?

In clinical practice, there is an expectation that we put our patients' best interests first, but does that mean sacrificing our own? As a business, a practice needs to stay solvent, and it is in nobody's interests if the practice is not run in a sustainable fashion. Dentistry straddles a tricky fault line. There is a need to combine effective healthcare with commercially efficient operating. The demands of these two potentially conflicting drivers can create an intense ethical pressure on the clinician.

In the commercial field, goods and services can be thought of as falling into three categories: search, experience, and credence.

'Search' purchases are those where a consumer makes the purchase based upon the known usefulness of the item (eg a car or a kettle). 'Experience' purchases are, as the name suggests, based upon previous knowledge and exposure to that good or service (eg a meal or hair appointment). 'Credence' purchases are where the consumer has limited understanding of the details or benefit of what is recommended and has to rely upon the advice of the technical expert. The information asymmetry makes the consumer reliant upon trusting the expert.

This may be good for the expert, but with such settings there is the risk of temptation to provide less than ideal recommendations. A faulty computer, for example, might not need quite as much work as has been suggested, and the consumer is at the mercy of the integrity of the provider.

Knowledge is power

In the dental setting, it can sometimes manifest as either under-treatment where the patient really requires an intervention that is complex, time-consuming, or technically challenging, but only receives much simpler treatment, or over-treatment where the intervention suggested is more than the situation really warrants.

Where one party has the upper hand in terms of information, there can be a temptation to act in his or her own interest. A practitioner keeping a business afloat can be torn between putting patient interests first and the demands of running a business successfully. There can be a conflict between the interests of the parties, which needs to be recognised.

There are distorting factors at play in ethical decision-making. These can include imperatives to hit certain targets, to upsell, to increase throughput, or to concentrate on high value treatments. Working at a loss will obviously be unsustainable for any business, but commercial viability should not come at the cost of ethical sacrifice, as there are risks for both patients and clinicians.

One risk is from raised expectations and the patient not having the full picture regarding options. Credence involves trust, and the information asymmetry mentioned above can create circumstances where patient choice can be distorted.

The public is hugely influenced by advertising and marketing. There are ever-increasing expectations around aesthetic dentistry. Some patients feel this will have transformative effects and improve not just their smile, but their opportunities, life choices and popularity. Impressive as your dentistry might be, meeting these sorts of aims is a bit of a tall order. Although you may not want to deflate their dreams, it is important to manage patient expectations with very clear communications. What we know is that failure in communication is a predominant factor in the vast majority of dental complaints and claims.

A particular risk from the demands brought to the practice by patients is that of patient-led care with a focus on high value treatment. With a willing consumer, the provider of credence purchases can easily, and inadvertently, move into the realm of over-selling, over-promising, and over-treatment. The combination of wanting to accommodate a patient's wishes, stretching our technical skills, and needing to pay the bills can be a powerful mix. It can lead to going along with, or even encouraging, unwise patient choices. The result can be beautifully executed overtreatment or a 'disappointment gap' between expectation and delivery. Dentists are subject to the realities of business, but need active ethical awareness to eliminate behavioural bias and be aware of hidden temptations.

How does a clinician keep their fingerprints 'ethical'?

Start by asking yourself what is driving a clinical decision. Is it clinical need? The patient? You? The practice? Or is it financial pressures? Are expectations realistic in terms of treatment outcomes, comparative benefits, and your own abilities? Is what is proposed a good thing, being done for the right reason, and the best option for this patient at this time?

When discussing treatment, stop to consider if the advice presented is accurate and fair, if alternatives, risks, and benefits have been presented clearly and that you are satisfied that what is proposed is within your ability, is in the best interests of the patient, and is what you would want for yourself.

Our ethical fingerprints reflect our behaviour and choices. Behaviour is susceptible to the pressure of circumstances and none of us is immune to temptation. The risk of our decisions being distorted by various pressures can be reduced simply by recognising this.

Short-term orthodontics

***Dr Richard Hartley**, Dentolegal Consultant at Dental Protection, looks at the considerations for any practitioner who might undertake short-term orthodontics*

Short-term orthodontics (STO) is becoming increasingly popular with adult patients, driven by factors such as social media and advertising. Where once adults were reluctant to embark on a course of orthodontic treatment, STO, particularly using aligners can offer a more aesthetic treatment option than conventional fixed orthodontics with the promise that it can be completed in a relatively short period of time, and with the added convenience of treatment being provided by a general dental practitioner (GDP).

Dentists are of course keen to satisfy this demand from patients although there are a number of factors to take into account when contemplating offering a course of STO, and there are potential difficulties for a GDP in providing treatment for which they have no formal specialist orthodontic training which they need to be live to before embarking on patient care.

These can include:

- Poor case selection can occur as a result of a lack of detailed knowledge on how the particular systems work and their limitations. This can be an issue when training has been undertaken in only one STO system and that training may be limited, sometimes comprising only one day. The providers of the training will naturally want to extol the virtues of that particular system and may underestimate their limitations; in addition, there may be other systems that would be better suited to a particular clinical scenario but which the dentist will have no knowledge of, having not been exposed to that modality through their training.
- Orthodontic assessment and diagnosis. STO, despite the commercial aspects and promise of a swift outcome, is of course still orthodontic treatment and as such a full orthodontic assessment and diagnosis should be undertaken at the outset. Often in cases Dental Protection assists with there is very limited documentation of the orthodontic assessment, leading to difficulties in defending the actions taken, and treatment provided. It is very easy for an expert appointed to review the treatment provided to identify early short comings, and how they flowed on to a poor outcome for the patient.
- Treatment planning and the ability to envisage the end result and any potential future problems, such as achieving a stable end point. Further, if the treatment does not go as anticipated, the practitioner may not have other treatment modalities better suited to achieve the desired outcome, such as fixed appliances at their fingertips.
- The consent process, which should include offering alternative treatment options, for example, referral to an orthodontist specialist. While often discussed, this is rarely documented, again, making the practitioner an easy target for a critical third party.
- Failure to identify and then manage patient expectations. The type of patient who may be seeking a cosmetic form of treatment such as STO may have high expectations that are difficult to manage. These patients often present as a new patient drawn to your practice because you offer STO. This means that you have not had the opportunity to build up a professional relationship beforehand, as you have with your regular patients. This can lead to issues surrounding compliance as you have no prior knowledge of the patient's motivation, attitude to treatment, and attendance pattern. Given that STO and subsequent retention require significant compliance this lack of prior knowledge can lead to problems.
- Retention: in the rush to embark on STO treatment patients can underestimate the retention process, leading to a nasty surprise for them at treatment end.

Many of the cases Dental Protection are asked to assist with are difficult to defend due to vulnerabilities relating to one or more of the factors outlined above, with the most common issues relating to consent and retention. By way of resolution patients will often seek financial recompense as STO involves a significant financial outlay, so that they can embark on a further corrective course of orthodontics. This can bring further issues such as the risk of root resorption from repeated tooth movement, and further financial and time commitment for the patient.

The best protection we can give ourselves, and our patients, as GDPs is to take the time to recognise when patients are not suitable for STO, including when their treatment needs are beyond our clinical capability to avoid getting into difficulty. While STO can be a great practice take care not to embark on treatment that may be beyond your knowledge and skills, or on a patient you can never please.

Diagnostic errors: three case studies

***Dr Nuala Carney**, Dentolegal Consultant at Dental Protection, looks at three cases involving diagnostic errors, all with very different outcomes*

Case 1

"I think I have a wisdom tooth problem..."

A 27-year-old patient attended her practice complaining of discomfort around her lower right wisdom tooth (48). She had had recurrent bouts of pericoronitis in the past and wanted the tooth removed. She was planning to head off on a round-the-world trip in a month's time and wanted to have the issue dealt with before then. The practitioner took a periapical and agreed that it was suitable for him to remove, once the acute infection had settled. He prescribed antibiotics and booked her in for an appointment in ten days to extract the tooth.

On the day of the extraction the practitioner was running late and was very stressed. He went through the consent issues briefly, just mentioning the risks of lingual and labial paraesthesia and postoperative swelling and pain. The patient was not shown the radiograph or given any specific warnings in relation to her tooth.

The extraction turned out to be much more difficult than anticipated and although there seemed to be some movement from the tooth, it just would not deliver. Finally, after 45 minutes of struggling, there was a popping sound and the tooth finally came out, much to everyone's relief. The dentist packed the socket and stitched it, and prescribed some antibiotics and painkillers. He warned the patient that there might be some swelling and pain for a few days, which would then settle. He wrote some very brief notes and got on with his day – now well behind schedule.

The patient returned later that week with severe pain in the area of the extraction. The dentist who had seen her originally was not working that day and his colleague reviewed the notes and diagnosed a dry socket. He explained what the problem was, irrigated the area and prescribed stronger pain killers. He explained it usually takes seven to ten days for dry sockets to settle and so reassured her that she should be fine in a few more days, and that there was no risk to her long-distance flights abroad, now two weeks away.

Unfortunately the pain did not settle, and by later the following week the patient returned, now very distressed and angry. She saw the original dentist, who reviewed the area and confirmed that there was still a dry socket. He apologised for the complication, irrigated the area and replaced the dressing, and prescribed further antibiotics. The patient was not reassured however and decided to seek an opinion from a local oral surgeon, as her trip was now imminent. The oral surgeon took a radiograph and confirmed that the curved tip of the distal root was in fact retained and that this was probably the cause of the non-healing socket. He advised her that it could be removed but it would require a GA and could only be done when the acute infection had settled and a GA slot was obtained for her.

This was subsequently arranged for three weeks' time in a local private hospital, involving an overnight stay, and the surgeon removed the troublesome root tip. Healing then took place without any further complications. However, at this point the patient had had to completely rearrange her travel plans, including flights and accommodation for the first month of her trip. A claim was subsequently received by the dentist. His notes proved to be sparse, with no evidence of adequate warnings or consent and a poor quality radiograph that did not show the full extent of the roots. The matter had to be settled on his behalf for a considerable amount.

Learning points

- Tight timeframes: be wary of carrying out any treatments that may have a risk of postoperative complications or not reaching the patient's expectations where there is a tight timeframe, such as an impending holiday or wedding. If treatment is absolutely necessary, make sure that the patient is fully informed of the risks and challenges that may arise and allow them time to review whether they wish to proceed or change their plans.
- Radiographs and consent: make sure that the radiographs you take are of diagnostic quality and provide the full information needed to plan the treatment appropriately. Consent needs to be tailored to the specific risks for the patient and treatment involved.
- Confirmation bias: if a patient presents with a postoperative complication or emergency, don't rely on the previous recent notes for a diagnosis – ensure you take other potential causes into consideration.

Case 2

Which tooth?

Dental Protection commonly receives complaints from patients who have presented with pain in a tooth, but the dentist cannot identify which tooth is the cause of the problem. This can be extremely frustrating for both the dentist and the patient. Patients will sometimes try and put great pressure on the dentist to intervene with irreversible treatment, against the dentist's better judgement – which can later come back to haunt them.

A patient presented with severe pain in the upper right anterior region. He had a habit of bruxism and was not diligent about wearing his nightguard; he also had a very stressful job on television and was frequently in the public eye. Having carried out a thorough clinical examination the dentist identified that the 12 was not responding to electric pulp tests and the canal appeared to be sclerosed. The other anterior teeth were all heavily restored and worn down. Both the upper right premolars were very sensitive to cold and had large amalgams.

The patient was insistent that the pain came from the anterior region around his lip. He was aggressive and short tempered due to the pain and the dentist felt under significant pressure to "sort it out". Having explained that she was not 100% sure of the diagnosis, the dentist agreed that she would start a root treatment on the 12, which seemed the most likely culprit. She suggested trying to carry out a test cavity without anaesthetic – which the patient flatly refused. Accessing the canal was extremely difficult and the appointment ran well over time, causing the dentist to be even more stressed. She managed to negotiate the canal to the apex and placed some calcium hydroxide and sealed the tooth.

Four days later the patient returned, saying that he had not slept in four days and was utterly frustrated that the pain was worse than ever. Still unable to localise the pain, the dentist decided a second opinion was needed and rang a local endodontist, with whom she had a longstanding relationship. The patient was given an urgent appointment the following day. The endodontist repeated all the tests on all the upper teeth and carried out a CBCT scan. She noted a radiolucency of the palatal aspect of 14 and explained to the patient that she was of the opinion there was a crack on this tooth. The large restoration was removed and a crack confirmed. She carried out a pulpectomy in order to relieve the symptoms, which settled almost immediately, and a plan was made to extract the tooth and replace it with an implant.

The dentist subsequently received a letter of complaint from the patient seeking the cost of the root canal treatment to be refunded, and the cost of the post crown which was now required, to be covered by the dentist.

Having reviewed the records carefully, we identified that the dentist was vulnerable because insufficient testing with heat/cold, EPT or probing had been carried out on the premolars, which would likely have picked up the crack at an earlier stage. Although it is unusual for referred pain to move forward two teeth, clinicians must always be conscious of the fact that pain can be referred anywhere along the maxillary and mandibular divisions of the trigeminal nerve, and that other causes, such as trigeminal neuralgia, might be causing acute pain.

If the clinical signs and symptoms do not add up, it is wiser to either inform the patient that you are not able to make an accurate diagnosis and need the problem to localise so that your diagnosis is supported by evidence – or seek a second opinion urgently. It was agreed with the patient that the cost of the remedial treatment required on the 12 would be provided at no cost and no charge was made for the root canal treatment. The patient accepted this as a gesture of goodwill, recognising that the dentist had carried out the treatment in difficult conditions.

Learning points

- Carrying out a thorough examination and special tests of all teeth is essential when trying to pinpoint the cause of potential pulpitis.
- Ensure that the results and evidence of all these tests are clearly recorded.
- If the evidence is not making sense and confirming the diagnosis, refrain from carrying out irreversible treatment until you have evidence to back up your decision-making.
- Refer for a second opinion if the clinical picture remains unclear – a second pair of eyes, different experience and second brain are always helpful.

Case 3

Missed CA

Sadly, we occasionally receive claims for malignancies that the patient feels should have been picked up earlier. This might have avoided significant surgery. These are always complex cases, leaving both the patient and often the dentist, devastated by what has happened.

A patient, a smoker, was having a new chrome cobalt lower denture made with his dentist because he was complaining of irritation from the old, poorly fitting, acrylic one. The denture replaced 35 36, 45 and 46. Following a successful try-in, the new denture was fitted. The patient returned several times complaining of irritation of the tongue on one side. The dentist could see nothing obvious and trimmed the lingual cusps of the acrylic teeth and polished them.

Four months later the patient returned, now complaining of an ulcer on his tongue, which he thought had been there for about two weeks. It appeared to be traumatic and the dentist wondered if he was catching his tongue when chewing or at night, as the patient admitted he was not taking his denture out at night. He advised the patient to leave the denture out, if possible, for three weeks and return at that point if it had not completely healed. He took photographs and measured the lesion. He warned that if it was not gone, he would be referring him for a biopsy to check that nothing more sinister was going on. He made it clear that non-healing ulcers need to be followed up and gave the patient an appointment for three weeks' time.

The patient failed to attend the appointment and efforts to contact him were unsuccessful. The practice made multiple phone calls, which were recorded in the notes, and sent two emails.

The dentist received a solicitor's letter two years' later explaining that the patient had subsequently developed squamous cell carcinoma of the tongue, which had been diagnosed the following year in another part of the country. He had had a radical neck dissection. The records were sought from our member. The member rang and sought our advice.

When the records were reviewed by our dentolegal team, it was clear that the dentist had managed the appearance of the ulcer appropriately and had done everything possible to follow up. There was clear evidence that he had warned the patient of the potential dangers of a non-healing ulcer and had made a definitive appointment to follow this up. When the patient did not attend, the practice went to considerable lengths to contact the patient, all unsuccessful. The dentist had therefore satisfied his professional responsibilities and the fault lay with the patient for not having followed up when the ulcer did not heal. We were able to write a strong letter in the member's defence, showing exactly what clinical evidence had been gathered, the advice given to the patient and the failure on his part to follow up as advised. The solicitors did not pursue the matter.

Sadly, there are sometimes cases where the advice given to the patient is unclear, and the lesion is not followed up due to communication or administration errors. Unfortunately, in these cases, the patient may be able to show that the dentist failed in his duty of care to the patient and that this directly led to a worsening of the prognosis due to the delay in diagnosis. These cases can lead to long, drawn-out and expensive legal claims.

Learning points

- With any suspect lesion, take a careful history and explain risk factors clearly to the patient.
- Document the lesion carefully: take photos if necessary and measure it. Check carefully for nodal involvement.
- Clearly explain the risks that might eventuate if the lesion is not carefully followed up, and document this. Give the patient a definite appointment for review according to the relevant guidelines.
- Make sure the team is aware that if the patient cancels this appointment or fails to attend that another appointment must be given, or the patient contacted to arrange follow up.
- Keep a careful record of all phone calls made and letters sent trying to re-establish contact with the patient.

Case study

Cosmetic expectations not met

*By **Dr Richard Hartley**, Dentolegal Consultant, Dental Protection*

A 65-year-old lady attended the dentist as she was unhappy with the appearance of her upper anterior teeth, given they were no longer as visible when she smiled. On examination it was noted that the upper six anterior teeth were veneered; the patient advised that they had been in situ for 17 years.

The dentist was keen to improve the situation for her and offered to replace the veneers with longer ones, although he advised he would also need to replace the lower partial denture in order to create some inter-occlusal space and stabilise the posterior support. Radiographs showed that the upper anterior teeth had approximately 25% horizontal bone loss, although the periodontal status was stable and oral hygiene good.

The patient agreed and the treatment proceeded without incident; the patient was pleased with the outcome. Unfortunately, the veneers on both upper laterals fractured after two weeks and the dentist replaced all six veneers, as the patient then decided she wanted them slightly longer and a lighter shade.

The veneers were fitted and the patient was delighted with the appearance, although she returned after one month as the veneer on the upper left lateral had fractured and the tooth was now slightly mobile. A periapical radiograph showed no pathology or fracture, so the dentist replaced the veneer and advised the patient that he would provide her with a bite guard to wear at night while the lower denture was removed. Before this could be fitted the patient lost confidence and attended another practice for a second opinion, where it was identified that the upper left lateral incisor was Grade II mobile and likely to be lost, that the veneers on all upper incisors had an unfavourable crown to root ratio and there were occlusal interferences on lateral and protrusive excursion.

The patient then put in a formal complaint, stating that she would never have agreed to the treatment had she been made aware of the possible consequences. She said she would have been happy simply to accept the lower lip line, as her new dentist had explained that it was a natural consequence of ageing.

How Dental Protection assisted

The dentist contacted Dental Protection, admitting that although he was very experienced, he had perhaps been persuaded by the patient's enthusiasm to provide treatment that was inappropriate. He accepted that his initial assessment and treatment planning was less than ideal as he had failed to carry out a full occlusal assessment, or considered articulated study models or a wax-up to assist in diagnosis and treatment planning.

With Dental Protection's assistance he was able to cover the cost of a referral to a specialist prosthodontist for remedial treatment, which satisfied the patient.

The dentist acknowledged that the lack of initial assessment and planning had compromised the consent process, and subsequently carried out targeted professional development.

Learning points

Cosmetic cases such as this can often present challenges, both technically and in relation to managing patient expectations. The following points are essential:

- Take care when managing the patient's expectations to avoid making statements that cannot be substantiated.
- Ensure that the patient has all the relevant information so that they can make an informed decision to consent to treatment.
- If things don't go to plan then step back and take stock to identify what may be happening so the same errors aren't repeated. As the old adage goes, if you are in a hole, stop digging!
- Only carry out a task or type of treatment, or make decisions about a patient's care, if you are sure that you have the necessary skills and are appropriately trained, competent and indemnified.

Case study

A near miss

*By **Dr Martin Valt**,*
Dentolegal Consultant, Dental Protection

Mrs C presented to a specialist in oral surgery, Dr W, having been referred by her general dental practitioner. The referral correspondence requested that her painful 47 be extracted under local analgesia with the adjunct of intravenous sedation, as Mrs C was somewhat apprehensive about undergoing the procedure.

Clinical examination revealed two standing molars in the lower right quadrant, and the OPG radiograph supplied by the referring dentist confirmed extensive recurrent caries in both these teeth. While no acute symptoms were reported at the time of this assessment, Dr W was able to identify a diffuse periapical radiolucency associated with the more distal of the two molars and accordingly ascribed Mrs C's historic symptoms to a periapical periodontitis associated with this tooth.

On this basis he was entirely satisfied that removal of this tooth was in accordance with Mrs C's best interests and outlined a number of potential risks and postoperative complications associated with doing so for her as part of the consenting procedure. The sedation process was similarly explained in considerable detail and a consent form duly completed.

When Mrs C returned to the practice reception area to arrange the appointment, she told her husband, who had been waiting there for her, that Dr W was planning to take out her "back tooth". It transpired that her husband was a retired dental technician, who was immediately concerned that the tooth which had apparently been scheduled for extraction was not that which had previously caused his wife a considerable degree of intermittent discomfort.

Mr and Mrs C were accordingly invited back into Dr W's surgery, where the former was able to explain his concerns. On reflection, Dr W was happy to acknowledge that, while he had simply assumed that the two standing molars were 46 and 47, they could equally have been charted by the referring practitioner as 47 and 48. Were this to have been the case, then 47 would have been the more anterior or mesial of the two teeth, rather than the more distal.

This distinction was not readily apparent in the referral correspondence. Given especially that Mrs C would have been sedated throughout the procedure, it is unlikely that she would have been aware of which tooth was being extracted until after the event. An incorrect tooth would therefore have been unwittingly extracted had it not been for the fortuitous intervention of a third party. A brief telephone discussion with the referring dentist clarified that Mrs C's symptoms had been those of a reversible pulpitis associated with the more mesial of her two lower right molars, and that he had indeed charted this as 47. An amended treatment plan was drawn up and Dr W subsequently removed the correct tooth without further incident.

Practitioners who undertake treatment on referral are unlikely to have significant personal familiarity with any given patient's dental history. It is therefore of the utmost importance that they ensure from the outset that they are entirely clear about the treatment that has been requested and that this correlates with the patient's understanding of the situation. Should any potential discrepancies come to light, these should be addressed with the referring dentist prior to proceeding. It is of course similarly incumbent on referring practitioners to ensure that the treatment is requested in unequivocal terms. In this particular instance, confusion could have been avoided by making it absolutely clear that the two molars had been charted as 48 and 47. Alternatively, a more descriptive request for the "most anterior/mesial" of the two standing lower right molars to be extracted would presumably also have proved entirely unambiguous.

Case study

A failure to refer

*By **Dr Martin Valt**, Dentolegal Consultant, Dental Protection*

Mrs A presented to general dental practitioner Dr Y as a new patient, reporting an increasing degree of intermittent discomfort emanating from her upper left quadrant. Clinical and radiographic examination revealed a fractured and grossly carious 18, which was self-evidently beyond restoration.

Dr Y accordingly diagnosed a reversible pulpitis and recommended the extraction of 18, to which Mrs A promptly agreed. Unfortunately, a root apex of 18 fractured during the extraction procedure and, despite his best attempts, Dr Y was unable to retrieve this. He advised Mrs A of this complication and made the necessary arrangements for her to attend a specialist in oral surgery for the root apex to be removed. Mrs A indicated that she would prefer to be referred on a private basis with a view to this remedial treatment being undertaken as promptly as possible.

While the surgical procedure was completed successfully and relatively uneventfully, Dr Y subsequently received a written complaint from Mrs A, requesting that he cover the specialist's fees on her behalf. Dr Y was initially reluctant to do so, on the basis that the root fracture could not reasonably have been predicted and/or avoided, and that Mrs A had in any event declined the option of being referred to a specialist colleague for the surgical extraction of the retained 18 root fragment.

Dental Protection's advice was sought, and it was in the first instance acknowledged that 18 was unrestorable on presentation. Dr Y's advice that it should be extracted was therefore perfectly appropriate and entirely in accordance with Mrs A's best interests. That being said, the pre-extraction radiograph also demonstrated a potentially intimate anatomical relationship between the 18 root apices and the floor of the maxillary antrum, which in turn clearly increased the likelihood of a complication arising.

While the clinical records certainly demonstrated Dr Y having informed Mrs A of this, these were unfortunately not supportive of him having offered or considered the option of her being referred to an oral surgeon from the outset. Dental Protection accordingly advised Dr Y that it could be successfully argued that Mrs A was not provided with sufficient information and/or options to enable her to give valid consent to him extracting 18. This would amount to what is known in law as a breach of duty of care on the part of Dr Y.

Similarly, while fracturing the root apex during the attempted extraction of 18 did not necessarily amount to a breach of duty of care per se, it transpired on closer investigation that Dr Y had attempted to remove the fractured apex prior to exposing a further radiograph. The image that was eventually obtained demonstrates this apex to have been either displaced into the antrum proper, so to speak, or to have been 'trapped' between the hard tissue wall of the antrum and its epithelial lining. Either way, it was evident that a bona fide surgical procedure was always going to be required to facilitate its removal.

While hindsight remains the most precise of all the biological sciences, a solicitor would nevertheless once again almost certainly be able to successfully argue that Mrs A's best interests would have been served by Dr Y simply postponing the extraction at the point of fracture and instead referring her immediately to an oral surgeon, rather than attempting to remove the root apex himself.

If either, or both, of these breaches of duty of care could in turn be demonstrated to have caused loss or harm to Mrs A, which they self-evidently did, she would then be entitled to recover compensation. Likewise, in the event of a regulatory challenge arising instead of, or possibly even alongside, a claim for compensation, one might reasonably speculate that the regulator would be somewhat critical of both the consenting procedure adopted in this instance and Dr Y's first line management of the complication of the 18 extraction.

With all this in mind, Dental Protection advised Dr Y that his professional position would be best protected by making every reasonable attempt to secure amicable resolution of Mrs A's complaint at local level, with a view to bringing the matter to a prompt close and, given his potential professional vulnerabilities, reducing the likelihood of it being escalated into another forum.

Dental Protection was able to assist Dr Y in preparing a suitably conciliatory response and covering the oral surgeon's fees on Mrs A's behalf as a gesture of goodwill. The latter was happy to accept Dr Y's explanation, apology and financial contribution as a means of resolving the complaint to her satisfaction.

This case illustrates the importance of considering (and documenting) the option of offering a referral to a specialist colleague as part of the consenting process whenever a substantial potential risk or complication associated with the proposed treatment has been identified. It is not generally sufficient to simply warn the patient of such a risk, but to omit to offer an available means by which it might be minimised or at least reduced.

It is similarly important to remain mindful that, should an unanticipated complication arise, the vast majority of dental procedures can generally be safely brought to a halt and the clinical situation stabilised on an interim basis to permit specialist input to be sought. It is rarely necessary, or indeed in the patient's best interests, for the dentist to simply press on regardless, irrespective of however well-intentioned such an approach might be, as to do so may inadvertently exacerbate the clinical situation and also render a subsequent professional challenge more likely.

Case study

A post-extraction infection

*By **Dr Martin Valt**, Dentolegal Consultant, Dental Protection*

Mr B presented to general dental practitioner Dr Z at an emergency dental clinic reporting pain and extra-oral swelling associated with his lower left quadrant. These symptoms had apparently been present for ten days or more, but his condition had significantly deteriorated over the course of the immediately preceding 48 hours.

Analgesics were no longer proving effective, and a degree of trismus had also developed. While the latter rendered clinical examination somewhat challenging, Dr Z was able to identify both 37 and 38 as being grossly carious and clearly beyond restoration. Mr B requested that both teeth be removed immediately. No radiographs were taken, with Dr Z relying on an OPG taken two years previously to assess the proximity of the 38 to the inferior alveolar nerve.

Despite the extra-oral swelling having been documented in the clinical records as "moderate to severe" and the inter-incisal opening apparently having been restricted to no more than 15mm, Dr Z nevertheless considered that he had been able to successfully extract both 37 and 38 under local analgesia, and accordingly discharged Mr B from his care following the appointment.

While Mr B did not attend or contact the clinic again, a written request for a copy of his clinical records from a solicitor acting on his behalf was received approximately six weeks later. The solicitor also intimated the possibility of a claim for compensation being pursued as being under investigation. It transpired that Mr B had subsequently been admitted to hospital for emergency care two days following the extractions due to increasing facial swelling and difficulty in breathing.

When the hospital records were made available to Dental Protection, these confirmed that, following the intravenous administration of a course of antibiotics, surgical drainage of the left submandibular and parapharyngeal tissue spaces under general anaesthesia had proved necessary, along with transalveolar removal of what appeared to be a retained portion of the distal root of 38. Mr B was discharged from hospital one week later.

Dr Z's clinical records were unfortunately extremely sparse. While it might perhaps be considered self-evident that the source of Mr B's symptoms was an acute periapical periodontitis at 37 and/or 38, this was not documented. Of far greater significance, these records were not supportive of Mr B having been warned of the possibility of any postoperative complications, particularly that of a spreading cellulitis and/or breathing issues, arising following the extraction of one, or possibly two, acutely infected teeth under local analgesia in the presence of pre-existing facial swelling and trismus.

No alternative treatment approaches, including that of being referred to an oral or oral and maxillofacial surgeon for hospital management from the outset, along with their associated relative benefits and risks, were recorded as having been offered or even considered. Similarly, no consideration appeared to have been given to the provision of a systemic antibiotic or to any aftercare or follow-up arrangements.

Dental Protection was accordingly required to advise Dr Z that each of the above oversights or omissions amounted to breaches of duty of care. In particular, in the absence of sufficient information having been disclosed to Mr B concerning the potential risk of complications arising out of the proposed treatment and/or any discussion of alternative treatment approaches, his solicitor would without question be able to successfully argue that Mr B was never in a position to give his valid consent to Dr Z undertaking the extractions of 37 and 38 at the appointment in question, despite him having requested that these be carried out immediately.

Beyond this, it was also considered that a suitable preoperative radiograph should have been exposed such that Dr Z would have been better placed to properly assess the likely complexity of the extractions, as the tooth had changed since the previous image. Failure to have done so in this instance amounted to a further breach of duty of care, and it would almost certainly be argued that, had he done so then, at least on the balance of probabilities, the retained root fragment at 38 would not have been overlooked.

Given the loss or harm which Mr B had clearly experienced from these breaches of duty of care on the part of Dr Z, it was considered that it would not be possible to successfully defend the proposed claim for compensation. It was therefore necessary for Dental Protection to settle the claim without admission of liability on Dr Z's behalf with respect to Mr B's lost earnings while being treated in hospital and also for a period of avoidable pain, suffering and so-called general loss of amenity.

This case illustrates the fundamental requirement to not only identify any potential complications associated with proposed treatment, but also to communicate these to the patient, along with the relative benefits and risks associated with any other feasible approaches. This information should be clearly documented in the clinical records. Without all this being in place, the dentist is simply not in a position to demonstrate having divulged sufficient information to enable the patient to give valid consent, should they subsequently be called on to do so. It is also of the utmost importance to appreciate that a patient simply requesting a particular treatment be undertaken at a given time does not in itself necessarily equate to them having provided valid consent.

Contacts

You can contact Dental Protection for assistance

Dentolegal advice

1800 444 542
notification@dpla.com.au

Membership enquiries

1800 444 542
membership@dpla.com.au

Calls may be recorded for monitoring and training purposes.

In the interests of confidentiality, please do not include information in any email that would allow a patient to be identified.

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