DDU Journal

Pulling power – when should a tooth be removed in general dental practice?

Bleaching, blisters and a lesson in note taking

Advice line dilemmas

Enclosed – DDU Education Support Supplement

†The Dental Defence Union is the specialist dental division of The Medical Defence Union Limited and references to the DDU and DDU membership mean the MDU and membership of the MDU.
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Changing times

This month sees a change in leadership at the MDU as Dr Christine Tomkins, until now deputy chief executive of the DDU’s parent organisation, MDU Services, takes over as chief executive with the retirement of the present incumbent Mike Saunders.

Mike has been at the helm of the MDU since 1995 and in this edition of the DDU Journal we reflect on the changes he has witnessed in the medico-legal environment (see page 7). There is no doubt many changes lie ahead too. One change the DDU certainly hopes to see soon is the introduction of mandatory professional indemnity insurance for all dental professionals, and we continue to campaign hard for this (see page 4). Another is the increasing use of new technology to help our members. Only recently we launched our first downloadable advisory podcast on our website (see page 10), and more of these are planned to follow.

As Christine Tomkins takes the helm of the MDU, you can be sure that she and all of us at the DDU remain 100 per cent committed to ensuring we provide the highest possible standard of service for all our members—whatever the challenges that lie ahead.

Also in this edition we include three pages of ‘Advice line dilemmas’, in which we share our responses to some of the typical calls we receive on our 24-hour freephone advisory helpline. Many of the calls we receive embrace problems, queries and sticky situations common to many dental professionals, so we thought it would be helpful to include them on a regular basis in your Journal. For example, in this edition, among other dilemmas, we consider working with NICE guidelines and the issues involved when dental nurses take part in oral health campaigns (see pages 13-15).

We know from feedback how popular the case studies that we publish are with members, and we hope ‘Advice line dilemmas’ will prove as informative, useful and enjoyable.

I hope you enjoy your Journal.

Rupert Hoppenbrouwers
head of the DDU and dental editor

Members’ benefits

A review of member benefits:

Professional indemnity
Insured professional indemnity — underwritten by SCOR Insurance (UK) Limited and International Insurance Company of Hannover Limited — for most paying members. Discretionary indemnity for student members.

Dento-legal advice
24-hour advice, guidance and support from our expert dento-legal teams.

DDU publications
Free dental advisory information.

DDU website
Access to members-only sections of the DDU site to read case studies and articles.

Online CPD
Practical risk management tools and advice.

Media
Expert media advice if you have to deal with a newspaper, TV or radio enquiry.

Book discounts*
Discounts on dental text books.

*The DDU always seeks to offer attractive benefits as part of membership and, from time to time, may add, withdraw or amend benefits at its discretion.
DDU calls for overhaul of UK’s ‘last century’ dental indemnity requirements

The DDU is campaigning on two fronts to make insurance mandatory for dental professionals, bringing dentistry in the UK into line with other developed European countries.

In most developed countries, practising dentists must have professional indemnity insurance. However, in the UK, while there is insurance there is also discretionary indemnity, which provides only the right for a dental professional to request assistance and have the request considered.

The DDU is the only dental defence organisation in the UK to provide its members with a contract of insurance for dental negligence claims up to £10 million as a benefit of membership.

Rupert Hoppenbrouwers, head of the DDU, said: ‘We cannot understand why the UK still allows unregulated indemnity. The UK has some of the most forward-thinking and technically advanced dental professionals in the EU but discretionary indemnity is distinctly last century.’

He added that the General Dental Council’s consultation, Requirement for professional indemnity for GDC registrants: issues and proposals, which closed in March 2009, presented an opportunity to resolve the anomaly. However, the GDC’s own proposals - for two lists of essential minimum requirements for adequate and appropriate indemnity, one for providers of insurance and one for providers of discretionary indemnity - were ‘fundamentally flawed, illogical and unworkable’.

He said: ‘If, in the interests of protecting patients, you set out minimum requirements for one type of provider, to ensure that patients will always receive appropriate compensation you must make the same requirements of other types of provider. In addition, there is an inherent contradiction in establishing minimum requirements for discretionary indemnity providers when they cannot agree to anything that would fetter their discretion.

We are disappointed the GDC has not seized the opportunity to bring dentistry into line with other healthcare providers, such as opticians and chiropractors, who have to have insurance, and that it has not followed the example of regulators in most other EU countries. For each dental professional to have the certainty that successful negligence claims will be paid under an insurance policy is indisputably in the interests of both patients and dental professionals. The case for insurance is strong and the DDU looks forward to proving it in our response to the consultation.’

The MDU, the DDU’s parent organisation, has also made a submission to the House of Lords Select Committee looking at a European Commission draft directive to safeguard patients’ rights in cross-border healthcare. The submission calls for the EU to ensure that insured professional indemnity is the way forward for dental professionals, doctors and patients in all EU member states.

Rupert said: ‘We hope that the European directive will be amended to ensure that indemnity must be provided only by the state or a regulated insurer. In the current volatile economic climate it is particularly important that professional indemnity is regulated as it provides a high degree of protection. Insurance offers a range of protection for policyholders and patients, including the Financial Ombudsman Service and the Financial Services Compensation Scheme. Discretionary indemnity has none of these safeguards.’

Data protection to be strengthened

Plans to increase the powers of the Information Commissioner’s Office (ICO) may affect dental professionals responsible for the protection of patient and other personal information.

The proposals, to regulate and enforce the Data Protection Act (DPA) 1998, were put forward by the Ministry of Justice last November. They follow a review of the use of information in the private and public sectors after a series of high-profile data losses. Dental professionals who hold personal information are considered data controllers under the DPA. The proposals, if introduced, will enable the ICO to:

• fine data controllers for deliberate or reckless loss of data.
• inspect central government departments and public authorities’ DPA compliance.
• require any person, where a warrant is being served, to provide information required to determine DPA compliance.
• impose a deadline and location for the provision of information necessary to assess compliance.
• publish guidance on when organisations should notify the ICO of breaches of the data protection principles.
• publish a statutory data-sharing code of practice.

The DDU will update members on how the changes may affect them when details become available.

DDU calls for overhaul of UK’s ‘last century’ dental indemnity requirements
NHS brand guidelines launched

Members who wish to use the NHS logo in practice literature or signage should be aware of new brand guidelines that cover the use of the NHS identity and govern where you can use the NHS logo.

The NHS brand guidelines were launched to ensure that the NHS brand is used consistently. They set out how the NHS logo and descriptor, ‘Providing NHS Dentistry’ can be used, including where it may be positioned, the type size, colour and font that can be used.

They make it clear that the NHS logo is a registered trademark and can only be used in accordance with the guidelines on the following materials:
• External signage
• Stationery
• Appointment cards

• Leaflets, posters and brochures.

They provide a range of examples to assist dentists when designing any of the above materials.

The logo, along with the full guidelines, can be downloaded from the website www.nhsidentity.nhs.uk/allguidelines/guidelines/dentists/introduction

Dentists are reminded they can only use the NHS logo and dentistry descriptor line on materials providing information solely on the NHS services they provide. They must also abide by the following do’s and don’ts:
• Never redraw the NHS logo artwork, change it in any way or attempt to create it yourself.
• Don’t use alternative colours to print the NHS logo or dentistry descriptor line.
• Don’t change the typefaces of either element.
• Don’t use any other arrangement of elements.
• Don’t create shapes or add lines around the elements.
• Always use the master artwork.

Dentists are advised that Primary Care Trusts will periodically review the use of the NHS identity within their NHS dental contract monitoring arrangements and that the NHS Counter Fraud Service will investigate cases of inappropriate use of the NHS identity.

Members can contact the NHS brand identity helpline on 020 7972 5250 or 020 7972 1501.

Members with dento-legal queries about practice literature can contact the DDU advisory helpline for information specific to their circumstances.

New minimum standards for Welsh private practice

Dentists who practise privately in Wales will need to register with a new regulatory body and adhere to minimum standards set out by the Welsh Assembly government.

Under the Private Dentistry (Wales) Regulations 2008, established under the Care Standards Act 2000, dental practitioners in Wales who provide any non-NHS dental treatment are required to register with Healthcare Inspectorate Wales (HIW).

The deadline for applications is 30 June 2009 for those already carrying out dental services before 1 January 2009. Those not practising in Wales before 1 January 2009 and who wish to provide private dental services after that date need to register with HIW before they provide any private dental treatment.

The registration fee is £50 and applications must be accompanied by a recent photograph. Other information that must be provided for registration includes:
• Professional experience and qualifications
• Details of two referees
• Evidence of inclusion on the General Dental Council’s (GDC’s) register or European Economic Area list of practitioners.
• An appropriate certificate of insurance.
• A birth certificate or passport.
• An enhanced Criminal Record Bureau (CRB) Certificate.
• A statement that the applicant will comply with the Private Dentistry (Wales) Regulations.
• A statement that the applicant is on a dental performers’ list.
• Details of any conditions on the applicant’s practice.

Applicants already on the NHS dental performers list are only obliged to provide their personal details, a statement of compliance with the Regulations, details of the performers list concerned and details of any conditions imposed on their practice. An enhanced CRB certificate is also required.

The new regulations set out minimum standards for quality of service provision. The National Minimum Standards for Private Dental Services commenced on 1 January 2009. The HIW will refer to them when making decisions about registration or enforcement action.

The standards echo the Healthcare Standards for Wales that already apply to NHS treatment and cover the same four domains: The Patient Experience, Clinical Outcomes, Healthcare Governance and Public Health. Many reinforce existing guidance from the GDC and other bodies.

HIW is currently developing a memoranda of understanding with the GDC and Dental Reference Service, and in future practitioners who fail to meet the HIW standards may also be referred to the GDC.

Further details about the new standards can be found on the DDU website, www.the-ddu.com The Private Dentistry (Wales) Regulations 2008 can be found at: www.wales.gov.uk
Hygienist and therapist subscriptions now include bleaching as standard

Dental hygienists and therapists performing tooth bleaching are now covered by the DDU, subject to providing us with details of their training.

The DDU’s decision to provide this indemnity insurance at no extra charge follows consideration of the General Dental Council’s announcement towards the end of last year that dental hygienists and therapists can carry out the procedure on the written treatment plan of a dentist, if they have the necessary additional skills.

Hygienists and therapists wishing to undertake tooth bleaching should contact the DDU membership department on 0800 085 0614 with details of their training.

Facial cosmetic coverage for less

Members undertaking only a small number of cosmetic procedures, in addition to their dental work, may be able to take advantage of the DDU’s new, lower subscription bracket introduced for those administering botulinum toxin and non-permanent resorbable dermal fillers.

The insurance offered by the DDU is in the form of a supplement to the standard subscription and is based on the amount charged to patients for these treatments per membership year* as well as on the understanding that botulinum toxin and dermal filler procedures do not represent more than 50 per cent of the dentist’s clinical time. The administration of botulinum toxin and resorbable fillers to the lips or face is included, but the neck is excluded.

In addition, the supplement is only available to dentists, and evidence of adequate and appropriate training will be required.

The new subscription bracket covers dentists earning up to £7,999 a year from non-indemnified cosmetic work. The other subscription brackets cover those earning between £8,000 - £24,999, £25,000 - £49,999 and those earning above £50,000.

For further information contact the DDU membership department on 0800 085 0614.

*The total fees received from patients undergoing these procedures before deduction of overheads, expenses and income tax.

DDU says goodbye to dento-legal veteran

Peter Swiss, a former head of the MDU’s Dental Division – the forerunner of today’s DDU – has retired, after more than 20 years specialising in dento-legal work. During this time he became well known to the organisation’s dental members, both through individual contact and his frequent lectures and professional meetings worldwide.

Peter joined the MDU in 1982 and was its dental secretary and dental division head for 12 years. In 1994 he took on a new challenge and was appointed dental director of Denplan. He returned to what was now the DDU in 1997 as a part-time dento-legal consultant.

Throughout his dental career, Peter has always also been active in the British Dental Association (BDA) and the FDI World Dental Federation. He was BDA president 2001-02 and has been chairman of the FDI Ethics Committee since 2000. A graduate of Guy’s, he spent 14 years in general practice before moving into dento-legal work. During that time he was also a part-time registrar in the department of dental prosthetics at Guy’s.

DDU 24-hour advisory helpline: UK 0800 374 626 / IRL 1 800 535 935
New chief executive for MDU announced

The MDU, the DDU’s parent organisation, announced last September the appointment of Dr Christine Tomkins as its new chief executive. Dr Tomkins will take over from the current incumbent, Dr Michael Saunders, after his planned retirement from the MDU Board at the end of April this year.

Dr Michael Saunders

Dr Saunders began his medical career as a GP in Newbury, where he was a member of the local medical committee and vice chairman of the Family Practitioner Committee. He joined the MDU in 1986, becoming general manager of professional services in 1990. He was appointed chief executive in 1995.

A great deal has changed, both externally and internally, in the 22 years that Dr Saunders has been at the MDU. The frequency of negligence claims in medicine and dentistry has rocketed, although it has levelled out in recent years, while the amounts paid in settlement continue to rise by more than the rate of inflation.

DDU subscriptions have been made proportionate to the risks involved in different areas of dentistry, without compromising the organisation’s mutuality. The State has also taken over the indemnity of dental practitioners employed by the NHS in the hospital and community dental services for claims of negligence in their NHS practice, while the DDU continues to provide indemnity for general and private practice as well as advisory benefits and representation before the General Dental Council.

Moreover, the discretionary nature of traditional indemnity, giving only the right to request assistance but not to receive it, has been predominantly replaced with an insurance policy. This gives each paying member the contractual right to receive assistance with dental negligence claims and provides dentists and patients with the security of knowing such cover is enforceable.

The DDU has also opened membership to further dental care professionals as the regulatory environment has changed.

The DDU’s strength remains in its being a mutual. It has established its own in-house specialist claims and legal departments to deal with the ever-growing case load, moved to modern new offices in the city of London and introduced home working for its dento-legal advisers.

As he prepares to leave the MDU, Dr Saunders admits that he will miss the challenges that lie ahead. However, he is proud to be leaving the organisation more business-focused, while remaining one in which members’ needs are central to every decision it takes.

‘One of the great advantages of a mutual company like ours,’ he reflects, ‘is that, where something really matters to the medical and dental professions, we are prepared to take up the challenge, even if it means pushing against current opinion. A lot of money may change hands and you don’t always win, but there are times when you have to make a stand for what’s right for the two professions we represent.’

Dr Christine Tomkins

Dr Tomkins, an ophthalmologist by training, joined the MDU in 1985 as a medico-legal adviser and was appointed head of claims handling in 1993, before joining the MDU Board as professional services director in 1995. She was appointed deputy chief executive in 2005.

Announcing Dr Tomkins’ appointment, Dr Christopher Evans, MDU chairman, said: ‘Dr Saunders, ably supported by the Executive, has highlighted the benefits of the MDU’s ‘doctors for doctors’ and the DDU’s ‘dentists for dentists’ ethos. As part of this team, Dr Tomkins is perfectly qualified to continue Dr Saunders’ work.’

For her part, Dr Tomkins wished ‘to thank Dr Saunders, who has put the MDU and DDU in the strongest possible positions to offer members the help and security they need. Like him, I am committed to the MDU’s and DDU’s values and purpose and recognise that our members expect and deserve the highest standards of service and support. I am delighted to be taking on this exciting and challenging role and look forward to leading the organisation from strength to strength.’

Services to members improved

Following improvements to our membership processes last year more than 80 per cent of calls to the DDU’s membership department are now answered within 20 seconds. We are now able to monitor more closely the quality and performance of membership calls and are pleased to be able to provide our members’ with a more accurate and efficient service.

Michael Downer

membership planning manager
Annual report highlights rising legal costs trend

Legal costs paid to the claimant’s solicitors by the DDU on behalf of its members frequently outstrip the damages awarded to negligently injured patients, according to the MDU Report and Accounts 2007.

Writing in the annual report, Rupert Hoppenbrouwers, head of the DDU, said: ‘While the number of dental claims against our members is relatively static at the moment, the average cost of indemnity payments (damages plus the claimant’s legal costs) is increasing. The most significant factor in this has been the rise in claimant’s legal costs, which now regularly exceed the compensation received by the patient.’

The annual report states that these rising legal costs were a particular issue with Conditional Fee Arrangements (CFAs), which now represent over 40 per cent of dental claims. This is partly because such cases tended to be more complex, with solicitors’ firms who specialise in dental claims making allegations involving multiple treatments to many, or sometimes all, of the claimant’s teeth, going back many years.

Over a recent five-year period, the average legal costs paid out in dental cases represented 55 per cent of the total settlement in cases settled under a CFA. For claims settled without a CFA, for example, those which are privately funded or funded by legal expenses insurance taken out by the patient before the event, the proportion was just over 40 per cent.

Rupert said: ‘This causes us to question the fairness of the process. It is important, in the absence of legal aid, that patients are able to have access to expert advice to help them bring a claim, and they should be fairly and promptly compensated where appropriate. However a system that provides solicitors’ firms with rewards out of all proportion to the value of the claim, cannot be right.’

The latest annual report also reveals that the average indemnity payment has risen, partly as a result of general compensation inflation and partly as a result of larger and more complex claims.

Claims incidence slows
The annual report notes that the previous year-on-year rise in claims slowed. In former times, using legal aid funding, some claims were advanced that had no reasonable prospect of success, and, although they were eventually abandoned, the practitioner still had to suffer the stress of the claims process.

Elsewhere in the report, Rupert discloses that General Dental Council’s fitness to practise investigations have increased in length and complexity, with hearings occasionally lasting several weeks. He said: ‘Our aim is to try and conclude the matter before the hearing stage and our in-house legal team has been hugely successful in this. In over 90 per cent of cases during 2007 where we have represented members, the matter has not been referred to a practice committee for a full hearing.’

Cautionary cases
The Annual Report incorporates Cautionary Tales, which includes a selection of dental cases that illustrate how the DDU offers dento-legal expertise, help and support to members with advisory and claims cases.

Rupert added: ‘We know from feedback we get that members enjoy reading these case histories but they are also a useful way of shedding light on how dentists might approach some of the common dilemmas they face in practice. We hope they will reinforce the message that, if in doubt, members should see the DDU as their first line of defence and seek advice from us at the earliest opportunity.’

A copy of the MDU Report and Accounts 2007 including Cautionary Tales has been sent to all members. It is also available to download from the DDU website www.the-ddu.com.
Providing a service to all

Senior dental claims handler Debbie Herbst cautions dental practitioners that they need to be aware of changes to the Disability Discrimination Act (DDA) 1995.

Recent DDU cases, highlighted below, indicate that disabled people are increasingly aware of their right to receive non-discriminatory dental treatment and that they are prepared to take legal action to defend that right.

Dental professionals need to be aware that the original definition of disability, under the DDA, was broadened in 2005 (see box). This means that service providers – including dental practices – are required to make reasonable adjustments to their premises, or the way they provide services, to facilitate the use of these services by an increasingly broad range of disabled people.

While in the past DDA compliance has often involved adjustments to the physical features of dental premises to overcome physical barriers to access for disabled people, this is by no means the limit to the actions dental practices need to take to ensure they comply with the DDA. Whilst earlier amendments to the Act may have focused dental practices’ attention on adjusting services to accommodate patients with recognisable sensory, mental or physical disabilities, it is clear that equal attention is now required to provide non-discriminatory services for disabled patients with other, less obvious conditions covered by the Act.

In the year from September 2007 to September 2008, the DDU provided assistance with eight complaints and four claims of clinical negligence against dental members in relation to the DDA. Of the eight complaints, four concerned inadequate access for wheelchair-bound patients, while the other four related to discrimination against patients with HIV.

Of the four clinical negligence claims, three concerned failure to provide appropriate primary care dental services for patients with HIV. One of these cases alleged failure to provide as comprehensive a dental examination as would be afforded a non-HIV patient, and two concerned referral of HIV patients within secondary dental care for treatment which, it was alleged, could reasonably have been provided by the dental practice.

The fourth claim, concerned alleged failure to make reasonable adjustments to a dental practice’s premises to facilitate access by a wheelchair-bound patient. In this case, the patient was allegedly forced to wait outside the dental practice while a ramp was put in place to enable access.

These cases demonstrate how important it is for all members of the dental team to be mindful of their ethical, professional and legal responsibilities with regard to the amended DDA. The DDU is on hand to advise members on specific queries relating to compliance with the Act.

What does the law mean by ‘disabled’?

The original DDA definition of disability includes anyone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal, day-to-day activities.

In this, ‘substantial’ is taken to mean neither minor nor trivial, and ‘long-term’ to mean that the effect of the impairment has lasted or is likely to last for at least 12 months. There are, in addition, special rules covering recurring or fluctuating conditions.

‘Normal, day-to-day activities’ include eating, washing, walking, or shopping. For inclusion in the Act, the activity must affect one of the ‘capacities’ listed in the Act, e.g. mobility, manual dexterity, speech, hearing, seeing and memory.

The 2005 amendments to the DDA extended this definition to protect the rights of a wide range of people with sensory, mental, or physical disabilities. They include:

- Wheelchair users
- Blind, partially sighted and deaf people
- People with arthritis
- People with learning disabilities, including dyslexia
- Severely disfigured people

Importantly, people with progressive, longterm illnesses or conditions, such as HIV/AIDS, cancer and multiple sclerosis, are also covered by the DDA – and from the date when the condition has some adverse effect on their ability to carry out normal, day-to-day activities.

Members should also note that, in certain circumstances, people who have had a disability in the past are covered by the Act too.
**Expert know-how**

Rupert Hoppenbrouwers, head of the DDU, helps dental professionals who write expert reports or give evidence in court or at hearings to avoid some common pitfalls.

The DDU often instructs experts in a wide range of dental specialties on behalf of our members. They are needed to provide evidence in a variety of legal proceedings, including negligence claims and General Dental Council cases, and so we are very aware of the qualities necessary to do the job. We also assist members with ethical dilemmas, complaints and claims arising from their own expert and professional witness work, and the preparation of reports for various purposes.

The expert witness is a key player in many dental cases, as the court or tribunal will want to hear the opinion of an experienced, impartial dental professional to assist in making a decision about the case. Judges and disciplinary panels may know nothing about a particular dental procedure and will look to the independent experts to explain the issues in a way they can understand, as well as to guide them on what constitutes reasonable and responsible practice.

In our experience, the vast majority of expert witnesses are perceived as doing a good job, but occasionally there can be criticism.

The common allegations against dental professionals acting as experts include:
- giving misleading advice to a court or tribunal
- failing to acknowledge an accepted range of opinions on an issue
- failing to be impartial and acting as an advocate for those instructing them
- failing to properly examine papers or the patient
- failing to declare a conflict of interest
- putting themselves forward as something they are not, e.g. not being an expert in the relevant specialty.

While the General Medical Council has recently published *Acting as an Expert Witness*, which sets out the role and duties of medical professionals who act as expert witnesses, there is no equivalent for dental professionals. The DDU’s tips for dental professionals who act as expert witnesses are as follows:
- dental professionals are not obliged to act as an expert but once you have accepted instructions, you have a duty to act until the case ends
- ensure that the instructions you are given are clear and unambiguous
- understand the legal basis upon which questions of breach of duty and causation are determined. Experts in England and Wales should be familiar with the requirements of the Civil Procedure Rules (CPR)
- keep up-to-date in your specialist area of practice and be aware of the standards and nature of practice at the date of the incident
- avoid acting as both an expert and factual witness on the same case and do not accept a patient for treatment if you are acting, or have acted, as an expert witness in a case involving that patient. Inform the person instructing you of any conflict of interest without delay
- tell the person instructing you, or the court/tribunal if you are attending a hearing, should something be beyond your level of experience or area of expertise, and do not be drawn to express an opinion on something you know little about
- do not disclose confidential information without appropriate patient consent, unless, for example, you are obliged by law or ordered by the court.

The DDU has also published a comprehensive briefing document, *Dental Reports and Court Appearances*, for dental professionals asked to act in legal proceedings, whether as a witness to fact or expert witness. Members can contact the DDU advisory helpline on 0800 374 626 for a copy or for specific advice on their duties as an expert witness.

**References**

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**New advisory podcast**

The DDU launches its first downloadable advisory podcast on its website www.the-ddu.com.

**Dealing with the media**

In this first podcast, DDU dento-legal adviser Mark Phillips provides advice for members who find themselves in the media spotlight. The podcast covers issues that the DDU is asked about including:
- what to do if a journalist contacts you about a patient
- how to deal with photographers or a camera crew
- how to respond to untrue or misleading stories.

You can listen to this podcast on the website or download it for listening to later. A number of additional advisory podcasts are planned for the future. Check the DDU website for further additions.

Jason Ellis
e-business manager ellisj@the-mdu.com
Learning from complaints

Dental professionals in England providing any element of NHS treatment should ensure they are complying with the new NHS complaints procedures introduced on 1 April 2009, advises Rupert Hoppenbrouwers, head of the DDU.

The vast majority of dental consultations are uneventful and most dentist-patient relationships are undoubtedly good, but complaints are an inevitable part of dental practice. In the 12 months to 31 March 2008, there were 7,494 written complaints received about NHS dental practices in England. Meanwhile, the Dental Complaints Service (DCS), which handles complaints about private dental care, reported that it had dealt with more than 1,620 complaints in the year to May 2008.

Every year, the DDU helps a significant number of members deal with complaints. In our experience, the motivation of many patients in making a complaint is to find out what went wrong and, if appropriate, ensure that steps have been put in place to stop the same thing happening again to them or somebody else.

Local resolution
This approach is echoed in the new two-stage NHS complaints procedure. Under these proposals, which follow the 2007 Department of Health consultation Making Experiences Count, all practices providing any element of NHS care are required to be able to demonstrate to their primary care trust that action has been taken following a complaint.

The emphasis is on practices resolving complaints at local level and involving the complainant throughout the process. The Healthcare Commission no longer carry out independent reviews of unresolved complaints, but where local resolution has been unsuccessful, complaints can be referred to the Health and Parliamentary Ombudsman.

Under the new procedure, practices are expected to consider patient complaints as significant events to be investigated, and it will be important to record (and act on, if necessary) comments and complaints, working within existing clinical governance procedures. For many years the DDU has recommended that investigations need to look further than any immediate human errors to the root causes of an incident. It has long advised that it is good clinical governance to log complaints as significant events and have a system in place to ensure that not only are they thoroughly investigated but, if appropriate, lessons are learnt and any changes to systems or practice are shared with the rest of the dental team.

Significant event audits and meetings provide a means for staff to discuss and contribute to the analysis of significant events in a supportive environment. Unfortunately, however, a National Audit Office report on complaints handling, published last October, highlighted a lack of learning from complaints.

Handling complaints
No one likes receiving a complaint, but a professional response, which addresses the patient’s concerns, can often help prevent the complaint escalating. The General Dental

‘No one likes receiving a complaint, but a professional response, which addresses the patient’s concerns, can often help prevent the complaint escalating.’
Council’s guidance booklet, *Principles of Complaints Handling* (2006) also emphasises the need to deal professionally with complaints, in line with the NHS practice complaints procedure, and to keep a written log so that you can monitor performance and identify possible areas for improvement.

Other key points in complaints handling include:

- It may be possible to resolve simple oral complaints within 24 hours and front line staff should be encouraged to do so. If it is possible to resolve a complaint in this way and the patient is happy with the response, the regulations do not require a formal written response, though that does not prevent you from confirming the discussion in writing if you wish to do so.
- Complaints can be made to the practice or direct to the commissioning body (usually the PCT). If a PCT receives a complaint about a provider, and the PCT considers that the provider can deal with the complaint, it must seek consent from the complainant so that it can send details of the complaint to the provider.
- Where a complaint has been received this should be recorded in writing and acknowledged by the dental professional concerned or the designated complaints manager within three working days.
- The complainant should be offered the opportunity to discuss an agreed approach to the complaint, either by telephone or in person. The complainant should then be informed how the complaint is to be handled, for example given details of how it is to be investigated, and of the expected timescales for a response.
- It can also be useful to offer the complainant a meeting to discuss the concerns raised. Such meetings might benefit from the presence of a trained lay conciliator provided by the primary care organisation.
- One person should be given overall responsibility for clinical governance and initiating action following any significant event. Their duties could include documenting the action to be taken, providing feedback to staff and implementing training where necessary.
- Investigations should look beyond human error in order to identify and eliminate risks that could lead to a recurrence. For more serious incidents, you may decide to hold a meeting to discuss the issues in greater detail where all staff can contribute. Ensure a record is kept of the meeting and agree a date to follow up any action points.
- Provide a full, detailed, speedy and positive response to a complainant. The GDC’s guidance in *Principles of Complaints Handling* recommends that a response should normally be made within 10 working days of receipt. This should ideally include an account of what happened, an apology where appropriate, and an explanation of any steps put in place to prevent a repeat of the problem. You may also choose to waive or refund the fee, or offer remedial treatment free of charge, as a goodwill gesture. Sometimes an independent second opinion from an appropriate clinician may help to resolve a complaint, particularly when the patient has suffered a recognised complication of the procedure in question.

References

Who needs to register with the DPA?

Q. Can you advise me about the register of data controllers for dentists? Do associates within a practice need to register as data controllers? Do vocational dental practitioners (VDPs) need to register too or are they covered by their trainer?

The DDU responds

The Information Commissioner’s Office advises that if a dentist is working exclusively in one practice (whether they be a VDP, an assistant, an associate, an employee or principal), and has no work whatsoever outside that practice, then if the practice or principal/owner is registered as a controller - that will suffice and this complies with the requirements of the Data Protection Act 1998. In those circumstances the other dentists in the practice are not data controllers, but are data processors and only the data controller (for example, the partnership/organisation/company) needs to be registered. Of course, in these circumstances, it would be wise for every dental professional to check the practice is indeed on the register of data controllers. If on the other hand, a dentist is working in several different practices, not all of which are registered, or has separate private work involving patients or processing patient or other personal data, then that practitioner should be individually registered. Notification costs £35. Download the form from the Information Commissioner’s Office website www.ico.gov.uk.

How do I work with CDT?

Q. An elderly female patient of mine recently attended a clinical dental technician to have a partial denture fitted. However, after an examination of the woman, the clinical dental technician referred her back to me. His letter to me stated that as the patient retains her upper and lower front teeth he needs to know that a full mouth assessment has been carried out and a treatment plan outlined before he can go ahead and design and fit new dentures. Is this right, and should I provide the details of the full mouth assessment and the resulting treatment plan direct to him?

The DDU responds

The recent amendments to the Dentists Act, and the resultant guidance from the General Dental Council (GDC) on the dental team, allow a clinical dental technician to provide partial dentures to a patient only after the patient has been examined by a dentist and that dentist has prescribed partial dentures as part of the plan for treatment. The GDC’s guidance Principles of Dental Team Working (2006) is also relevant here. It requires a dentist to co-operate with other members of the dental team in the best interests of the patient. Also, paragraph 2.3 of this guidance states: ‘Patients should have a full mouth assessment by a dentist. The dentist should then give the patient an outline treatment plan or full treatment plan if necessary, depending on the patient’s needs.’

Paragraph 2.7 of the same guidance goes on to state: ‘Until the date of the full mouth reassessment by a dentist, the patient may take the treatment plan to an appropriate registered dental professional who can, within the overall limits of the plan and limits of their competence, treat the patient (and make an appropriate referral) until that date.’

As the patient’s dentist, you first need to establish that the treatment proposed by the clinical dental technician is both appropriate and necessary for the patient. You may have sufficient information to decide this from a recent examination, otherwise you may need to re-examine the patient to establish what treatment is appropriate and necessary. You may also have a view as to who is the most appropriate person to carry out this treatment, such as a clinical dental technician, yourself or a specialist prosthodontist, and you should advise the patient accordingly. However, clearly patients are at liberty to seek treatment from anybody they choose.

You should also be aware that your case
raises issues about sharing information with the clinical dental technician. The GDC’s guidance on this, set out in paragraphs 2.1 to 2.3 of Principles of Patient Confidentiality (2005), is that dental professionals are required to explain to patients the circumstances in which information about them might be shared with others involved in their healthcare, that patients should be given the opportunity to withhold permission for the dental professional to share information about them, and, where the patient consents, the patient should understand what will be released, the reasons it will be released, and the likely consequences of releasing it.

You should seek the patient’s consent to disclose information, before responding to the clinical dental technician. You need to liaise with the patient in any event, and you may, of course, also need to examine her in order to formulate a plan for treatment, before communicating that plan to the patient, and in turn to the clinical dental technician. Alternatively, you could simply provide the treatment plan direct to your patient, along with any additional advice you feel she should have, leaving her free to seek treatment from any dental professional she chooses.

Be aware too that you will also need to consider how much information you need to pass to the clinical dental technician and include details about the patient’s clinical condition and the design of any dentures in the treatment plan to enable the person carrying out the treatment to provide a proper standard of care.

Can I deviate from NICE guidelines?

Q. On several occasions recently I have received communications from cardiologists telling me to prescribe antibiotic prophylaxis to elderly patients with heart conditions when they are about to undergo invasive dental treatment. However, I am aware of the new NICE guidelines that say that antibiotic prophylaxis against infective endocarditis is no longer recommended.

Am I able to overrule the NICE guidelines on the instructions of a particular cardiologist or cardiac surgeon? And what happens if the advice is from a general medical practitioner rather than a cardiac specialist?

The DDU responds

A dentist who follows the NICE guidance is likely to be in a position to justify his or her actions if criticised. As you correctly infer, it is when a dentist deviates from the NICE guidance that he or she may have to justify the decision to a court, the General Dental Council (GDC) or some other forum. A dentist who is unable to justify a decision to deviate from the NICE guidance, to the satisfaction of a court or tribunal, could then be at risk of an adverse finding by that court or responsible body and sanctions could be applied.

However, each patient should be considered individually and all the clinical factors taken into account, including advice received from any medical practitioner also involved in a patient’s care. As with any element of dental treatment, it is important that you as a clinician can demonstrate that you acted reasonably and in accordance with a responsible body of dental opinion (the Bolam principle’). There may, though, at any one time be more than one responsible body of opinion within the healthcare professions in relation to a particular issue or treatment modality. In this situation, provided you follow the practice advocated by one such responsible body, even if that body is in the minority, you should not be found to be negligent if a claim were brought against you and your fitness to practise should not be considered to be impaired by the GDC.

However, since the case of Bolitho, there has been emphasis on the need to support a ‘reasonable practice’ defence with a ‘logical’ argument based on risk-benefit evidence. In other words it is no longer enough to mount a defence simply because others would have done what you did. You need to show it was an appropriate course of action in the circumstances.

If in a specific case you prescribed antibiotic cover at the request of a cardiologist or cardiothoracic surgeon who had provided you with sound reasons for deviating from the NICE guidance, then you are likely to
be in a position to justify your actions in following the recommendations of a medical colleague with greater knowledge in the specific area concerned.

If, however, a medical practitioner requested antibiotic cover in circumstances which appeared to contravene the NICE guidance, it could be seen as incumbent upon you, the dentist, to discuss the request with the medical practitioner concerned in order to ascertain his or her rationale for requesting cover. If you then considered it inappropriate to prescribe cover, you should inform the medical practitioner, giving your reasons. This would give the medical practitioner the opportunity to prescribe the cover or review the decision.

If there appears to be a blanket position in favour of prescribing antibiotic prophylaxis adopted by your local cardiologists in circumstances when NICE guidance would not recommend it, you could consider discussing the issue with your line manager, if you are employed, with colleagues in the practice, with the Local Dental Committee representative, or with your primary care organisation. Your primary care organisation may want to develop a policy, protocol or advice on the subject.

Reference
1. Bolam v Friern Hospital Management Committee (1957) 1 WLR 582.

Can my practice nurse take part in an oral health campaign?

Q. I am a practice principal and have just received a letter from my primary care trust about a fluoride advice programme it is embarking upon. It is asking whether any dental professionals in my practice would be willing to go into local schools, supermarkets and community centres to talk to children and their parents about oral health and fluoridation. I would really like my dental nurse to do this as I think she is responsible and adequately knowledgeable. Is there anything else I should consider before she undertakes this work?

The DDU responds …

There are two main points you need to consider. First, although you believe your nurse to be adequately knowledgeable, is she trained to give advice and is she competent to give it? The General Dental Council’s (GDC’s) guidance Scope of Practice – who can do what in the dental team (2009), includes ‘further skills in oral health education and oral health promotion’ under the additional skills that dental nurses could develop during their careers. It makes it clear that oral health education and oral health promotion are not skills a dental nurse has when qualifying and that these are skills that need to be acquired post-qualification.

Oral health promotion courses are available and your nurse should have undergone appropriate post-qualification training before she goes out to advise the public. If some problem were to arise over advice she had given, for example a complaint to the GDC, the nurse might well have to demonstrate to the GDC that she was adequately and appropriately trained to provide the advice in question. If your nurse has access to her own membership of the DDU, she can be assured that she is entitled to request all the usual benefits of membership, including assistance with any GDC investigation.

The second issue to consider is whether your nurse has adequate indemnity. If a nurse is appropriately trained and qualified and gives advice to patients as part of his/her professional duties on the instructions of his/her employer, the employer can be held liable for his/her acts and omissions, and is said to have vicarious liability. However, as nurses’ roles increase, they are more likely to face negligence claims in their own right. For this reason, the DDU recommends that nurses have their own indemnity insurance arrangements in place. Practice principals and practice managers need to be satisfied that nurses employed at the practice have adequate and appropriate insurance.

Indemnity may not seem very important when giving advice about fluoride but imagine, for instance, what might happen if your nurse failed to advise the people she was addressing to check the fluoride level in the water supply where they live. If she only gave advice relevant to those living in the low fluoride water area in which she was speaking, but someone was visiting from a high fluoride area, she may face a claim of negligence, many years after giving the advice.

The DDU introduced individual membership for dental nurses in 2008. DDU members’ dental nurses are eligible to receive a discount of 50% on the full DDU nurse subscription.

Any dental nurse who wishes to apply to join the DDU can do so by going to the DDU website www.the-ddu.com and downloading the relevant forms, or calling the DDU membership department on 0800 085 0614.
Pulling power

When should a tooth be removed in general dental practice?
Paul Robinson, oral & maxillofacial surgeon and chairman of the DDU’s Dental Advisory Committee, examines the changing circumstances surrounding this question and offers risk management advice for those tackling extractions.

The removal of a tooth or teeth in general dental practice is an everyday dental procedure. For several reasons, however, it is becoming increasingly challenging. Amongst these is that the average extraction is taking place at an older age. The teeth of these older patients are often more extensively restored and the bone is harder.

‘the rise in patients’ dental awareness and the spectre of dento-legal litigation, make extractions in general practice an increasingly difficult area’

There may also be more impacted teeth as fewer teeth may have been extracted earlier. With older patients, too, comes the problem of more complicated medical histories.

Also important is the changing experience of the general dental practitioner (GDP). The average dental graduate today has less experience in exodontia than his or her predecessors as there are fewer easy teeth suitable for students to treat. Gaining experience in minor oral surgery in the general practice setting may also be difficult for the newly qualified dentist: suitable post-graduate courses are often limited in the ‘hands on’ work provided, adequate close supervision may not be available, and learning by trial and error is obviously unacceptable.

These two broad areas of change, combined with the rise in patients’ dental awareness and the spectre of litigation, make extractions in general practice increasingly difficult.

Example 1: Oro-antral communication/fistula
A 30-year-old patient presented to her GDP with pain from UL7 and requested an extraction. The radiograph taken (Fig 1) demonstrated the roots of this lone standing second molar crossing the white line of the antral floor, signalling a risk of oro-antral communication (OAC) that should have prompted at least a warning to this patient. Removal of the UL7 resulted in an OAC that was not repaired, and a fistula was established. A subsequent claim for damages was settled.

Learning point:
Though OAC is a complication that is not accurately predictable and is not always preventable, discussion of the potential for it with the patient should be undertaken pre-operatively, if the risk is accessed as significant. If the complication is avoided, the operator’s skill is appreciated, and if

Importance of preoperative assessment

The removal of a painful tooth should mean relief for a patient and job satisfaction for a dentist, but if the tooth breaks, the bone is tougher than expected, your favourite elevator is missing, or the patient turns out to be a fidget, the outcome may be less than satisfactory. Recognition of potential difficulty is therefore prerequisite.

There are three main areas to consider in preoperative assessment and deciding whether a case falls within your surgical repertoire:

1. Physical surgical factors
   - Consideration of the tooth itself; the number, shape, and size of its roots; the state of the crown and any restorations; whether there has been root treatment; the mobility of the tooth and its roots; and whether there is ankylosis and/or hypercementosis.
   - The surrounding bone levels too should be considered, as well as the bone texture or toughness (e.g. the radiodensity of the bone may look similar to the dentine - a bad sign!)
   - Look at nearby structures: consider the proximity of nerves; the antral floor and the roots/crown of adjacent teeth. You should check that your radiograph shows these features adequately.

2. Patient factors
   a) Looking at the medical history - various conditions from haematological to musculo-skeletal (including problems of access to the mouth) can require modifications to management, further information/investigations; or referral to a specialist may be indicated.
   b) Getting patient co-operation - a much under-estimated facet of assessment. An apparently ‘simple’ procedure on an uncooperative patient may turn out to be not so easy.

3. Operator factors
   In assessing these, you should consider the following:
   - Is the procedure within your repertoire of experience and competence?
   - How confident are you of your clinical and radiological assessment skills?
   - If the procedure turns out to be more difficult than expected, can you cope and do you have the necessary instrumentation available?
   - Do you know what to do if you get stuck?

The General Dental Council’s Standards for Dental Professionals (2005) states that dental professionals should work within their knowledge, professional competence and physical abilities. It adds: ‘Refer patients for a second opinion and for further advice when it is necessary ... Refer patients for further treatment when it is necessary.’ (paragraph 1.3)
the problem materialises, then at least it was accurately predicted.

When a communication into the antrum has occurred, it is important to recognise and document it. The patient should be informed, and then appropriate management should be arranged as soon as possible, to avoid the communication becoming an established fistula. If a referral is required, this should be on an urgent basis and preferably by telephone.

**Example 2: Nerve damage**

A 57-year-old male patient complained of unremitting pain at LL7 diagnosed as irreversible pulpitis, and extraction was offered. The radiograph (Fig 2) clearly demonstrated the mesial root of LL7 to be closely related to the shadow of the ID bundle implying a potential risk to the ID nerve, (a feature normally confined to the roots of the third molar). No pre-operative warning was given to the patient. Numbness of the left lower lip followed the forceps extraction of the tooth and a subsequent negligence claim for damages was settled.

**Learning point:**

In cases such as this, the level of risk assessed needs to be balanced against the benefit of the treatment, and in particular, the level of symptoms. In this case there was an appropriate indication to extract the tooth, but the risk of the treatment was not recognised and explained to the patient as part of the consent process.

A risk benefit analysis of this kind, discussed with the patient, will assist in informing the patient and helping the patient to reach an informed decision of whether to undergo the treatment or not. Unless the indication to extract is clear, and the risk to the inferior dental nerve is low, then referral of the patient by the GDP for specialist management may be advisable.

**Example 3: Osteoradionecrosis (ORN)**

A 53-year-old man, with a previous history of a parotid tumour which was treated by surgery and radiotherapy aged 38, presented to his dentist with a painful periodontally involved lower molar that was in the field of the radiotherapy. There were skin changes of telangiectasia over the cheek effectively marking the area affected by the radiation that were not recognised by the dentist, and the medical history form failed to pick up the previous radiotherapy. The extraction was simple, but the socket failed to heal and ORN followed. The affected portion of jaw was subsequently resected and reconstructed with a vascularised free flap containing bone from the hip. The patient was awarded substantial damages following a negligence claim.

**Learning point:**

Any patient who has had radiotherapy to the jaws and presents for dental treatment in which an extraction may be needed, should be referred for hospital management.

**Risk management**

So, what is best practice in assessing and treating patients who might require an extraction? And, if an extraction in general dental practice does result in a negligence claim, what will help in the defence of it? You should be confident that:

- Appropriate decisions were taken in the light of the best information available.
- The treatment was justified, i.e. it conformed with an evidential base, either directly from the literature or via published guidelines.
- An appropriate person carried out the treatment.
- The patient appeared to understand the risks involved and accept the proposed treatment and any significant risk involved.
- Other treatment options were considered, including the option of no treatment.
- There was good communication between dentist and patient throughout.

Good communication is arguably of most importance. If your patient understands why you are advocating a particular form of treatment, and understands and accepts the risks of any potential complications, then he or she is liable to remain on your side even if events fail to turn out exactly as expected.

**Remember – what you tell your patient pre-operatively is sound professional advice; what you tell them afterwards may be viewed as an excuse.**
Ethics in practice: cosmetic cases

High Street general dental practice includes a growing number of cosmetic procedures. Alongside veneers, crowns and bridges, these days dentists may also be offering osseointegrated implants, tooth bleaching, botulinum toxin and dermal fillers. Clinical ethicist and educator Mark Brennan discusses two fictional cases that illustrate the kind of ethical dilemmas dentists may face when patients seek cosmetic dental treatment.

A teenage model
The scenario:
A 15 year-old female patient attended her general dental practitioner, together with her mother, requesting instant improvement in the appearance of the upper lateral incisors which were proclined and well outside the line of the dental arch. She told her dentist that she wished to start a modelling career soon. Her dentist examined her and recommended a course of orthodontic treatment over a two-year period to straighten her teeth. The patient said, however, that she was unwilling to undergo this treatment as she wanted to start attending modelling auditions immediately.

The dentist explained that the only alternative treatment, namely veneers or crowns, would be highly interventional, involving significant loss of healthy tooth tissue, with the resultant risk of loss of tooth vitality, and that he could not recommend or agree to provide such destructive treatment. The patient went on to say that her modelling agency had recommended another local practitioner who had carried out similar work in the past, and that if her usual dentist could not help, she would go to see this other dentist instead.

After further discussion with the patient and parent, the dentist reiterated his advice regarding the inadvisability of a restorative solution, and offered an independent second opinion from a specialist practitioner. The dentist felt he needed dento-legal advice. An ethicist’s view:
Dentists should always consider their ethical obligations to their patients when faced with such a situation. Importantly, although dentists should respect the dignity of patients and their right to make their own decisions on whether to accept treatment offered, dentists equally have the right to say ‘No’ if, for good clinical and ethical reasons, they disagree with what a patient wants them to do. If a dentist complies with a patient’s request which he or she knows is not in the patient’s best interests, he or she would be failing in their ethical duty of care to that patient.

DDU advice:
A patient may, of course, request a second opinion (and the dentist should always comply with this request) – or indeed patients are free to consult another dentist of their choosing. A dentist should not offer, or agree to provide inappropriate or unnecessary treatment just because the patient requests it. Having regard to the GDC’s ethical guidance set out in Standards for Dental Professionals, we would endorse the ethicist’s view and would give the same advice to a member calling our 24-hour advice line with a similar scenario.

In the event the patient seeks treatment elsewhere, some dentists might feel obliged to discuss with the patient whether it would be appropriate and in the patient’s best interest for them to continue to provide routine dental care if the patient receives the requested restorative treatment from another practitioner.

A personal choice
The scenario:
A patient presented to his dentist with a missing upper right second premolar and requested that the space should be restored because he found it embarrassing. He had a job which involved meeting the public, and he felt his appearance was holding back his career. The dentist recommend bone grafting, followed by an implant and implant retained crown as the best treatment at a fee of several thousand pounds.

‘Although dentists should respect the dignity of patients as well as patients’ rights to make their own choices, dentists have the right to say ‘No’ if for good and ethical reasons they disagree with what they are being asked to do’

DDU 24-hour advisory helpline: UK 0800 374 626 / IRL 1 800 535 935
but the patient declined this, partly on the
grounds of cost, and partly because he
was very reluctant to undergo a bone
grafting procedure.

The dentist had also discussed other
options with the patient, including a denture
and a bridge, and their risks and benefits,
and costs. The patient requested a bridge,
which he confirmed he could afford. Both of
the potential abutment teeth for the bridge
were already moderately heavily restored, and
the dentist advised they might need crowning
in due course in any event. The dentist agreed
to provide the bridge.

The dentist felt he could justify providing this
treatment, taking into account the clinical
condition and the patient’s wishes. Although
the dentist felt the treatment was not the
optimal treatment, he assessed it was still
clinically appropriate, in accordance with a
responsible body of clinical opinion, and in
the patient’s best interests.

An ethicist’s view:
There are times when patients may not choose
what their dentist assesses to be the optimal
treatment. However, there often can be a range
of treatment options, and provided that a patient
has made an informed decision, even if the
patient chooses a sub-optimal treatment, this
does not mean it is unethical, unacceptable
or inappropriate for a dentist to provide it,
as long as he or she can justify the decision.
Some dentists may initially find it hard to
accept that their patient has not chosen the
optimal procedure, which may, for example,
be more expensive and/or invasive, and has
instead opted for one that is not the dental
professional’s preferred choice. It might seem
that their professional advice has been ignored.

If a patient chooses a sub-optimal treatment this does
not mean it is unethical, unacceptable or inappropriate
for a dentist to provide it, as long as he or she can justify
the decision

DDU advice:

Dentists should remember that in cosmetic
cases there may well be a range of treatment
options, including the option of no treatment
at all, and if so, all reasonable and appropriate
options should be considered and discussed
fully with the patient, even if the patient has
expressed a clear preference for a particular
type of treatment. Only by explaining all the
viable options can the patient make an
informed decision – which may not be in
favour of the best available on the dentist’s
list. The patient may make their decision
based on cost and other factors, as is their
autonomous right, and the GDC’s guidance in
Standard for Dental Professionals, requires
that dental professionals recognise and
promote patients responsibility for making
decisions about their bodies, their priorities
and their care…” (paragraph 2.2).

In addition to the General Dental Council’s
guidance set out in Standards for Dental
Professionals 2005 and Principles of the
Patient Consent 2005, readers may wish to
refer to the DDU’s extensive range of dento-
legal briefing booklets which provide advice
on ethical and legal issues. The booklets are
available to members free of charge on request.

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the Postgraduate Deanery for Kent, Surrey
and Sussex. He lectures for the MDU on
educational matters.
Emergency treatment or treatment plan?

A member sought the help of the DDU after a patient claimed more than £3,000 for what he alleged was negligent emergency treatment.

Case History
The patient sought emergency dental treatment without an appointment at the member’s practice, complaining of an ache in the upper right quadrant following a fall.

On examination the upper-right seventh molar (UR7) had recently been restored and the dentist, who was a member, adjusted the occlusion on the restoration to remove a premature contact. The patient was advised to come back if there were any further problems.

The patient returned for a second emergency appointment three days later, as the ache had not subsided and was in fact now specific to the UR7. No appointments were available, but the patient was seen for a limited time, started on a course of antibiotics and told to make an appointment if the tooth did not settle.

Four weeks later the patient attended another general dental practitioner who carried out root canal treatment on the UR7 and crowned it. The patient experienced no further problems.

The claim
The patient later brought a claim in excess of £3,000 against the first dentist. The patient alleged that, had his tooth been adequately treated initially, he would not have required root canal treatment, which had resulted in an increased likelihood of the tooth being lost.

The patient sought compensation for the cost of the root canal treatment, the pain and suffering of having to undergo root canal treatment, the cost of a crown and future replacement crowns, the accelerated future loss of the tooth, and for the pain and suffering experienced during the four weeks that lapsed before the tooth was root treated.

DDU assistance
The member contacted the DDU. The DDU sought a copy of the clinical records of the treatment the patient had received prior to that provided by the member. These were shown to an expert, together with the contemporaneous records made by the member and those of the subsequent dentist.

The expert was of the opinion that it was important for any dentist investigating a complaint of toothache to record sufficient detail about the patient’s pain to confirm a diagnosis of irreversible pulpitis, and that in this instance the appropriate tests, such as the response of the tooth to hot or cold stimuli or the use of an electric pulp tester, had not been undertaken and/or recorded. In addition, the expert said that symptoms or signs of infection, such as tenderness or swelling, should be found and recorded before prescribing antibiotics.

However, the patient’s previous dental records indicated that the existing restoration at UR7 was clinically and radiographically very deep, and that the patient had been advised of this by the previous dentist, together with the possibility that root canal treatment may be required in future.

With the consent of the member, a Letter of Response was sent to the claimant’s solicitor, denying liability for the majority of the claim. It stated that on the balance of probabilities root canal treatment and crowning of UR7 would have been required in any event, based on the previous dentist’s records and radiographs. However, a small offer of compensation was made, and subsequently accepted, for the avoidable pain and suffering experienced from the last attendance with the member until seven days later - by which time it was argued the patient had a duty to mitigate his loss and seek further treatment.

Learning points
The following learning points can be considered:
• In order to be able to demonstrate that a reasonable diagnosis has been made, and justify the advice or treatment given, it is necessary to carry out and record appropriate tests, such as radiographs, vitality, percussion, and palpation tests, it is also important to record the diagnosis itself.
• It is important that patients are given full clinical information about the risks of treatment and the likely prognosis so that they have realistic expectations of what to expect. They should be advised of any future treatment that is, or maybe, necessary.

Sam Hedges
claims handler, DDU

DDU 24-hour advisory helpline: UK 0800 374 626 / IRL 1 800 535 935
The wrong premolar

A member contacted the DDU after a communication failure led to the emergency extraction of the wrong tooth.

**Case history**
The patient had attended the member’s practice just before the weekend complaining of pain from the upper left second premolar. A colleague in the practice had taken a radiograph, diagnosed a very extensive carious lesion and associated acute abscess, and advised extraction of the tooth. He had prescribed antibiotics and asked the patient to make another appointment five days later for the extraction, advising the patient to return in the meantime if the pain worsened or failed to improve.

Over the weekend the patient visited the practice for emergency treatment, complaining of persistent pain on the left side of her mouth. The dentist on duty and, the DDU member, reviewed the records and the radiograph taken a few days earlier, which indicated that the upper left second premolar was the source of the problem. She then discussed the options of root canal treatment and extraction with the patient and they agreed that the tooth should be extracted.

The dentist anaesthetised the upper left second premolar and proceeded to remove the tooth, during which the patient did not raise any query or concern.

After the tooth was extracted the dentist checked the bleeding had stopped and gave the patient postoperative instructions. At that point, the patient said that she thought the wrong tooth had been taken out as the pain was in the lower jaw. Naturally, the dentist was distressed to hear this and proceeded to examine the patient, taking a radiograph of the lower left area.

This radiograph showed a deep cavity in the lower left first molar which was close to the pulp and the tooth was tender to percussion, with hypersensitivity to hot and cold stimuli. The dentist contacted the DDU seeking advice on what she should do next.

**DDU assistance**
On the DDU’s advice, the dentist apologised to the patient for the obvious misunderstanding which had arisen, and for treating a different tooth to that which the patient expected. The dentist explained that the tooth she had extracted was the tooth previously identified by her colleague, and she confirmed that the radiograph clearly indicated it needed to be extracted.

She went on to explain her findings in relation to the lower left first molar. She discussed the options of root canal treatment or extraction with the patient, and they agreed that root canal treatment would be the best option.

This was subsequently completed and the patient was satisfied with the care she had received, and with the explanation and apology given.

The dentist and dental nurse reviewed the adverse incident after the patient left. The nurse thought the patient had indicated the left side of her face rather than specifically her lower jaw. They shared this incident at the next practice meeting so all the dental team could learn from the adverse event to help prevent a recurrence.

**Learning points**
- Ensure you ask the patient enough questions to take a detailed history.
- Carry out an appropriate clinical examination and special tests to positively identify which tooth is the cause of the problem, excluding other concurrent problems.
- Confirm with the patient which tooth is to be treated before local analgesia is given and again before extracting a tooth.
- Keep good records that detail the history, the clinical findings on examination, the special tests carried out, the diagnosis, the treatment options discussed with the patient, any adverse events and explanations given to the patient, and the outcome of the treatment.

Bryan Harvey
Deputy head of the DDU
Bleaching, blisters and a lesson in note taking

A patient claimed £1,500 damages from a DDU member after the tooth whitening treatment he requested turned into a ‘traumatic experience’.

Case history
A young man asked his dental practitioner about tooth whitening for his front teeth on each of several visits he made to the practice for the restoration of a fractured molar. He was keen to have the procedure as his teeth had become stained from smoking.

The dentist, a DDU member, did not specially promote tooth whitening in his practice but he had undertaken the procedure on several occasions before and felt confident doing it. He advised the patient that an improvement in the colour of his teeth could be made of, perhaps, two shades, and an appointment for whitening the twelve anterior teeth in a month’s time was made.

At the appointment, before the treatment took place, the dentist warned the patient that there may be some discomfort but that this, along with any discolouration of the gum tissues that may occur, was likely to return to normal within an hour. He also warned the patient not to expect ‘brilliant’ teeth at the end of the treatment.

The procedure went ahead without incident and the dentist received no indication that the patient was experiencing any undue level of discomfort. At the end of the treatment, he noted that the gingival tissues were slightly blanched, as might be expected, and the colour of the teeth had improved by a shade.

Despite this, the patient seemed annoyed and said he would never undergo the procedure again. He paid for the treatment and left the surgery.

Two days later, the patient called the practice complaining that his gums were sore. The dentist explained that it was likely he had had an adverse reaction to the whitening agent and the soreness would subside within a few days. He advised the patient to rinse his mouth with sodium bicarbonate.

The patient also visited his general medical practitioner that day, who noted ‘gums blistered – very sore’ and advised taking ibuprofen.

The following day – three days after the procedure – the patient again called the dental practice and the dentist reassured him once more that the discomfort should subside with time. He wrote a prescription for a local anaesthetic spray which the patient collected later that day.
The claim
A month later, solicitors for the patient issued a letter of claim in which it was alleged that the dentist had failed to:

- warn the patient of any potential risks to the procedure and so had failed to gain informed consent for it
- adequately protect the patient during the whitening process, resulting in immediate multiple blistering of the upper and lower gums.

The letter alleged that the patient had ‘cried out in pain’ during the procedure and had been shouted at by the dentist when he had complained that it hurt too much to rinse his mouth out. The blistering, it was further claimed, caused severe pain as well as difficulties in eating and drinking for a week, and the traumatic experience had left the patient with a fear of dental surgery. A claim for damages was made for more than £1,500. The member contacted the DDU.

DDU assistance
The dentist denied the allegations and claimed he had correctly followed all the instructions given by the manufacturer of the tooth whitening system used, including the use of a gingival barrier and cheek retractors. His assistant backed him up in his assertion that the patient had not shouted out during the procedure, and had not appeared to be experiencing pain or discomfort.

However, the DDU noted that there were no contemporaneous notes of the warnings given to the patient, so it was a question of the patient’s word against that of the dentist. In addition, there was no documentation of the verbal complaint made by the patient following the treatment.

It also later emerged that the dentist had made an offer of £200 to the patient to settle the complaint, soon after it was first raised by the patient and before consulting the DDU. This offer was not couched in any particular terms and it was considered that if the claim were to proceed to trial, the judge might conclude that with this offer of settlement, the dentist accepted some legal liability for the patient’s injuries.

The DDU therefore advised the member that it might be in his best interests to settle. With the member’s agreement, an offer of £650 plus reasonable costs was made, with no admission of liability. The patient accepted the offer.

Learning points
The following learning points arise from this case:

- Patients should be informed clearly of any significant risk associated with treatment, including that of pain or sensitivity and this should be clearly recorded in the notes.
- Complaints of symptoms, however minor following dental treatment, should be noted in the clinical records.
- Offers of compensation to settle a claim should not be made without first seeking dento-legal advice. Though they may be intended as a gesture of goodwill or to avoid a matter taking up valuable time, they may later be interpreted as an admission of liability unless they are couched in appropriate terms.

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For membership queries please call the freephone membership helpline on **0800 085 0614**
Lines are open Monday to Friday, 8am to 6pm

**Further advice**
For detailed advice about specific instances and situations, call the DDU’s 24-hour freephone advisory helpline on 0800 374 626 (UK) and 1 800 535 935 (IRL). You will also find a range of helpful advisory and risk management articles on the DDU website.

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