Why do people complain to the ADA about their dentist-

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Unfortunately, with all the very best of intentions and with all the professional training, skill, care and experience the dental team may exhibit, things don't necessarily turn out as expected. This can result in an adverse treatment outcome and patient expectations not being met. The vast majority of these situations are managed in-house by the treating professional by offering to re do a procedure for the patient or referring the patient for specialist attention. Most patients are accepting of this approach, especially when the professional shows genuine concern for the patient's well being and the patient is not greatly disadvantaged.

However, when a patient, their parent or guardian considers they have not been treated in a considered, appropriate nor professional manner, they may make a complaint to an authority such as the Dental Board , the Health and Community Services Complaints Commission or the Australian Dental Association.

Such a complaint to the ADA may then be forwarded to the Review Committee of the Association or a Community Relations Officer to review the circumstances involved, in an attempt to reach resolution to the mutual agreement of the parties involved whilst minimizing the chance of escalation of the dispute to expensive and time consuming litigation.

Unfortunately, poor communication is one of the most frequent complaints anywhere in any workplace and certainly lies at the heart of many complaints received by the A.D.A. Many patients complain that they received treatment they weren't expecting, were not fully informed of the costs involved, and didn't understand the nature of the treatment, the complexity of the treatment or that things could in fact go wrong. For instance, they may have attended an appointment in pain and expected the treatment provided and paid for would fix their problem, totally unaware that the pulpitis may not resolve with an extensive

restoration and could actually progress to root canal therapy. Naturally, one of the first questions asked when reviewing such a complaint with a dentist is "What did you say to the patient and did they understand what was said?"

Communication is both telling and listening and the very nature of communication is to clarify and understand. It involves words, the tone of voice and body language yet too often it would seem that "telling" is perceived as communicating. Dental patients are invariably at a distinct disadvantage whilst having procedures performed on them, especially under rubber dam, because they can't ask clarifying questions whilst their mouth is open.

Tight time constraints are often blamed when communication fails because "we were busy" or "running behind time" and an assumption is made that the patient actually heard and understood what they were told on a single occasion.

Informed consent is so critical in this day and age. Unfortunately, it is very hard to defend any complaint when the patient says "I wasn't told", "I wasn't aware" or "I didn't understand" as it then becomes one person's word against another. A follow up appointment, a written quotation for treatment or an explanatory handout helps people understand what is involved with their treatment and should help to avoid misunderstandings.

Good records help enormously in defending a dentist's actions when a dispute arises, as they record facts. Record keeping is fundamental for any clinician and the record must be contemporaneous and accurate. Case notes must be dated, clearly written to define the procedure involved and contain sufficient content for a third party to understand what treatment was actually performed. Whenever a complaint is made against a dental professional one of the fundamental pieces of evidence requested to help defend the person, their actions and what was said, is the clinical record. It is extremely difficult to help and defend a practitioner against an allegation if their own records are inadequate, incomplete or poorly written.

Naturally, clinical records include charts, radiographs, photographs, study models or any other items associated with the examination or treatment of the patient and provide evidence to help justify any treatment provided by the dental team. Radiographs in particular provide supportive evidence of why decisions are made to undertake treatment and as such should be of good quality and show the area

of concern, such as the periapical area when root canal therapy is required or the entire tooth of an impacted wisdom tooth requiring extraction. Surprisingly, many endodontic treatments are still initiated today without a clear pre-operative radiograph as partial evidence for that decision to be made.

Incidents and complaints made to the ADA vary enormously in nature. On many occasions when an incident or complaint is reviewed it becomes clear that the dentist has not done anything wrong at all and there is very little basis for the complaint. There may be some misunderstandings, however the treatment and services provided, the itemisation of accounts and the fees charged are deemed proper, appropriate and professional. The dentist can be defended by the ADA as having acted in the best interests of the patient, the treatment can be explained to the patient and generally the complaint can be considered as closed.

However, when treatments fail or fail to meet patient expectations and the dentist involved is not prepared to admit to the failure nor offer to address and correct it, things become more difficult to defend. The ADA must then address and be seen to address the patient's complaint seriously and appropriately.

Surprisingly, some dentists refuse to even discuss the situation with the patient or they get their administrative staff to deal with the issue. Naturally patients resent this approach, become indignant, emotional and occasionally hostile. Even so, they are still encouraged by the ADA as a first step to return to the practice and request a discussion of the situation with the dentist involved in an attempt to resolve the issue. Should this approach fail, the ADA becomes more heavily involved and a more formal and time consuming process to mediation is required.

Complaints can range from a simple mismatched colour of a bonded composite resin, to a broken restoration, post operative discomfort, a failed endodontic treatment, a non retentive full lower denture through to a complex and extensive multiple implant case. A common sense approach is naturally required with all these cases with the facts being gathered and the emotions controlled to understand both sides of the dispute and enable the problem to be solved. Fortunately, the majority of dentists cooperate with the ADA in an attempt to rectify the situation and as a gesture of goodwill with the patient.

Unfortunately, some dentists are seemingly unaware of their own limitations of competency and often undertake treatments that are beyond their capability to

provide. A little bit of knowledge and expertise can be a dangerous thing and knowing one's own limitation is extremely important for any professional. Specialties exist in dentistry to deal with the more difficult, complex and challenging cases faced and in this age of increasing litigation a practitioner needs to make decisions on a daily basis as to what treatments he or she decides to undertake for a patient and what to refer.

For instance, a very common complaint arises when a general practitioner undertakes a molar endodontic therapy for a patient, places a crown on the tooth, charges the patient accordingly and the patient pays the fee assuming the problem has been rectified. Within several months however, the tooth becomes painful again, the patient returns to the dentist and is then referred to an endodontic specialist who then charges his appropriate fee to retreat the tooth. The patient is naturally and justifiably unhappy to be charged again and complains to the A.D.A. about the initial unsatisfactory treatment, the extra time and inconvenience involved and the extra costs.

Similarly, when complex restoration involving veneers, crowns, bridges and implants is undertaken involving considerable costs for the patient, dentists must ensure that patients are fully informed and aware of the expectations and limitations involved with the treatment. So often complaints arise due to a failure some time after the restoration has been placed, such as fracturing or breakage as a result of trauma or occlusal overload, with the patient then seeking and expecting financial compensation for replacing the restoration from the original treating dentist.

These are just a few of the reasons why people complain to the ADA about their dentist. There are many more which involve unprofessional conduct, excessive fees, clinical incompetence or an arrogant or dismissive attitude of a dentist.