The second dentist and patient dissatisfaction-

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There is little doubt that in this day and age, patients are becoming "clients". Consumerism is on the rise, and "dental practices" are often seen and referred to as "dental businesses". This is associated with a diminution of the perceived professionalism of the practitioner, with the result being an increase in the likelihood of a patient compliant. If one is lucky, your patient will bring their issue(s) to you, the practitioner, in whom they have placed their trust. However, when trust is gone and respect gone with it, then a patient becomes a consumer and is far more likely to lodge a complaint.

As always, the decision to financially assist a patient should turn on the merits of the case. There is no absolutely right or wrong approach which can be universally applied to all situations. Rather, there are possible avenues that may be worth exploring in most cases to settle a grievance before such dissatisfaction becomes a claim. The three cases below highlight how the outcomes that exist for settlement of grievances may be affected by the comments or actions of the "second" dentist.

Case #1

A dentist contacted the DDAS(Dental Advisor- Lawyer) wanting advice as to how to settle a dispute with a patient. The DDAS recorded the following complaint history: "Dr X saw an EPC Medicare patient who initially presented in February 2005 with an RCT which had already been started on the #21. Dr X finished the treatment and subsequently performed another two RCT's (teeth #35 and 46) and issued 3 crowns (teeth #25, 35, 46) some three years after the initial treatment. About one year later, in February 2009, the patient was in pain and could not get an appointment to see Dr X, so saw another dentist, Dr B. Dr B allegedly informed her that the crown margins on one of the crowns were deficient. She is now unhappy with the crowns."The patient saw the "second" dentist, Dr B, who had concerns about the standard of some of the endodontic work carried out by Dr X. He referred the patient to an Endodontist, with a request for the work to be assessed. Dr B noted that tooth #21 had been veneered with a porcelain veneer, subsequent to the root canal treatment.

The Endodontist reported to Dr B: "The initial intra-oral examination revealed gingival inflammation at the cervical margins of the anterior veneers. A grey discolouration of the clinical crown was noted . . . The pre-operative radiograph revealed an adequate root filling in situ with no obvious periradicular deterioration. Diagnostic testing was within normal limits and no tenderness to percussion or palpation was noted. As no definite endodontic diagnosis could be made at the time of consultation, no treatment has been initiated or is indicated. (The patient) requested that I take a radiograph of teeth #35 and #36.

Although no obvious apical pathology was evident, a deficient crown margin at tooth #35 was noted. She has been referred back to your

office for ongoing management….."

The patient was referred back to the original dentist Dr X by Dr B. Dr X referred the patient to a Prosthodontist for an opinion on the treatment he had carried out. The Prosthodontist reported on the patient's condition in March 2009:

"The patient required assessment of previous treatment provided by you on endodontically treated teeth including teeth #21, 25 and 46. The patient expressed concern regarding the reasons for having root canal therapy in the first place. She could not understand why she required such extensive treatment as she felt that her oral hygiene was very good. As you are aware the patient has now seen three other dentists for a second opinion regarding the quality of the crowns placed by you over the years. She has had varying opinions regarding this, with some stating that the crowns required replacement due to inadequate fit.

Intra-oral examination revealed adequate oral hygiene with minimal interproximal plaque, apart from teeth #21, 25, 36, 35 and 46. There was a Class 1 incisal relationship with 30% overbite and 3 mm overjet. Anterior guidance was noted on the right lateral mandibular movement and group function was noted on left lateral mandibular movement due to wear of the canines. Centric relation was not coincident with centric occlusion, with a minor slide of less than 1 mm from CR to Co. There was moderate tooth wear, isolated to teeth #17 and #13.

Assessment of individual teeth noted a PFM crown on the #25, 36, 35, 46 plus porcelain veneers on #11 and 21. An OPG radiograph noted endodontic treatment on teeth #21, 25, 36, 35 and 46. Radiographic assessment also noted possible pulp capping of tooth 17, to which the patient alluded at our initial discussions.

Careful assessment of indirect restorations noted restorative overhangs on the buccal aspect of #11 and 21, mesio-palatal aspect of #25, buccal of #35 and disto-bucaal aspect of 46. Soft tissue irritation with bleeding upon probing was noted related directly to plaque accumulation around these overhangs. Caries was noted around the mesial aspect of #37, requiring immediate attention and careful probing of the margin around the #36 noted possible caries on the distal aspect as well as the disto-lingual and mesio-lingual aspects of this particular tooth. The same was noted on the distal aspect of the #35 and radiographic assessment of these teeth noted open margins/caries on the distal aspect of #35 and 36."

Subsequently, the patient saw another general dentist who provided a plan of treatment which included the following:

- Retreatment of RCT @ #21, including lengthy dressing with calcium hydroxide
- Retreatment of RCT's @ #35 and 36 and placement of 2 crowns
- Placement of new porcelain restorations on teeth #16 and 26
- Recontouring of restorations @ #11, 25 and 46
- Provision of an occlusal splint
- Ongoing preventive/hygiene maintenance

The fees quoted for this retreatment were over $13,000.

The DDAS Peer Advisor was of the view that some of the work was not of a reasonable standard, and was supportive of the preference of Dr X to settle the matter early on the best terms possible. Early action to bring some certainty and finality in this case was indicated if it could be achieved. Perhaps somewhat surprisingly, the patient accepted the offer of Dr X to settle the matter by refunding Medicare the total cost of the two crowns that would require replacement. Initially, the patient

herself sought a direct personal refund, but given that she had paid nothing out of her own pocket, this was not appropriate.

The DDAS provided the member with a Deed of Release to assist with the refund. The refund was provided to Medicare with a request to apportion the refund against the patient's account. A Deed of Release is a simple legal document which, once signed by the parties, confirms the resolution of the patient's dissatisfaction and provides some certainty to both parties moving forward. The resolution of the case in this fashion was certainly an excellent outcome for the practitioner Dr X.

What if?

What were the alternatives in this matter for Dr X? Firstly, as the patient was a Medicare EPC patient, had she wished to make a formal complaint, the likelihood of her engaging a solicitor and alleging negligence was not the strongest possibility. Indeed, it would have been considerably more likely that she would have logged a complaint with either the Health Care Complaint Commission (the HCCC) or the Dental Board. Given the abundant and clear evidence in the case which was available to the DDAS Advisor, he opined that if the matter were to go to the Dental Board, the Board would likely have been critical of the following:

- Crowns at #35 and 36 with deficient margins and this within a year of being placed.
- All root canal therapies being performed without rubber dam isolation.
- Inadequate treatment planning and documentation.

Comment

Time and time again, the issue of dental records comes up in cases such as this. We all know that it takes time to generate good clinical records.

However, when things go wrong, so often we see that inadequate records generally reflect inadequate treatment, and this is the view taken by Courts and solicitors alike.

The Dental Board has minimal requirements for dental records and so for failings in this area, ignorance is no excuse. Of course the Board requirements for records are only a minimum standard and any self respecting practitioner should look upon them as such. Remember that your clinical records are evidence to support your side of the story, and a lack of appropriate information in the records leaves you in a difficult position as to defending your treatment.

Dr X sensibly decided that he would not wish to come before the Dental Board in such a matter, which is where many Medicare EPC complaints end up. Indeed, the DDAS, like the Dental Board, has experienced a considerable increase in complaints over the last year or so, and much of this increase is associated with Medicare EPC complaints. There is every chance that, if the Board had to consider a complaint from the patient, not only would a full refund of fees been ordered, but also the practitioner would likely have been found to have been guilty of unsatisfactory professional conduct and been asked to undertake refresher courses in Endodontics and treatment planning, with the possibility of having a practice restriction placed limiting the dentist's rights to provide endodontic treatment pending further assessment or approval from the Board after the completion of the necessary coursework as approved by the Board.

Direct negotiation with a dissatisfied patient, as difficult as it might be, is usually preferable to having to deal directly with a Dental Board complaint.

In Dr X's case, due to the dentist's timely response, there was no Dental Board complaint and the DDAS provided a Deed of Release which the patient duly signed.

Of course, this case is noteworthy for the level of respect and cooperation achieved between the dentist, other general dentists and specialist colleagues. At no time was there any direct criticism of the dentist subsequently by the other practitioners involved in the case. There was certainly full and frank disclosure of all relevant details by the subsequently-consulted dentists which was evidence of a high level of communication and trust.

Sadly, however, so often this is not the case. Time and time again at the DDAS we hear of patient's disquiet and subsequent decision to complain after comments alleged to have been made by the "second dentist". Dentists need to be on the alert so that, when asked to give an opinion on treatment that has not had a satisfactory outcome, they do not comment on the standard of care of the treatment provided by another.

In saying this however, it is important to realise that our patients pay well for our services and care, and we should not turn a blind eye to problems which exist. All patients at all times are owed a proper and professional diagnosis. A clear discussion with the patient with explanation and co-discovery of problems that are apparent at the time of consultation are what we should be considering if we find ourselves being in the unenviable position of "the second dentist".

Case #2

The patient attended for routine restorative treatment on some posterior teeth. Deep caries was removed, linings placed and the teeth restored. There were no pulp exposures evident. However, the dentist warned the patient that, due to the extent of the decay present, there was a chance that further treatment might be required and that if the teeth became painful, they should contact the practice.

Some six months later, the patient had pain emanating from one of the teeth treated. As her usual dentist was unavailable that day, she saw a second dentist who took a radiograph, diagnosed irreversible pulpitis and recommended RCT or extraction. The patient chose to have the tooth extracted.

When she asked why this had happened on a tooth recently restored, the second dentist advised that it was due to caries being "left behind" under the restoration. The patient was upset, not surprisingly, and obtained a copy of her records with the second dentist. She also requested to keep the tooth. Subsequently, she took the tooth and the records to her usual practitioner to show her.

The first dentist was somewhat flabbergasted at the claim voiced by the patient that she had "left decay behind". A radiograph was obtained of the extracted tooth which showed no caries under her restoration whatsoever! In this situation, obviously the tooth was exhibiting the common signs of pulpitis and pulpal death. As we all know, many posterior teeth with a long restorative history will ultimately require endodontic procedures if they are to be saved in the long term, and this is often associated with an extensive caries history, rather than the perfectly fine restoration which is placed.

Above all else, practitioners should remember not to falsely criticise others in an attempt to justify the treatment they are recommending.

No dentist looks 'bigger' in a patient's eyes by making the previous dentist (in whom the patient has placed their trust) look 'smaller'.

Case #3

A dentist was contacted by a patient from interstate who was visiting relatives in town. The patient had a crown on an upper central incisor tooth come out, and wanted it recemented. The dentist who saw the patient noted a small crack in the root face of the incisor which supported a post crown. He also noted a periodontal pocket on the distal aspect of the root. A radiograph was taken which showed that there was a fractured file remnant in the apical third of the root and a distal perforation of the root at the level of the post end.

The dentist discussed the problem with the patient who didn't appear to show any concern for the clinical problems. She simply demanded that it be recemented and she would worry about it when she got home.

In fact the patient did not worry about it when she got home! Some 15 months passed before the tooth became painful. Now living in a different town, she attended a local dentist. She recounted that she had some work done when visiting relatives a year or more earlier. The new dentist took a radiograph and, it seems, saw an opportunity to criticise:

"Well, we've certainly got a problem here! We have a fractured instrument in this tooth and a crown with a post coming out the side of the root! I've seen better work done by students – Vet students! You'll have to have it taken out and replaced with an implant. Very expensive!

But do you know what I think? I don't think you should have to pay for it! Do you?

In the case mentioned above, the last dentist only saw the patient as an emergency patient. He was not the dentist who did the suspect work!

Sadly, some dentists are expert at being the 'second dentist'. Don't let this be you! If you come across a case where work done recently is going to need to be replaced, ask permission from the patient before contacting the previous dentist and research how things have got to this point. Point out the clinical problems that exist in a calm manner without criticising others. Remember that one day you may be in the position of having your work criticised by others so be honest with the patient and fair to your colleagues.

In every such case, an early discussion with a friendly DDAS Peer Advisor can provide reassurance and assistance as how to approach a patient if you feel that they have recently had substandard work done which you feel will require replacement.