

Article

A reminder of the need to follow up patients and advise the patients of the possible consequences of not returning for review.



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A dentist recently sought legal advice after a complaint was made by a former patient to Australian Health Practitioner Regulation Agency ('AHPRA') regarding dental treatment provided.

The former patient alleged that an occlusal splint provided to protect her teeth from bruxing, caused an eruption of her molar teeth, and that the dentist failed to inform her of the possible complications of splint therapy.

The patient alleged that at no time was she given advice about wearing the splint, nor did the dentist discuss with her any risks associated with wearing the splint.

The patient presented to her dentist with complaints of pain around a molar in her upper jaw. It was noticed on examination that the patient had flattened cusps in the molar areas. A periapical radiograph indicated a widening periodontal ligament. Based on the clinical findings, the dentist made a diagnosis of bruxism. The agreed treatment was to provide the patient with an occlusal splint.

The splint was provided to the patient at an appointment one week later. The splint was a hard and soft full upper occlusal splint. The splint caused the patient to gag and the dentist shortened the size of the splint. The dentist advised the patient to wear the splint nightly. The patient was also advised to contact the dentist if there was a problem with the splint or if she experienced pain.

The dentist conceded that she failed to record her diagnosis of bruxism in her clinical notes. The dentist did not provide the patient with an

information leaflet on the use of the splint. The dentist did not advise the patient of any risks associated with the wearing of the splint. The dentist did not record her instructions to use the splint only at night, in her treatment notes. The dentist did not advise the patient to make a review appointment to check that the splint was comfortable and that there were no soft tissue problems. The dentist did not advise the patient to return for review if there was movement of her teeth.

The patient wore the splint nightly. Approximately two months later, the patient noticed that her four back molars had moved. The patient was finding it difficult to chew and on occasions her teeth scraped. After wearing the splint for approximately 2 months, the patient made an appointment with another dentist, at a date approximately 6 months after the splint had been inserted. The second dentist advised the patient that her molars had over erupted as a consequence of wearing the shortened occlusal splint. The patient was informed that she would require braces or, alternatively, crowning of the four molars to correct her occlusion.

The dentist made a number of concessions. The dentist admitted that she had not acted in accordance with expected standards for competent practice. The dentist advised that she was aware of a risk that the wearing of an occlusal splint could cause changes to the bite and that molars can over erupt. The dentist,

however, considered this to be a very rare complication. The dentist conceded that she did not discuss the possible complications with the patient or provide her with any warnings. The dentist also conceded deficiencies in her clinical records in that they failed to refer to the patient's diagnosis of bruxism and failed to detail any instructions regarding follow up appointments.

The dentist had since changed her practice by ensuring that she now properly warns patients with splints of the risks of super eruptions and ensures that they are given an information leaflet further explaining the risks and need for review. The dentist now arranges for patients with occlusal splints to be reviewed after one week, one month, two months and six months following the splint being fitted.

Panel Determination

The Panel took into account the concessions made by the dentist and in particular, that that the dentist had admitted fault, had displayed clear insight into her errors, and that she had made significant changes to her practices. The Panel found that the dentist had engaged in unprofessional conduct of a lesser standard and issued the dentist with a caution in respect of her treatment.

Comment

Dentists must ensure that they are warning their patients of all 'material' risks and potential complications involved with treatment even if the dentist considers that the eventuation of such a risk is low.

It is important that dentists explain to patients, not just of the need for follow up appointments, but also of the reason for the appointments. Patients must be given sufficient information to enable them to understand the need for review and the risk of failing to attend where a review is a critical part of the course of treatment.

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