AUSTRALIA

Risk management from Dental Protection
for hygienists, dental therapists and oral health therapists

Dental Protection

TEAMWISE

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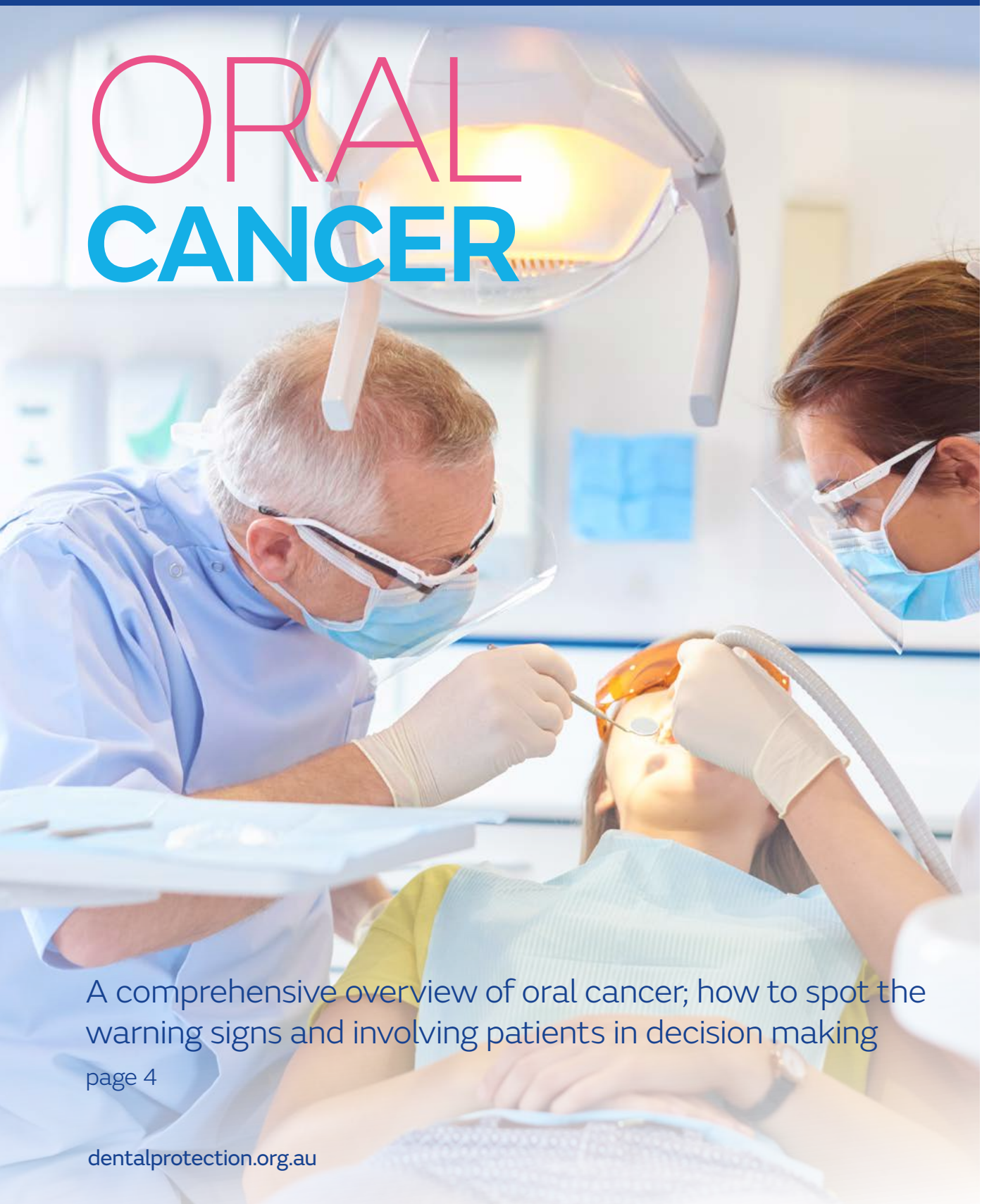

ORAL CANCER

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NEWS FROM DENTAL PROTECTION

Welcome to the latest edition of *Teamwise* which I hope you will find to be as enjoyable as it is interesting. Previous issues of *Teamwise* have referred to the increasing challenges confronting the dental profession and the volume of information with which you need to keep up to date. Whatever your area of practice there are now more new developments to consider than ever before.

In the past, qualification might have been regarded as a lifetime's licence for clinical practice, however, the significant and varied responsibilities of the clinician today means that your graduation only marks the start of a journey.

SOURCES OF INFORMATION

Keeping up to date in your own areas of practice requires knowledge and understanding derived from a variety of sources. Dental Protection members can access a huge range of risk management material, advice and support to inform their current thinking as part of the updating process. Dental Protection provides education online, in print and in person. The choice of time and place is yours.

NEW HYGIENIST/THERAPIST ADVISER

As part of our commitment to meeting members' needs, we have appointed Shireen Smith as our new Adviser and Case Consultant for dental hygienists, dental therapists and oral health therapists. She is there to help you both as a colleague and adviser – don't hesitate to contact her or the Dental Protection office on 1800 444 542 for advice or support in your professional practice.

Shireen graduated with a Bachelor of Oral Health from The University of Queensland. She is a compassionate and accomplished Oral Health Practitioner with over 10 years of distinguished performance in both high volume private practice and within the public dental sectors of Queensland health.

She has served as one of the general executives on the Queensland Board for ADOHTA for the past four years.

THANKS KEN

Ken Parker retired from his position as Operations Manager at Dental Protection Australia at the end of March, after 16 years of service to the organisation. Ken has offered invaluable support to oral health members and their representative organisations (DHAA and ADOHTA) during that time. Ken's warm and approachable presence (along with Vicki Biddle) at the end of the phone, and in person at state and national conferences, was always a welcome source of advice and camaraderie. Ken's hard work and enthusiasm were the foundation of Dental Protection's success in Australia.

To support the new structure, Dental Protection is delighted to announce that Rebecca Imrie has been appointed as Regional General Manager for Australia and New Zealand. Based in the region, supported by teams in Brisbane, Melbourne, Auckland and Wellington, she will play a business wide leadership role in the strategic development, alignment and execution of the business for our dental members.

If you have any feedback about this issue of *Teamwise*, please feel free to get in touch.

Best wishes,

Dr James Foster BDS, MFGDP(UK) LLM
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ORAL CANCER

A comprehensive overview of oral cancer; how to spot the warning signs and involving patients in decision making

In most developed countries, oral malignancy is a rare finding in primary care dental practice; indeed, the presence of malignancy is reported to be as low as 1-1.5 cases per 100,000/year and on this basis it is unlikely that most dental practitioners will see more than 1 or 2 cases in a lifetime. However oral cancer is still on the increase in most developed countries and this, coupled with the large number of cases seen by practitioners every year, make it clear that a vigilant approach should be adopted for every patient if malignancies are not to be overlooked and, most importantly, identified early as prognosis is largely dependent on early intervention.

All oral and facial lesions, swellings, discharge and ulceration require detailed investigation with careful consideration of the history and presenting features. The establishment of a differential diagnosis will then allow the practitioner to reflect on the possibility that the lesion is serious and/or sinister.

It should be remembered that most common oral lesions will have a logical aetiology and be readily treatable. However, practitioners should be alert to the unusual presentation eg, the loosening of one or two teeth in a mouth where there is no active periodontal disease.

ASSESSMENT

Whatever the evidence for and against a regular check-up with respect to periodontal disease and caries, these visits, as they occur, present an ideal opportunity for assessment of the oral mucosa.

Adopting a systematic approach to history taking and dental and oral examinations will enable the dental practitioner to become alerted to the possibility of a benign or malignant lesion requiring investigation, and will certainly assist in the inclusion of such a problem in a differential diagnosis. For example, an awareness of any particular ethnic propensity for malignancies of various kinds, and the relevance of factors such as age and sex are important for all clinicians.

Careful history taking can often reveal a recognised risk factor for oral cancer which may or may not be relevant to lesions seen in the mouth. For this reason, any such screening should include a lifestyle enquiry (use of tobacco, alcohol, betel nut etc.) and a regular review of the patient's medical history. Smokers should be encouraged to seek professional help with smoking cessation, with signposting to appropriate local cessation services.

The most effective oral assessment is one that follows a consistent, structured and reproducible format, for each and every adult patient. Ideally this should involve a visual inspection of all areas of the mouth, including the floor of mouth, gingivae, sulci, palate, tongue and oropharynx. The face should also be reviewed and the neck examined by palpation, with a note being made of the location and consistency of palpated lymph nodes and whether any node is attached to surrounding tissues as opposed to mobile.

GOOD ILLUMINATION

An adequate source of light is a fundamental requirement for the clinician performing the examination, along with a means of recording the findings in the patient's notes. Any unusual lesions should be palpated and examined by touch. A note should be made of the site, size, colour and consistency of any lesion, with the help of diagrams in the clinical notes, but ideally in the form of intra-oral camera images, against which any future comparisons can more easily be made.

Ulceration in the mouth can often be caused by trauma, and dental practitioners will be familiar with aphthous ulceration, denture trauma, cheek biting etc. Occasionally, practitioners themselves cause ulceration through the overzealous use of prophylaxis brushes or cups, or the accidental trauma which results from a rotating instrument abrading soft tissue.

An extra-oral examination should be performed, routinely checking the salivary glands, lymph nodes and bones of the mid and lower face. A careful view of the face can reveal a variety of skin lesions, such as melanoma, basal cell carcinoma and squamous cell carcinoma. In particular, concerns about facial asymmetry, persistent swelling or bleeding, or continuous pain should give reason to instigate fuller investigation. Masses in the salivary glands and nodes can be detected, and an early referral made. It is entirely appropriate for a dental practitioner to make a referral to a specialist for further investigation even when s/he is unsure as to the diagnosis. However, local guidelines for referral should be followed.

It is important to assess and document nerve function when dealing with any patient who complains of unusual or persistent facial pain. Areas of motor or sensory loss, particularly when associated with pain should be investigated by oral medicine, maxillofacial or neurology colleagues without delay. Dental practitioners should be mindful that they may be the only healthcare provider, who has the opportunity to see the patient and identify these conditions in time to make a difference to the prognosis.

PATIENT INVOLVEMENT

Patient concerns should be listened to carefully, investigated and acted upon. Further, the clinician must be prepared to have difficult conversations with patients about lifestyle and health choices, whilst at the same time explaining the clinical findings and concerns without either alarming the patient or glossing over the seriousness of the condition. These important conversations need to be documented clearly in the records, at the time they take place.

It is best practice for the practitioner to ask the patient to monitor the identified lesions and ask them to return for review within a defined period of time – usually two to three weeks depending on local or national guidelines. Making a formal review appointment provides an opportunity for the patient to be reassured that the lesion has indeed healed, and if not, arrangements for referral can then be discussed, ensuring the patient understands and consents.

SECOND OPINIONS

If there is any doubt about an individual case, it is good practice to ask a colleague in your practice to have a look at the patient with you. Any referral to a secondary care colleague should be made with the patient's consent, including an explanation of why a second opinion is being sought. If this is done firmly but sensitively, it need not alarm the patient – but try to avoid trivialising the matter, or the patient may not appreciate the need to act upon the referral.

A referral letter should be a proper summary of the case, including a provisional diagnosis or at least a clear statement of your concerns about the patient. It should include all the necessary data that the specialist will require in order to determine the urgency of the referral and the contact details for the patient. It should contain a statement about the patient's relevant medical history and relevant risk factors.

A digital clinical photograph is often helpful to demonstrate the area of concern and the appearance of the lesion, thereby allowing the specialist to prioritise the referral more appropriately. It is important for practitioners to be aware of the local protocols for referring patients with suspected malignant lesions, thereby avoiding unnecessary delays in the referral. Urgent referrals may be discussed with secondary care colleagues by telephone prior to having the referral letter sent to them. Letters of referral should not be handed over to the patient (unless a copy is also being sent) as the letter may be lost or simply forgotten about – or destroyed if the patient changes their mind. An audit trail for follow-up of any non-attendance is essential.

FOLLOW-UP

Establish a system that can follow up and monitor every referral relating to oral lesions and suspected pathology. If the lesion is serious enough to merit a second opinion, it is serious enough to follow up. To suggest a referral and then to take no further interest in the outcome has in the past been criticised as a breach of the practitioner's duty of care. Where that delay results in a delay in diagnosis and a delay in treatment and resultant negligence demonstrated, the size of the financial damages paid out may be significant.

RECORD KEEPING

The purpose of record keeping is to demonstrate over a period of time, that the clinician has set down, logically, the findings of one or more clinical events, in sufficient detail that the event can be recalled with accuracy, without relying upon memory alone. These records will show positive and negative findings, perhaps with the aid of diagrams, photographs or charts.

In the situation where a patient alleges negligence concerning an undiagnosed malignancy, or a significant delay in referral, the content of the records becomes particularly important. If the records contain no reference to the mucosa having been examined, it is difficult to disprove the allegation that the patient "first reported an ulcer to the dentist over six months ago". Equally, if the records can show that an ulcer was found, described clearly, and the patient was advised to return for review ten days later, the situation is greatly improved.

However, if the contemporaneous records demonstrate that an ulcer was found, described clearly, the implications explained to the patient and an appointment made for a review ten days later and there is evidence that the patient was followed up with another appointment made and broken, the defence against such an accusation is improved.

If the records also demonstrate that the patient failed to attend the review, and despite reminders they ignored documented attempts to arrange a review appointment, the refuted claim is less likely to be successful.

THE PERSISTENT PROBLEM

Any persistent problem, which has not responded to conventional treatment, should raise a red-flag of concern. Such difficulties can be highlighted in the patient who constantly takes analgesics but doesn't feel the pain is getting better, the apical cystic area which does not respond to root canal treatment, and an ulcer which does not heal within a couple of weeks.

Dental practitioners may inadvertently delay the early identification of suspicious lesions by using antibiotics as a first (and incorrect) line of treatment. If what appeared to be, an acute infection has not responded to a single course of antibiotics, then a formal review of the differential diagnosis should be considered and the clinical findings and discussions with the patient carefully documented.

Failure to respond to simple treatment is sometimes an indicator of more sinister problems. An ulcer adjacent to the flange of a denture or which is still present two to three weeks after the denture has been eased or removed, or after a rough tooth has been smoothed, requires further investigation.

A swelling that is still discharging or a radiolucent area, which does not improve following conventional root canal therapy (with or without antibiotics), might be something other than a simple infection. In a patient who has cooperated with treatment and attended regularly, a "two week response, or lack of response" to treatment can be an indicator of the need to refer quickly for a specialist opinion.

Close contact with the local hospital department should be fostered in order that acute cases can be seen in days rather than weeks, whenever possible. If a referral is felt to be in the patient's interest then the patient should be followed up to ensure that the visit has taken place. Indeed, if there is any lengthening of a treatment process because of poor patient co-operation or a failure to attend, then the patient should be informed of the urgent need to attend for an appointment with the consultant. Copies of referral letters and the replies, along with correspondence to patients regarding referral, should be safely retained.

INVESTIGATIONS

A variety of tests and investigations are now available to investigate suspicious intra-oral lesions. The use of these products requires a short formal training in their use and a clear understanding of the limitations. The danger of a false negative, creating a false sense of security, could lead to inappropriate reassurance and an inevitable delay in referral. The fault cannot be attributed to any particular product since clinicians must still rely on their own observations, suspicions and judgement.

This highlights the need to balance the natural desire to properly investigate a clinical condition, with the difficulty that might arise if the patient becomes concerned, distressed or frightened that s/he may have a malignant lesion. Patients should be handled sensitively and carefully, and a proper explanation given of the concerns and the need for referral. A false alarm will always be preferable to a missed diagnosis.

CO-OPERATION

Cases have been reported where, because of the ongoing acute symptoms associated with a malignant lesion, patients have returned regularly to a practice but have seen different dental practitioners on each occasion. In some cases, the urgent/emergency opinion is given by a general medical practitioner and it is possible for patients to see a combination of dental practitioners, doctors and hospital consultants, complaining of persistent symptoms, which are not being resolved by the succession of attendances – perhaps because no-one has the complete picture. It follows that at each emergency, casual, or urgent attendance, care should be taken to establish a patient's precise history, both in relation to the current complaints and in relation to any symptoms which might be associated or related, and which might be receiving treatment elsewhere.

With the patient's permission, progress can sometimes be expedited if the examining dental practitioner consults others who have been involved in the patient's treatment. If the patient would have benefited from a specialist referral, then all those doctors and dental practitioners who examined the patient recently could be involved in an investigation.

DELAYS

It is worth remembering that a late referral for a suspected malignant lesion will almost inevitably cause the patient and their family avoidable distress, pain and suffering through the delay in obtaining a diagnosis and then treatment. This may also worsen the overall prognosis for a patient.

There are many cases when some delay in referral is inevitable because of the need to eliminate the more common problems, but any delay must be justified within the records, showing a proper consideration through the histories, investigations and appropriateness of treatment plans and monitoring decisions. In order to ensure that any lumps, bumps, patches, swellings, discharges or ulceration that might turn into something unusual are properly assessed, it is important that dental practitioners stay abreast of current developments in the diagnosis of these types of lesions.

SUMMARY

The management of the patient depends on the specific diagnosis and the stage of the tumour (TNM classification). It is therefore crucial to refer patients with any suspicious lesions to a specialist at the earliest opportunity. A delay in referral can have devastating consequences for the patient, leading to allegations of negligence. Good patient management in these cases is a balance between effective communication, best clinical practice (informed by regular continuing professional development) and underpinned by accurate and appropriate record keeping.

Dental Protection is grateful to Prof John Gibson for his assistance with this article.

John is Professor of Medicine in Relation to Dentistry and Honorary Consultant in Oral Medicine, University of Glasgow Dental School & NHS Greater Glasgow & Clyde.

This letter documents one patient's journey from the initial detection of the lesion through to surgery.

Dear Practice Owner

I am really scared about the future. I am very confused about what has happened to me in the past two months. I have been thinking about the last couple of years and wondering whether my current situation could have been avoided.

You sent me to hospital six weeks ago because my bottom jaw had been swollen and my teeth had become loose. Since then, there has been a whirlwind of appointments and scans and investigations. I now know that I have a tumour in my jaw and I am worried that it was not noticed two years ago when I came to you about a loose tooth. You told me that there was nothing that could be done and it had to come out. You didn't take an x-ray – you just took out the tooth. How I wish I had gone somewhere else.

I have had x-rays of my teeth, jaws and chest. I have had CT and MRI scans, biopsies under general anaesthetic and given numerous blood samples. The specialist says I have a cancer that is not very common. Samples have to be sent away to be examined and this creates further delay. I am worried because all the while this cancer is growing. I don't know if it will spread further and I am now having sleepless nights.

The cancer has already spread to the front of my jaw. I am surprised that you didn't notice the swelling. I certainly noticed my other front teeth loosening and now I am told that they will all have to come out when I have an operation and my lip may go numb. What are you going to do to make this right? How will you make sure that this does not happen to anyone else?

I await your reply.

The case mentioned in this article is fictional but is an example of a common scenario that might occur in practice.

DENTAL PROTECTION'S APPROACH

This sort of case is always heartbreaking for the patient and their family. It also has the potential to create enormous sadness and stress for the practitioner(s) concerned when they reflect upon the impact of a single clinical incident which was subsequently consigned to the memory banks as entirely unremarkable.

Unless there was a significant event associated with the clinical decision at that time, it can be difficult for the practitioner to picture the event, having to rely entirely on the contemporaneous clinical records, which may be limited, given the lack of significance attached to the event at the time.

When analysing such a case in retrospect, it is relatively straightforward to identify a number of breaches of duty (failure to investigate the cause of the sudden tooth mobility, failure to adequately document the history and failure to consider/take a radiograph of the tooth prior to extraction).

The major failing in the case was the lack of curiosity about why the tooth had loosened in somewhat unusual circumstances. This lack of curiosity and care for the patient was at the heart of the treatment provided by the clinician during an appointment that didn't last more than 15 minutes. It is always hard to balance the risks of using ionising radiation against the potential benefits to the patient, although in this case it would have been justified to expose a single intra-oral film.

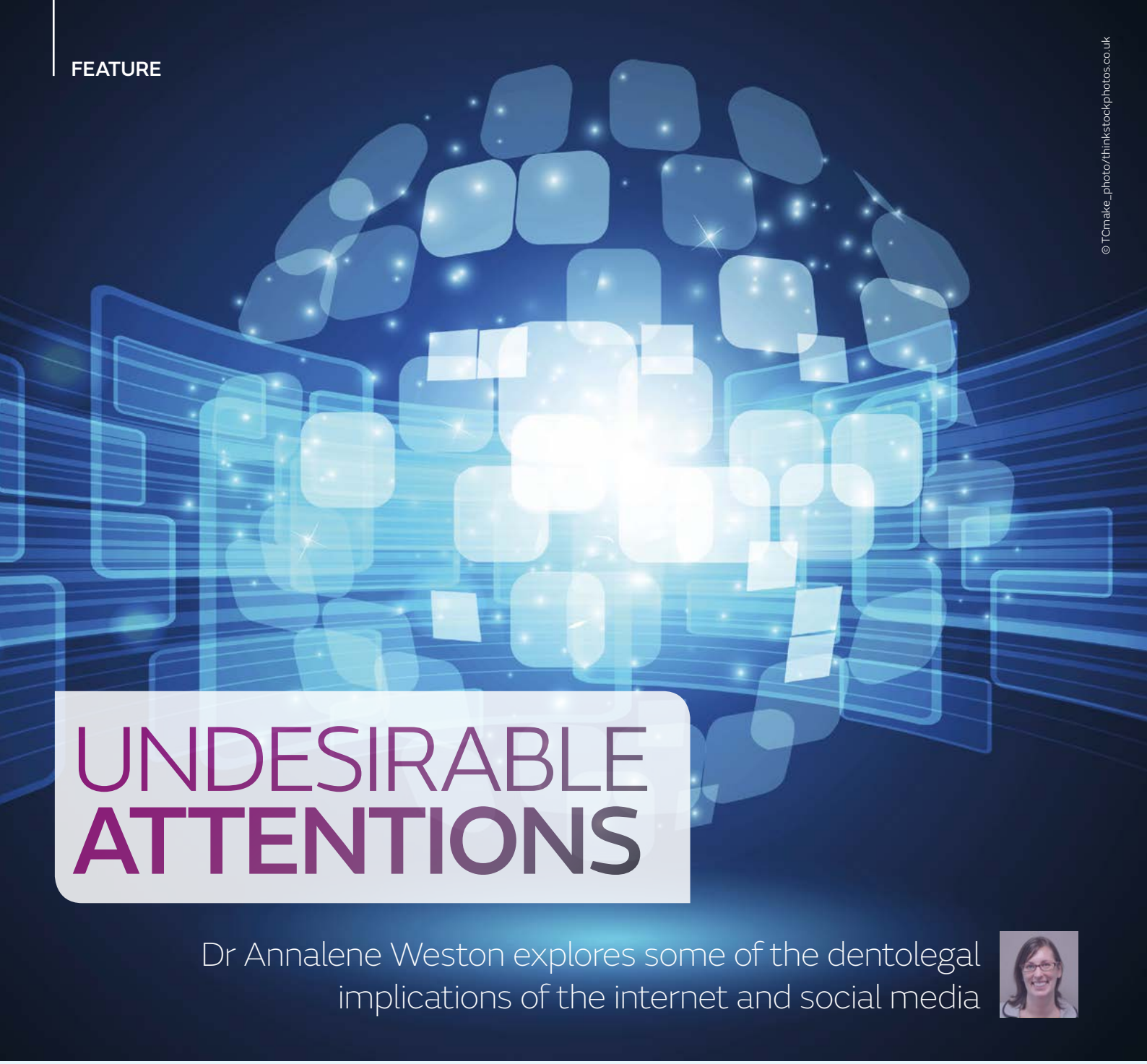
When responding to a letter of complaint or even a negligence claim, it is important to remember the human stories involved. But Dental Protection will also work to ensure that the member's journey through this traumatic process is as stress-free as it can be.

This particular case involved input from the whole Dental Protection team to ensure that the dental practitioner's experience of a harrowing clinical negligence claim was optimised. The dentolegal adviser assisted the practitioner to respond to the initial complaint and subsequently provided empathetic support throughout the case.

To run the case smoothly, both internal and external legal teams are involved as soon as a claim starts or a regulatory investigation is initiated. Usually one or more independent experts will be involved, examining the patient, their records and advising on the current condition and the prognosis for the patient. Most importantly experts advise on the relationship between the breaches of duty and causation and what resulted from the breach of duty. In a case like this, establishing causation would be the key to the final outcome.

In this case the experts were asked to predict whether the tumour had in fact been present/detectable when the tooth came out, and indeed, did the tumour cause the loosening of the original tooth that was extracted?

If the answer to such questions is "no", there may just be a way to defend the case in court even though the records are poor. If the answer is "yes", it may be necessary to settle the case on behalf of the member. Every case is considered on its merits. But it should be remembered that any decision to go to court is not without risk to the clinician concerned, even with the full support of Dental Protection and its extended team. Journeys through a legal system are rarely quick, and no party involved can achieve any kind of 'closure' until the process is complete.



UNDESIRABLE ATTENTIONS

Dr Annalene Weston explores some of the dentolegal implications of the internet and social media

The internet has certainly revolutionised the way we live our lives. The 1990s was the decade which saw the rapid expansion of the internet, which in turn paved the way for that most ubiquitous of internet tools, the search engine. Without a search facility, the scale of all the information available from the Internet would be a terrifying prospect. Google is only 18 years old but for some time now has been established as the most widely used of the popular search engines, three times more popular than the next three most used search engines (Bing, Yahoo and Ask in that order).

The internet can be a valuable friend, promoting and expanding our business and saving us time and money. But it can also be an enemy when it carries information that we would prefer not to be on public view. The management of your marketing activities and messages across all platforms (including the internet and social media) is quickly becoming one of the hottest international dentolegal topics and the pace of change is leaving the profession and its regulators struggling to keep up.

There are legal and ethical pitfalls to avoid – some being more obvious than others – and the purpose of this article is to assist a wider appreciation of these dentolegal risks and challenges.

BACKGROUND

Healthcare professionals are, of course, subject to the same laws as any other member of society, but they must also adhere to ethical principles and professional standards that are laid down by their professional regulatory body – in our case the Australian Health Practitioner Regulation Agency (AHPRA).

Many of these dental healthcare professionals are also practice owners and they, like the owners of any other business, need to make potential customers (patients) aware of the availability of the services they provide. Since the global financial crisis, not only have businesses been wrestling with the pressures of an

economic downturn and a prolonged stasis in the economy, but they have also had to adapt to the other factors that have transformed the social, business and professional landscape.

The explosion in the use of social media of all kinds, especially but not limited to the so-called "Generation Y" (born early-mid 1980s to about 2000) and the two generational cohorts either side of them – "Generation X" (born mid-60s to early-80s) and "Generation Z" or the "Millennials" (born since the millennium). These groups are often described as 'digital natives' because they readily embrace new technology and use it to assist them in choosing and using services in very different ways to the generations that preceded them.

Convenience, immediacy, continuous and seamless connectivity with friends and with the world, and ease of access to information sits at the heart of how many of us now live and dental practitioners ignore this fact at their peril.

The internet has been only one of many factors – but a very significant one – in the emergence of the empowered consumer of today. The internet and your practice website with an embedded map has replaced the brass plate as the signpost to your practice. Yet few dental practitioners are aware of the legislation surrounding advertising in all its forms, including the information placed on practice websites. Members of the dental team also demonstrate variability in their understanding of AHPRA's guidance on advertising and the use of social media and websites by dental registrants.

PATIENT FEEDBACK

It is one thing to invite patient feedback within your own practice, where it remains confidential between the patient and the practice. But it is quite another thing when patients can share their thoughts with anyone in the world who cares to read them. Not only has the internet made that possible, it has made it incredibly easy and many of our patients will have posted reviews on Yelp!, TripAdviser, Expedia and other such sites. Increasingly, patients can and do post feedback and other comments about their dental practioners and their experiences of a particular dental practice on a range of readily accessible websites, with some forums such as NIB Whitecoat directly inviting patients to 'review your healthcare provider'.

HOW NOT TO POST

1. If you elect to respond to any posting (whether favourable or unfavourable), bear in mind your duty of confidentiality. Just because the patient has chosen to make their views public does not give you the right to breach confidentiality by divulging details of the patient's treatment without their consent. This would contravene both AHPRA's Code of Conduct and the Privacy Act.

2. Any response you choose to make to a public posting is also public. Your patients and potential patients will form views about you and your professionalism which may not be the ones you were hoping for, and you may unwittingly bring an adverse comment made by a single patient, to the attention of a much wider audience. Remember that postings are generally easier to put up than to take down.

3. Never become involved (directly or through third parties) in any fictitious postings designed to put yourself or your practice in a favourable light. This would certainly be viewed by AHPRA as misleading and (depending on the circumstances) could be viewed as deliberately misleading or dishonest conduct.

> The internet is becoming the town square for the global village of tomorrow
>
> Bill Gates

AHPRA'S GUIDELINES

The starting point must be to familiarise yourself with AHPRA's published guidance on professional conduct, *Code of Conduct*.

WEBSITES

The guidance for what can and cannot be published on a practice website can be found in AHPRA's *Guideline's for Advertising Regulated Health Services*. You should be mindful of the fact that you can be held personally responsible and accountable for incorrect and misleading information about you which appears on a practice website over which you have no control. Satisfy yourself that such information fully complies with AHPRA's guidance, check it regularly and take immediate steps to raise any irregularities or concerns with those who have control over the website. Confirm these conversations in writing and retain copies to allow you to demonstrate, if challenged, that you took all reasonable steps to remain compliant with AHPRA's requirements.

Make sure that any actual or implied claims and statements on a website, that contains your name, can be substantiated and are not designed to mislead patients or suggest outcomes that are unlikely to be achieved for every patient. When working with web designers and marketing consultants remember that you, not they, will be held professionally accountable if their proposals cross the line of acceptability. Registered dental practitioners do not enjoy the same freedom as many of the other businesses that these consultants may be more familiar with working with. If in doubt, seek advice and guidance from Dental Protection.

THE USE OF SOCIAL MEDIA

AHPRA released a social media policy in March 2014 which contains specific advice on the use of social media by dental registrants. It is important to be aware that what you do and say in your personal and social life can still attract the interest of AHPRA in just the same way as things that you do in your professional life.

Any actions and statements made "on the spur of the moment", once in the public domain may remain there long after you might wish them to be - and perhaps for ever. Remember also that you have no control over how others might pass on your words and pictures. This is true of all forms of communication of course, but digital communication does carry much greater risks. Its ease of use and relative informality combined with high levels of connectivity means that errors of judgment can rapidly result in an unintended consequence far away from the intended target.

HELPFUL DOCUMENTS

Guidelines for advertising of regulated health services, Social media policy and Code of conduct found at **dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx**

Fact sheet detailing the 17 Australian privacy principals (from the Privacy Law 2014) **oaic.gov.au/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles**

BIOGRAPHY

Annalene Weston BDS MHL

Until recently Annalene was practising in Central Queensland and serving on the local HCC; however, she is now based in Brisbane and, in addition to her role as a dentolegal adviser for Dental Protection. Annalene works part-time in a suburban dental practice.

MINIMALIST APPROACH

Len D'Cruz considers what additional risks arise for clinicians adopting a minimally invasive approach to dentistry

TOP TIPS

- Ensure consent is valid
- Motivate patients to participate in dietary and oral hygiene protocols
- Keep excellent notes
- Share your approach with other colleagues who may see the patient
- Proactively counter any suggestion of "supervised neglect"

Whilst a minimally invasive (MI) approach to dentistry is not entirely new – its evidence base and popularity amongst forward thinking practitioners is gaining momentum in a number of countries across the world but most especially in Australia and the UK.

WHAT IS MINIMAL INTERVENTION DENTISTRY?

There are a number of definitions around but this would be a good starting point;

"The concept of minimal intervention dentistry is based on all the factors that affect the onset and progression of disease and therefore integrates concepts of prevention, control and treatment. The field of minimal intervention dentistry is wide, including the detection of lesions as early as possible, the identification of risk factors (risk assessment) and the implementation of preventive strategies and health education for the patient. When the effects of the disease are present, in the form of a carious lesion, other therapeutic strategies are required, but in this case the least invasive solutions should be chosen, for example remineralisation, therapeutic sealants and restorative care aimed at conserving the maximum amount of sound tissue."

STOP DESTROYING TISSUE

Ever since the concept of "extension for prevention" was discredited in the 1980s as a method of managing fissure caries, the drive to a more minimally invasive approach to caries has been ever-faster, utilising technology, leading edge diagnostic tests, modern materials and practice-based research.

Why does this conservative way of thinking warrant an article in a risk management publication? The first and most obvious reason is that it is new. And when something is new it has its innovators and early adopters and then the majority take some time to come on board. It is at this time that the concept presents the greatest challenge and risk for the innovators and early adopters.

For example, a non-interventive approach, to the untrained eye, and in the absence of good clear records could well appear to be supervised neglect, unless the notes indicate otherwise.

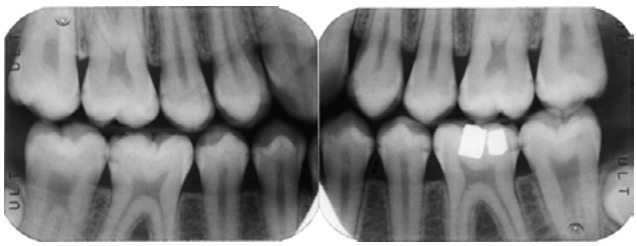


Figure 1 (radiographs © of Dr Louis Mackenzie)

If we look at the radiographs in Figure 1, it is clear there are lesions in several teeth. This is a young patient and the shared decision made with them was to adopt a non-interventive approach. The only evidence that this has worked will be based on a series of radiographs which will

show no further progression of the caries. The radiolucent areas won't miraculously disappear so there is every danger another practitioner may intervene either because they do not subscribe to the MI philosophy or they have not taken the opportunity of obtaining and reviewing the radiographs taken by the previous dental practitioner.

CONSENT

It is important that the patient should agree to the approach taken based upon the knowledge of the purpose, nature, likely effects and risks of the treatment, including the likelihood of its success and a discussion of any alternative to the MI approach.

The obvious alternative to a preventive approach is an interventive one and the risks of that should be made clear. When a non-operative approach to caries is taken, there needs to be significant understanding and cooperation from the patient in order to manage their personal diet as well as committing to a daily preventive regime which could well be time consuming. The patient might choose not to do this and instead would prefer to have their cavities restored conventionally; it is their right to choose.

There is a large body of evidence to support these MI principles and the concept now forms part of the curriculum at undergraduate level.

There have also been a number of publications and conferences on this issue such that it is becoming increasingly mainstream. The Dental Board of Australia Code of Conduct states that it is a dental practitioner's responsibility to provide good-quality care based on current evidence and authoritative guidance. The Code advises: "Good practice involves... practicing in accordance with the current and accepted evidence base of the health profession, including clinical outcomes" and "maintaining clinical records".

RECORDS

It is not unusual for a risk management article to exhort the readers to make good clinical notes. It is standard advice for the delivery of all clinical care but it assumes greater significance when patient compliance is the actual treatment delivered to the patient. These clinical records will include the written notes, radiographs, intra oral photographs, diet sheets and advice (both written and oral).

A minimally invasive approach helps to preserve pulpal health when there are deep cavities. By isolating a lesion and incarcerating the bacteria under a restoration, the clinician will be judged by some to have adopted an effective approach. But, to the uninitiated, it may appear to resemble recurrent caries or a failure to remove all the caries when viewed by other practitioners subsequently either in another practice or by colleagues in your own practice, if they have not been made aware of this approach.

When communicating this philosophy to the patients they should understand their ongoing commitment and duty to inform future dental practitioners that a non-interventive approach has been adopted. Without this information, the philosophy will be squandered through ignorance.

RISK TRANSFER

The MI approach to managing caries needs patient compliance. In this sense it resembles the management of periodontal disease, but unfortunately there is not an equivalent experience for the patient who can see an improvement in gum health, reduction in bleeding sites and reduction in measured pockets. Such feedback helps to reinforce behaviour change and compliance, but for the patient whose early lesions are actively monitored, there is no such feedback. This may have an impact on a patient's devotion to the daily routine of prevention and to re-attendance.

The dental practitioner who adopts the minimalist approach could find they are unwittingly transferring the risk of failure back to themselves. They are taking a gamble that the patient is sufficiently motivated to act on the preventive advice and attend for regular reviews. If they get it wrong, arguably the patient's condition may worsen.

This is not analogous to periodontal disease management since there is no alternative to the non-surgical management of periodontal disease and plaque control. Either they do it or they don't. In MI dentistry the alternative to them not doing the prevention is for the practitioner to intervene. Patient selection is therefore important and understanding their motivation may very well become increasingly important.

If their lifestyle and commitment militate against the MI approach, this needs consideration. The impact should be explained to the patient and recorded in the notes. If the patient is willing to try the concept in order to save enamel, this should be a shared decision.

MI dentistry offers a new way of providing high quality care to patients that is biologically sound and in the patient's best interests. There remains some risk to both patients and dental professionals in providing this but with careful and thoughtful communication with the patients these risks can be largely ameliorated.

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BIOGRAPHY

Dr Len D'Cruz BDS LDSRCS MFGDP(UK) LLM PGC MedEd Dip FOd

Len is based in the UK and divides his time between his work as a dentolegal adviser for Dental Protection and his own general practice.

DID THEY **UNDERSTAND** WHAT YOU SAID?

Dr Mark Dinwoodie explains the importance of checking that the patient has fully understood everything that you have told them about their treatment

BENEFITS OF CHECKING PATIENT UNDERSTANDING INCLUDE:

- information has been understood
- patient decisions are correctly informed relating to outcomes, options, risks and benefits
- misunderstandings are less likely
- future actions are accurately confirmed
- clarity over costs

HAVE YOU ORDERED A TAKE-AWAY MEAL RECENTLY?

Do you remember the last thing the other person did?

In most cases the person taking your order will run through what you ordered to check that they have understood you correctly and that the correct items are listed before they calculate the cost and take payment.

LISTING DETAILS IN A DENTAL SETTING

I wonder how often we check through all the key points when communicating information to others in clinical practice; for example, when important information is passed from the dental practitioner to patient or between members of the dental team.

It's not uncommon to discover a patient, returning after their initial treatment, who has not done what was advised because they had misunderstood what was intended. For example, they may have overloaded a quantity of bleaching gel in the trays designed for home use and so created a degree of inflammation to the gingival tissue.

We know that these sorts of misunderstandings about treatment, self-care, cost or follow up arrangements frequently occur, further compounded by natural memory decay, the use of jargon and our inability to accurately retain even relatively small amounts of information.

A common everyday scenario arises when we are given directions by a stranger – we are usually confused after about the fourth instruction. Likewise, the same confusion may arise with the sequence of events required in the assessment and placing of implants, or the timescale to complete a course of orthodontics, or the instructions around oral health care at home.

Interestingly in a recent poll of 2,000 patients who had been to see their medical general practitioner, 31% did not understand what their GP was telling them leaving them feeling confused, anxious or uneasy. A quarter of these did not ask for clarification – 11% said nothing because of embarrassment, with 10% doing likewise because they didn't want to waste their doctor's time. 3% gave up altogether and went to see another doctor.[1] There is no reason to think that dental patients would act any differently.

ELIMINATING MISUNDERSTANDING

A process of repeat-back/read-back is used by many high reliability organisations to help ensure "message sent is message received"[2] so reducing the likelihood of misunderstanding or incorrect transfer of information. Interestingly the process of repeating back words and phrases seems to help recall[3]. Of course there are other ways of supporting information transfer such as patient leaflets, photos, models or other written or online material. However, they may not be enough on their own to ensure understanding.

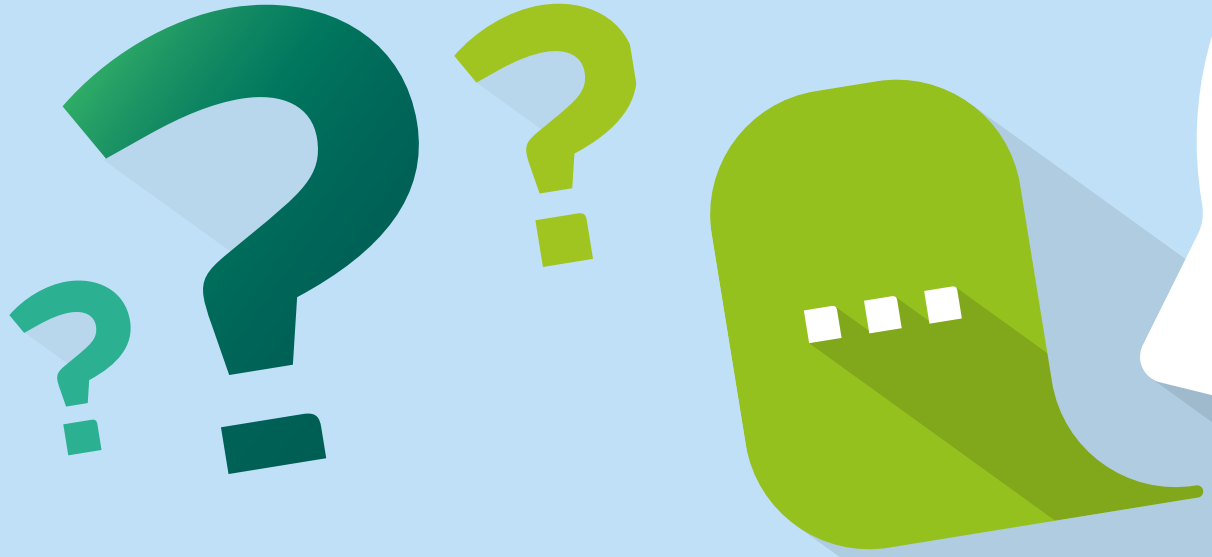
THE CHALLENGE IS HOW AND WHEN TO DO THIS?

The greater the consequences or likelihood of misunderstanding, then the greater is the imperative for checking understanding; such as complex or lengthy dental treatment, language or communication difficulties. The consequences of poor communication are increasingly significant when the proposed treatment carries greater risks, such as surgical treatments, when patients are anxious, or treatment is elective, such as cosmetic work, or equally when patients decline treatment.

There is an elevated risk of misunderstanding when patients wish to discontinue treatment, such as requesting the removal of orthodontic appliances before the treatment is completed.[4]

It is important that they clearly understand the consequences of:

- proceeding with a proposed treatment
- declining treatment
- discontinuing treatment.



> A process of repeat-back/read-back is used by many high reliability organisations to help ensure "message sent is message received"

REALISTIC EXPECTATIONS

Disappointment about a particular treatment can arise from unmet expectations. Consequently, checking your own understanding of patient expectations can help ensure that they are realistic.

Many healthcare professionals find it difficult to find the right words or phrases to use in these circumstances and feel that the patient may feel patronised. Reassuringly, research suggests that if done sensitively, patients actually welcome it.

Commonly used techniques as highlighted by Kemp[5] are shown below, with the third option being the preferred option. The first option may result in a patient saying they think they understand, but they may not or may prefer not to admit they don't understand. In the second option, the patient may feel like they are being subjected to a test. The third option is the preferred option – the key aspect being to not make the patient feel bad if they don't understand, what Kemp describes as a "shame-free space"

This process obviously takes time and it may not be possible or appropriate to check absolutely everything has been understood. By deciding in advance the most important things that you would want the patient to understand will focus your efforts on those things which you need to check.

Although this article has focused on interactions between dental practitioners and their patients, checking understanding is just as important when sharing clinical or administrative information to other members of the dental team, eg. when a patient requires an urgent referral, requires further investigation of their medical history, or when new guidelines or protocols have to be introduced to your own practice dental team.

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KEMP'S TECHNIQUES

1. *"I've given you a lot of information. Is there anything you don't understand?"* (Yes-No)
2. *"It's important that you do this exactly the way I explained. Could you tell me what I've told you?"* (Tell Back Directive)
3. ***"I've given you a lot of information. It would be helpful to me to hear your understanding about your condition and its treatment."*** (Tell Back Collaborative) – preferred

BIOGRAPHY

Dr Mark Dinwoodie

Dr Dinwoodie is Director of Educational Services for Dental Protection.

One of the first principles one learns at dental school is that of the importance of taking a detailed medical history before treating any patient. Most dental schools have their own design of medical history questionnaire, and this shapes the format, style and extent of any further questioning of the patient on particular points arising from their medical history.

Many practices, in similar fashion, use their own medical history questionnaires which patients are asked to complete when attending the practice for the first time. In most cases the design provides for the patient to answer "yes" or "no" to a set of specific predetermined questions, and then to sign and date the completed questionnaire. The dental practitioner then ensures that the patient has properly understood all of the questions (for example, where patients leave one or more answers blank), and where "yes" answers have been given, further questioning of the patient will allow the details of any response to be clarified and expanded upon. Sometimes this highlights areas where further information needs to be gathered – perhaps by contacting the patient's medical practitioner (with the patient's consent), or by asking the patient to bring any medication they are taking along to the next visit, so that the precise drugs and dosages can be identified with certainty.

In several recent cases, the patient's medical history has been at the heart of negligence claims brought against dental pratitioners. For example, a failure to take into account certain allergies to drugs (especially penicillin and other antibiotics), or to recognise the significance of long-term anticoagulants predisposing to post-operative bleedings, or the potential for drug interactions. Medications can also have side effects that cause visible changes

> In all cases, the taking and confirmation of a medical history is the role of the dental practitioner and is certainly a key part of a dentist's duty of care

in the soft tissue (phenytoin, calcium channel blockers and anti-retrovirals).

Cases such as these often reveal the fact that although a practitioner might have taken a comprehensive medical history when the patient first attended as a new patient, this process has either not been repeated, or has been much more superficial, when the patient has returned for successive courses of treatment. In the majority of cases, no further written medical history questionnaire is undertaken, and indeed there is rarely any note on the record card to confirm what (if any) further questioning has taken place to update the patient's medical history. Clearly the clinician's record needs to keep pace with attendances by the patient.

It is self-evident that a patient's medical history status is not static, and indeed, a patient's medication prescribed by others may change from visit to visit. It is wise, therefore, to ensure not only that changes in medical history (including medication) are regularly checked and updated, but also that this fact is clearly recorded as a dated entry in the patient's clinical notes. Guidance from the Dental Board of Australia states that a "completed and current medical history including any adverse drug reactions" should be recorded and maintained within dental records.[1]

Many dental practitioners take medical health histories verbally and if no positive or significant responses are elicited, an entry such as *"MH – nil"* is made in the records. While better than no entry, this approach carries the disadvantage that it can be difficult or impossible to establish precisely what questions were asked of the patient, in what terms, and what answers were given. A well-structured health record questionnaire form, which is completed, signed and dated by the patient, and subsequently updated on a regular basis (ideally, during each successive course of treatment), is not only in the patient's best interest, but is also the best platform for the successful defence of cases where failure to elicit or act upon a relevant aspect of medical history leads to avoidable harm to the patient. If there is doubt regarding a patient's medical history, it may be sensible to defer treatment pending clarification of any areas of uncertainty.

In all cases, the taking and confirmation of a medical history is the role of the dental practitioner and is certainly a key part of a dental practitioner's duty of care. Medical history forms also need to be kept up to date to comply with The Privacy Act 1988 and this Privacy legislation was further amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which was enacted on 12 March 2014 in order to provide for a more open and transparent handling of personal information in particular the Australian Privacy Principle (APP) 10, the Quality of Personal Information.

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CASE STUDY

A patient visited a dental practice complaining of a sore gum. His regular dentist was off work sick on that day and the receptionist informed the associate of the problem.

The associate, who was under pressure as he was seeing a number of his colleague's patients, saw from the record card that the patient had suffered from recurrent pericoronitis for a long time and took the view that an examination was not required. He passed a message via the receptionist that this was likely to be a recurrence of the same problem and provided a prescription for metronidazole.

Unfortunately, the patient's medical history was not checked and, in fact, he was on long-term warfarin therapy. The antibiotic potentiated the action of the warfarin and caused profuse bleeding when the patient accidentally cut himself whilst using a saw at home. This led to the patient being hospitalised and needing an emergency transfusion.

The associate sought advice and it was agreed that he would arrange to see the patient for review and explain the problems that could result from a prescription of this type of antibiotic despite it being a drug commonly used to treat pericoronitis. This was an embarrassing discussion for the associate who apologised and assured the patient that he had learnt from this incident. The patient took no further action.

LEARNING POINTS

This case illustrates:

- the importance of a clinical examination to confirm that the prescription was a justified treatment and also the need for careful consideration of the patient's medical history for possible drug interactions
- the value of an apology when the patient has a poor experience.

The case mentioned in this article is fictional but is an example of a common scenario that might occur in practice.

ASK AT YOUR OWN RISK

Joan James looks as the importance of asking for help from Dental Protection in light of AHPRA statistics

Dental Protection recently sent a message to oral health members (dental hygienists, OHTs and dental therapists), reflecting on the reasons that members choose Dental Protection and the many benefits of membership. We hope you found the information valuable and have explored some of the online member benefits and will find time in busy schedules to attend one or more of the complimentary workshops or seminars.

I have been a member of Dental Protection for 15 years and have more recently been proud to work with the team in Brisbane while Vicki Biddle has been on extended leave. In my experience, one of the most valuable benefits of Dental Protection membership is the availability of colleague-to-colleague support. That means that, as an oral health practitioner, you have access to an oral health colleague when you require advice or support. That support can include phone call advice regarding practice issues or support in responding to a complaint or notification.

NO WAITING

Support begins from the moment you receive a complaint or notification – we can guide you through the entire process which many find stressful. Members are encouraged to take advantage of that support following an adverse clinical outcome, even before a complaint has been made. Your oral health adviser can assist you to handle the situation – and how best to avoid the incident escalating to another level.

AHPRA data supports the fact that 1 in 10 dental practitioners will receive a complaint annually and that oral health practitioners will be represented in that mix. The most recent data from AHPRA about notifications regarding Dental Practitioners states:

"This year, 1,025 notifications were received nationally (including HPCA in NSW) about dental practitioners. This represents an increase of 33.8%. AHPRA received and managed 497 of these matters (excluding the HPCA). Notifications about dental practitioners represented 8.2% of all notifications received by AHPRA (excluding HPCA) this year.

Nationally, 1.5% of registered health practitioners received notifications this year. The percentage of notifications received by

registered dental practitioners was 4.7%, which is 3.2% higher than the national percentage across all registered professions."[1]

COMMON COMPLAINTS

The most common complaints made to oral health practitioners relate to consent, scope of practice and infection control. It is not a coincidence that the popular Dental Protection Sliding Doors Seminars thoroughly cover those topics, and are available to members at no cost. There are a number of seminars scheduled throughout Australia in 2017. Further information and registration is available at: **dentalprotection.org.au**

TALKING TO PEOPLE WHO UNDERSTAND

Unfortunately, members may not appreciate the value of the support provided by the Dental Protection advisers, in particular the colleague-to-colleague support, until there has been an incident, complaint or notification. The oral health adviser at Dental Protection is an empathic colleague who understands the particular circumstances around oral health practice – that we are well-educated, registered dental practitioners, are responsible professionals within structured professional relationships, and are key providers of oral health care to individuals and the community.

WHAT COLLEAGUES HAVE SAID ABOUT THE SUPPORT THEY RECEIVED:

- *"I can't thank you enough for helping me through this difficult time, your advice and prompt emails have really taken the pressure off me."*
- *"Thank you so much.....this is exactly what I've been trying to say and now I have it in writing to support me."*

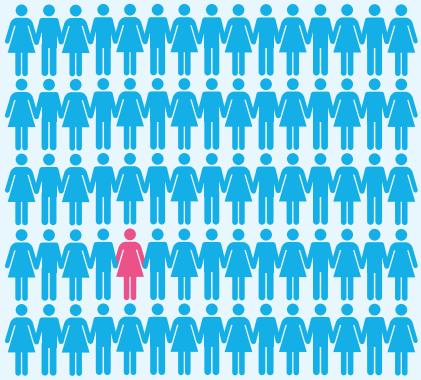
I encourage members to readily seek advice and support, particularly when faced with the unpleasant situation of having received a complaint or notification. Your Dental Protection adviser-colleague, along with a team of dentolegal advisers, will work closely on your behalf to achieve an acceptable outcome.

THE AHPRA ANNUAL REPORT 2016 IN NUMBERS

- **Growth in notifications nationally:**
  There were 10,082 notifications (complaints or concerns) received nationally during the year, an increase of 19.7%, representing 1.5% of the registration base. This is largely due to the 105.5% increase in matters referred to AHPRA from the Office of the Health Ombudsman in Queensland.
- **An increase in mandatory notifications:**
  The National Law requires that a registered health practitioner must notify the Board if, in the course of practising their profession, they form a reasonable belief that another registered health practitioner has behaved in a way that constitutes 'notifiable conduct'. Mandatory notifications increased nationally, from 789 in 2014/15 to 920 in 2015/16.

NOTIFICATIONS

(Note: all totals and percentages quoted are inclusive of AHPRA and NSW data)



1.5% of 657,621 practitioners were the subject of a notification. That is 10,082 notifications in 2015/16

81% of finalised 'immediate actions' – for the most serious risks to public safety – led to restrictions on registration. (Restrictions include suspension, conditions, undertakings or surrender of registration)

BIOGRAPHY

Joan James

Joan James stepped into the role of Hygienist/OHT Adviser on a temporary basis until Shireen Smith was appointed this year. Dental Protection is very grateful to Joan for her valuable input during this time.

REFERENCE

1. AHPRA Annual Report: ahpra.gov.au/annualreport/2016

CONTACTS

You can contact Dental Protection for assistance dentalprotection.org.au

Membership Services
Telephone 1800 444 542

Dentolegal advice
Telephone 1800 444 542

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