

LEAVING YOUR PRACTICE



CONTINUUM SERIES

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OVERVIEW

Dental Protection's **Continuum** series of Advice Booklets forms part of our commitment to assist and support members every step of the way from student to graduate, from the early years of professional life on to safely negotiating the many challenges that can arise at critical moments throughout a professional career, and helping them through to a happy and worry-free retirement (and beyond). In particular we aim to make members aware of the dento-legal pitfalls associated with all these critical moments, so that they are more able to cope with them at a personal level and to manage them safely and successfully in a professional sense.

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1.0 MOVING ON?

Leaving a practice may mean a fresh start for you, but if your record keeping and general practices have been a little casual, the whiff of negligence claims may not be far behind.

Settling into a dental practice is tough work, but get it right and the reward is a loyal patient base. For some, choosing to stay for many years in the same practice is a happy option; for others, family influences, geographical preferences, financial strains or just wanderlust can mean moving practices often, particularly in the early years. Of late, economic challenges and political policies have exacerbated the instability of practice positions and accelerated this movement, particularly of young dentists. Some authorities report that more than 25% of young graduates are working relatively transiently in two or more practices at any one time. Equally, an increasing number of dentists in their 50s are selling practices and moving from practice ownership to retirement or full or part-time associateships.

Noteworthy moments

The first years after dental school (Foundation training in the UK), setting up a new practice, maternity or paternity leave, unexpected illness, a sabbatical, opting for a part-time role or retiring fully from clinical practice are all noteworthy career moments.

The significant thread that runs through these is that they represent a moment in time when someone else will take over the responsibility for all – or some – of your patients. It is this that presents a potentially critical moment where you may be – either quickly or over a more prolonged period – vulnerable to criticism, complaints and allegations of negligence. But there are ways in which the risks associated with leaving your practice can be reduced and, if the unthinkable happens, ways in which subsequent risks can be contained.

GREY DAY

Within a dentist's patient list, there are always those who make the job a joy and, at the other end of the spectrum, those with whom the professional relationship is one of constant unease – their name in the appointment making it a grey day. We assume no problems will arise with the first group after we leave a practice and suspect risks of complaints may emanate from the second. But, evidence suggests this is not necessarily the case. There are more complex factors that can lead to a patient's dissatisfaction about our care of them once we have left our practice.

DENTAL DISAGREEMENT

It is often said, with a degree of irony, that if a patient is presented to five different dentists, individually they will come up with seven different treatment plans. While this illustrates the inexact science of dental diagnosis and treatment planning, it also demonstrates the frequency of disagreement between dentists. Normally, in a practice where there is good communication between clinicians, differences of opinion are easily worked through in the patients' best clinical – and financial – interests.

The situation can significantly alter, however, once responsibilities transfer entirely to a new clinician and the new dentist finds that, from their perspective, all is not well. On the one hand, it is to be expected that some treatment plans will need completing, a few fillings will break and the odd crown or veneer will fracture in the first few months. Agreement about financial arrangements within a contract to allow for this work to be completed should prevent any ill feeling arising. On the other hand, there are some circumstances that lead to issues which are not so simply resolved.

ALLEGED UNDER TREATMENT

It is becoming increasingly common for patients to bring claims alleging under-treatment when a patient moves to a new dentist or when a practice changes hands. This scenario is often complicated by the involvement of a private capitation scheme. Patients who are registered under such capitation schemes, for example, may have felt secure, believing their regularly monthly payments have ensured that all their dental needs have been regularly cared for.

Unfortunately, there is a minority of dentists who accept the regular income from the capitation scheme but do not provide the necessary care when appropriate. There are, of course, times when it is prudent to observe and monitor rather than dive in and treat. If the clinical notes do not record and justify this approach, inevitably clinicians are left in a compromised position. This is particularly true when a new dentist diagnoses problems that have patently been present for a number of years. There will always be differences in clinical opinions but, where there are significant issues for the patient in terms of undiagnosed and/or untreated disease, the new clinician has a duty to discuss this with the patient.

PATIENTS FIRST

It is not surprising that the General Dental Council (GDC) – whose purpose is to protect patients – has sought to revise its ethical guidance to reflect current market conditions. *Standards for the dental team* was published in September 2013 and sets out the nine principles that registrants must uphold at all times. The first of these is, 'Put patients' interests first'.

It emphasises that '*You must put patients' interests before your own or those of any colleague, business or organisation.*' (1.7). This statement, and many others, are clearly written in response to moderating behaviours that may lead to inappropriate treatment provision or misleading statements about its availability under the National Health Service.

In 1.7.2, the GDC states '*if you work in a practice that provides both NHS (or equivalent health service) and private treatment (a mixed practice), you must make clear to your patients which treatments can be provided under the NHS (or equivalent service) and which can only be provided on a private basis.*'

A further statement under 1.7.3 adds that '*you must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately.*' The upward trend in GDC cases is alarming and poses a threat in everyday practice. In particular, the GDC takes a serious approach to an allegation that a dentist has misled a patient, frequently considering it to amount to an allegation of dishonesty.

A finding of dishonesty leaves a dentist at risk of erasure from the register. To mitigate the risks, it is important to reassess the clinical decision process to ensure patients are fully informed, Leaving a

Did the records show?

- Identification of the relevant problems in the patient's mouth
- Monitoring of the patient's condition, and/or the carrying out of the appropriate investigations that would provide the information necessary to reach a proper diagnosis and treatment plan
- Identification of any relevant risk factors that might be contributing to the patient's oral health (oral hygiene, diet, smoking, bruxism or parafunction)
- Whether or not the dentist had informed the patient about their oral condition, and communicated effectively with the patient about what was being done and why, or what the patient could do to help, control or improve the situation
- The available treatment options available to the patient that, in some circumstances, might include the possibility of a referral for specialist advice or treatment
- What was discussed with the patient, the option of a referral for a second opinion or specialist assistance
- That the patient has successively declined the dentist's recommendations for certain treatment or, perhaps, a referral
- The recommendations that were made and the patient's response.

There may be trouble ahead if..

- A patient has only ever seen one dentist for their care and treatment
- The dentist and the patient thought they had long-term treatment understandings
- A patient has enjoyed the familiarity and culture of a practice
- The medical and dental histories and information about patients has been kept only in the dentist's head rather than in the records
- Over the course of a long career with few complaints, the practitioner has not kept up to speed with the record-keeping detail regulators require
- It has not been thought necessary to record the conversations leading to a familiar and regular patient giving consent for treatment choices
- The dentist knows a patient so well that the progression of some slowly emerging conditions, such as periodontal disease or chronically infected teeth, was not spotted
- The dentist favoured a 'patch up' style of dentistry, considered by a patient as the less stressful, quicker and cheaper treatment option
- Not enough time had been given to complete or discuss a long-term treatment plan due to short-term practitioners dealing with a patient which resulted in a crisis management of the situation
- The dentist leaves midway through completing treatment plans, leaving some work to be finished by a successor.

2.0 HAUNTED BY THE PAST

practice may mean a new start for you, but it's impossible to leave everything behind. Difficult situations you have gone through may return – this time in the form of a legal case.

Most practitioners will have had patients, at some stage in their career, who seem to stagger from one crisis to another and whose treatment never really feels to be in the practitioner's control. These patients often present with so many unexpected emergency problems in between their scheduled review appointments that one course of treatment seems to merge seamlessly into the next. There is a danger that the patient's treatment might be approached on these occasions in a reactive 'patch and mend' fashion, rather than a more proactive 'what's happening here, and why?' fashion. You will probably, prudently, in these cases have stood back from time to time and taken a more detailed overview of the patient's oral health, approaching this in the same logical fashion as one might approach a patient you were treating for the first time.

DISTRACTIONS AND ASSUMPTIONS

'Supervised neglect' is the emotive phrase often used to describe a situation where a patient's oral health has been allowed to deteriorate over a period of time but can be confused with a situation where the patient's oral health has been deteriorating despite the dentist's best efforts.

Many factors can contribute to supervised neglect to a greater or lesser extent. A dentist who is under stress for reasons unrelated to dentistry (perhaps financial worries, or domestic/personal problems) may be distracted by these outside pressures and become less attentive in the treatment of patients. Other dentists are unwell physically or mentally, and may not always realise this at the time; in one instance, the explanation was no more complex than that the practitioner in question had not realised the extent to which his eyesight had deteriorated. Sometimes dentists are simply too busy, perhaps having a treatment target that is effectively unachievable, and supervised neglect becomes a response to having to see too many patients in too little time.

A feature of supervised neglect can be an assumption on the part of the treating clinician that the patient 'wasn't interested' in a certain treatment option, or that some old and discoloured restorations 'didn't worry them'. As long as confirmation of your discussion about the options, the risks and benefits, your recommendations and the patient's response is consistently and fully recorded in the patient's notes, he is not easily able to say 'how did you know – you never asked me'. This becomes particularly important when treating patients with whom you have a less formal relationship – perhaps professional colleagues, or staff, or friends, or family members. However, it is important to remember that the patients' circumstances, health and attitudes can change and clinical conditions can slowly deteriorate over time. Recording a methodical process of examination and treatment planning at each course of treatment, together with discussion with the patient of all options that might be suitable for them, will help to demonstrate high-quality care and current best practice.

PERIODONTAL RECORDS

Dentists can find themselves criticised when patients claim their periodontal condition has been deteriorating for some time and they have not been made aware of it. It is then critical to have consistently recorded that the patient's periodontal condition has been properly assessed, monitored and treated. It is expected that a Basic Periodontal Examination (BPE) should be carried out and recorded for all new patients, at least annually for those with scores of 0 to 2 and more frequently for patients with scores of 3 and 4. The purpose of the BPE score is for screening the periodontal health of a patient and to inform the planning of treatment and review. An extremely clear and helpful publication, 'Young Practitioners Guide to Periodontology' has been developed by the British Society of Periodontology (BSP) and can be found on the BSP website at www.bsperio.org.uk

Other countries will have their own national guidelines for monitoring and managing periodontal disease with which clinicians should be familiar and adopted in practice.

AVOIDING THE PITFALLS

Regular and effective communication with the patient about their oral condition, and about what treatment is (and isn't) being proposed, and why, is a valuable protection against an allegation of under-treatment. Full and meticulous records, based upon appropriate investigations, are equally invaluable. These two strategies, coupled with an up-to-date awareness of current thinking in diagnosis and treatment planning, will avoid the majority of problems in this area.

Good record keeping...

- Is probably the most important area in managing and eliminating risk in practice
- Is the best way for the dental team to reduce the risk of an adverse event occurring
- Provides a valuable defence against allegations of negligence or poor practice
- Gives a good defence to allegations, a poor record provides a poor defence and no record provides no defence at all
- Means comprehensive and accurate clinical notes
- Should contain sufficient information (both administrative and clinical) for a third party to be able to see and understand precisely what occurred at any particular time
- Normally includes details of the medical and social history, sufficient background information on the patient, and a full record of all discussions with, and treatment of, the patient.

3.0 SO LONG, FAREWELL...

Leaving a practice to work elsewhere can mean patients wanting to come with you or you leaving them in another clinician's care. So, what are the legal implications of these two scenarios?

Most dentists want to leave their practice without the anxiety of future complaints, claims or conflict. If you become aware you are leaving your practice at some time in the future, it is not yet the moment to relax and rejoice in the comfort of knowing that someone else will be taking over your patient list. Common sense tells us this is actually the time to step up the efforts to establish credible patterns of best practice and preparation should start some four years before you leave a practice in order to give you the best chance of an anxiety-free departure.

When a dentist leaves an existing business arrangement in a practice – and continues to work reasonably close to the practice they have just left (subject to any contractual terms precluding this) – it is likely some patients will want to follow the dentist for their on-going dental care. In that case, it may be possible to arrange with the original practice owner to forward records for those patients who wish to continue treatment in the new practice. Working from the original set of records would be in the patient's best interests as it avoids the need to retake radiographs and allows the clinician to monitor care and review historical treatment more accurately.

Situations also arise whereby an assistant dentist may leave a practice and wish to take the patient records with them. While there is no statutory basis for this, it is widely thought that, unless agreed otherwise, the records are owned by the practice. However, any departing practitioner should be given reasonable access to the records if required in the future.

This will allow them to respond to any concerns later raised by patients. To avoid grounds for dispute on the departure of a practitioner, it is recommended that reference to the ownership of records be made at the outset in a written contract between the practice owner and associate dentist.

CONTRACTS

If you are leaving a practice, but continuing to practise elsewhere, you may be moving sufficiently beyond the immediate area that it is unlikely to provoke any contractual, ethical or other dispute with your former colleague(s). If you are moving more locally, you may have contractual obligations regarding what you can or cannot say to the patients. However, it is important to recognise, notwithstanding any such contract, that the patient must be free to choose to receive treatment from a particular clinician and nothing should be done by any party to obstruct that choice eg. deliberately providing them with incomplete, misleading or untruthful information about the whereabouts of the previous dentist. Ideally, the outgoing dentist should personally introduce the new dentist to patients. It may be possible for a professional and amicable compromise to be reached between the parties, so that the rights of patients are respected, while making appropriate arrangements for the recognition (financially or otherwise) of the transfer of goodwill.

CRITICISM

Overt criticism of colleagues – and the treatment they have provided – when expressed directly to a patient is, obviously, poor practice. It reduces the patient's confidence in the profession as a whole and will cause unnecessary irritation for the recipient. There are always those practitioners who feel they have a duty to offer a view on treatment provided elsewhere, especially when a patient seeks their professional opinion, but it is best avoided. Such opinions may be given with the best of intentions but, often, the clinician may not be in possession of all relevant facts.

That said, patients are entitled to know their dental status and practitioners have a duty to inform them of the clinical facts. For dentists called upon to provide second opinions, report on a patient's condition after treatment provided by a previous dentist or expert reports, it is better to avoid these pitfalls when presenting the facts in an objective way.

CHILDREN

An important area to consider when planning to leave a practice is the care of your child patients. When a dentist has worked in a practice for many years, one of the great pleasures is that loyal patients bring their children for dental care. However, because children are growing and developing constantly, it is all the more critical to record the changes, particularly where eruption of teeth is being monitored and future orthodontic needs considered. These accurate records will give the patient's future dentist the confidence to know that the child – and his parents – will not be surprised by treatment suggestions. This is also the case where particularly caries-prone children continue to present with cavities. It would be unfortunate if the parents alleged they had never received any prevention advice and the records did not provide the counter-evidence.

CARING CORRESPONDENCE

When clinicians disappear without warning – other than in the most exceptional of circumstances – patients will often feel let down, or even abandoned. This, in turn, can make them less forgiving if it later transpires there is some kind of problem with work that was previously provided. The simplest of gestures, such as a letter to former patients (agreed where necessary with any other interested party such as a new practice owner or incoming colleague) thanking them for their past loyalty, confirming any arrangements you have made for their future care and treatment, and wishing them well for the future, ends what may have been a long and happy relationship on a positive, professional note.

Record makers – and breakers

- Leave the best possible information for a subsequent clinician. It is often the missing or forgotten parts of the story that create misunderstandings and frustration
- It is essential you can demonstrate you have always acted in your patients' best interests
- Guidelines do change so keep up to date
- A regular audit of sections of patient records is an excellent way of checking they include reference to all issues an independent expert may expect to find
- Take the opportunity over a period of time to make sure records are in order and are labelled correctly with patients' unique identifiers (eg, name, date of birth, medical registration number)
- If digital radiographs and photographic images are filed in a different place from the practice main computer software, it will be essential to develop a system that is straightforward for other practitioners to navigate easily
- Discuss patients' oral health with them at each of their examination appointments and record that the conversation has taken place
- Review short- and long-term treatment plans and the patient's expectations of them, particularly where treatment is likely to be provided by a different dentist.

4.0 ROADMAP TO RETIREMENT

So, you've enjoyed a long and happy career and are putting down your probe, mirror and bur for the last time. But with this exciting turning point in your life can come problems.

Retirement is a significant and critical point in a career. For non-practice owners, all the issues mentioned so far in this booklet remain relevant to your leaving a practice. But if retirement involves selling a practice, the impact of planning to leave your practice is all the more challenging. There are clearly financial and legal issues about which you must seek early and expert professional advice. There are contractual arrangements to be put in place that will help you to manage your risk during and after the sale. Buyers of practices and their advisers will usually want to see financial records for three years and it is important these are available and in a form that can be easily analysed.

A legal contract will be binding on both the buyer and the seller and it is usual for the contract to contain a clause to prevent the seller from working in the area after the sale. If a clinician intends to continue working as a dentist then make sure that this clause allows you to do so. Some practitioners continue working in their own practices under the new ownership as an associate or assistant. Ensure the appropriate contracts for this are negotiated at the same time as the sale.

The new owner will be paying for the goodwill and will not want to lose what he has bought. Working nearby is certain to be noticed by old patients and could possibly be a source of friction with the new owner. If you are not going to continue working as a dentist, then an exclusion clause is quite reasonable.

INVESTMENT, CULTURE AND STYLE

If you are continuing to work in the practice after the sale, you will have the opportunity to manage relationships, complaints and the transition for the staff. Where this is not the case, it might be helpful to try to create a situation where your successor is either already well known in the practice (a current partner or associate) or is able to have a significant period of transition and hand over. Welcoming a potential buyer into the practice as an associate or partner for a meaningful length of time means that any changes in culture and style can be handled and developed carefully and accepted by both patients and staff before you finally leave.

It is important to consider whether the practice can be run at full capacity until the time of the sale, as this will necessarily increase its value. The sale price of the practice may be a vital part of your financial plan for retirement and a run-down practice does not sell at its true financial potential. Over the four years or so in the run up to retirement, you should also review and – if necessary – improve the qualities that confirm the value of your practice. Your records will need to be comprehensive and there should be audits in place for all the areas that help to manage risk.

PARTING OF THE WAYS

Sometimes, the end of a professional relationship is a moment of sadness and other times when it can be tinged with a sense of relief. In all cases, the continuity of patient care becomes an issue requiring our consideration. In most (but not all) cases you can plan for the moment when you will cease practising altogether and, because of this, there is generally sufficient notice to allow the departing dentist to explain the situation face-to-face with each patient who attends for treatment in the months prior to departure. This may even be a condition of the practice sale.

However, patient records are a different matter and the key here is to ensure you maintain access to them all. If you are simply closing down, then you need to find safe storage but if you are selling the goodwill or the complete practice, build into the contract a clause that binds the new owner to keep the records while allowing you reasonable access to any that may be needed. Computer records provide the opportunity to take a complete back up away with you. Your financial records will also remain on the computer unless you choose to delete them before you leave.

When a practice owner plans to retire without the intention of selling the practice as a going concern, it may be possible to transfer the records to another local practice with the intention that the local practice will offer on-going care. In these circumstances, the practitioner would be advised to write to the patients to inform them of the proposal to transfer the records to another practice and allow them the opportunity to object to this action.

Orthodontics presents a particular challenge to the retiring clinician because there is always the potential for patients to be on a waiting list, in mid-treatment or at a critical stage in their development. Where a practice is sold as a going concern, problems are likely to be minimal. But, in some situations a suitable purchaser cannot be found for an orthodontic practice and, in some areas, local colleagues are not in a position to accept patients under active treatment or review. In these cases, retiring orthodontists should try their best to discharge their duty of care to the patients, perhaps 'triaging' them to give greatest priority to those patients who stand to be the most disadvantaged (or harmed) by the break in the continuity of care. Keeping patients and their parents informed is the key to minimising problems. The patients' needs, welfare and best interests must always be paramount, whatever the background to the parting of the ways – and in order to ensure parting does not become 'such sweet sorrow'.

Contract should include agreements in relation to:

- Your relationship with your successor/remaining partners and practitioners
- Withholding of funds for remediation of treatment where necessary
- Communication
 - With patients
 - About complaints
 - With suppliers and labs
 - With local colleagues/practices.

Take professional and expert advice on

- Timing of the sale
- NHS contractual arrangements
- Financial, business and tax arrangements
- Employment law
- Informing and complying with appropriate regulators
- Pension arrangements.

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