

# RISKWISE

ISSUE 28 | MAY 2017



## ORAL CANCER

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

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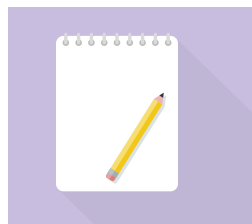
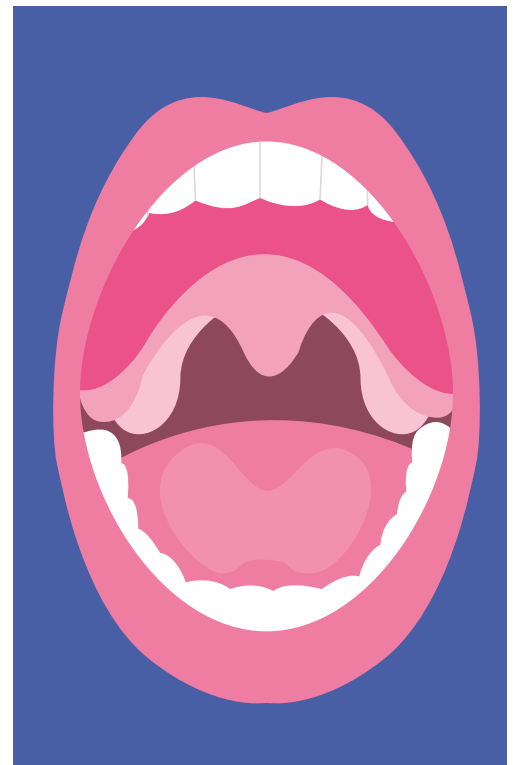
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## NEWS FROM DENTAL PROTECTION

**W**elcome to the latest edition of *Riskwise*, featuring a range of articles and case studies on dentolegal topics that we hope will improve your practice.

In this edition our main feature is on oral cancer, Prof John Gibson looks at assessment, patient involvement and the importance of good record keeping. I've worked with Dr Yvonne Shaw to produce an article looking at third party orthodontics, which is becoming an increasingly prevalent issue. I hope this issue helps develop your practice and look forward to seeing many of you at our upcoming roadshow.

### SOMETHING FOR EVERYONE

Did you know that over 86% of attendees at last year's Managing Clinical Risk Roadshow would recommend the event to colleagues? Last year the audience of around 500 heard Dr PJ Byrne's excellent and thought provoking presentation on periodontal disease and Mr Fintan Hourihan's knowledgeable and timely presentation on probity, along with a variety of hot topics presented by Dr Stephen Henderson and me.

The 2017 roadshow will cover the highly relevant subject of cosmetic dentistry with renowned international speaker Dr Martin Kelleher. Dental Protection's Dr Sue Boynton and Dr Stephen Henderson will present the latest developments and understanding when it comes to safe dental practice in Ireland. Discover more here [dentalprotection.org/roadshow](http://dentalprotection.org/roadshow)

### WORKSHOPS

We recognise the challenges you may face in clinical practice and have created new workshops to help you. The full day Masterclass is an interactive and practical session, tailored to the needs of general dental practitioners. The programme aims to enhance delegates' skills in achieving more effective consultations.

[dentalprotection.org/ireland/events-e-learning/masterclasses](http://dentalprotection.org/ireland/events-e-learning/masterclasses)

The half-day workshop 'Dental Records for GDPs' will provide you with a thorough understanding of the importance of dental records and aims to enhance your skills in making and keeping quality medical records.

[www.dentalprotection.org/gdpdentalrecords](http://www.dentalprotection.org/gdpdentalrecords)

### THE NEW INTERNATIONAL DIRECTOR

Allison Newell is our very first Executive Director of International Operations. Her main aim will be to ensure that we continue to meet members' dentolegal needs, delivered through a consistently high quality of service. She has already met with the Dental Advisory Panel and you'll be hearing from her in a later edition of *Riskwise*.

### CONFERENCE COUNTDOWN

We're looking forward to a busy Annual Scientific Conference in Kilkenny. Some of the team including Dr Raj Rattan, Dr Sue Willatt and I will be there. It looks like it will be a great event, so if you're there, do come over for a chat.

I hope you enjoy this edition of *Riskwise*.

Best wishes

Sue Boynton

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# THE BUSINESS OF DENTISTRY



*Dr Raj Rattan, Dental Director at Dental Protection, outlines the importance of trust and relationship management in general dental practice - a recurring theme for his presentation at the IDA conference 2017*

**A**t the heart of every valued human interaction lies the notion of trust. Our world could not function without it.

Trust is one of the most important constructs in the dentist-patient relationship. It creates longer and more stable professional relationships, reduces the incidence of conflict, promotes satisfaction, reduces complaints, and builds loyalty. It is therefore one of the key drivers of success in general dental practice.

## WHAT IS TRUST?

There are many definitions of trust that identify credibility, benevolence, confidence in honesty and reliability as key components that can lead to trust being established. We make promises to our patients and our patients expect us to keep them. They expect us to be knowledgeable, skilful and competent. As Joseph Graskempner noted in his article in JADA (June 2002), “dentists should gain the patients’ trust in them as reasonably knowledgeable, reasonably talented, caring dental health providers.”

## CAN TRUST BE QUANTIFIED?

Degree of trust created= (R x C x I) / SO

R= reliability, C= credibility and I = intimacy are multipliers and self-orientation (SO) is the divisor.

Significantly, the greater the divisor, the lower the quantity of trust generated.

## CREDENCE MARKETS

In economic terms, dental services fall into the category of credence goods. Patients don’t always know whether they need the suggested treatment, and in some cases even after they receive the treatment, they cannot be sure of its value. This is because the “buyer” does not have the knowledge of the “seller” – a feature of the dentist-patient relationship referred to as information asymmetry. It is this asymmetry that makes the credence

goods market particularly challenging because it may give rise to aberrant behaviours.

It is interesting to note the comments made in 2012 by Brown and Minor in their paper Misconduct in Credence Good Markets<sup>1</sup>.

“Providers of technical advice are common in the automotive, medical, engineering, and financial services industries. Experts benefit from customers trusting and buying their advice; however, experts may also face incentives that lead them to provide less than perfect recommendations. For example, a mechanic can provide a more extensive fix than warranted and a dentist can replace a filling that has not failed.”

The need for regulation to protect the consumer in the credence space is implicit.

Another challenge is that perceptions of clinical success and failure in this market are largely subjective for patients because there is no external verification. It is only because of trust that patients do not routinely seek to independently verify every transaction and clinical outcome.



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## BUILDING TRUST

Building trust should underpin a practice’s risk management strategy. Without this, any business risks loss of market share and loss of reputation. This can be achieved by making a commitment to:

1. **Meeting patient needs and preferences when it comes to service delivery.**
2. **Ensure patients feel cared for. We use the phrase care and treatment in our everyday language and tend to focus on the technical elements of treatment. Remember to show them you care.**
3. **Get it right when patients most need you – when they are in distress.**
4. **Manage the expectation and create experiences built on continuity of care with individual clinicians. This builds relations and fosters trust.**
5. **Improve communications – both clinical and non-clinical.**
6. **Ensure there is transparency in pricing.**
7. **Empower your front-line staff – the first contact with the team will form lasting impressions.**

The consumer mantra has long been “caveat emptor” (buyer beware). It is not appropriate for the business of dentistry. It should be replaced with “credit emptor” – let the buyer trust.



## BIOGRAPHY

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With a background in general dental practice, Raj first worked as a dentolegal adviser for Dental Protection in 1993. He is now the Dental Director

# ORAL CANCER

Oral cancer is something we should all be aware of when treating patients. This comprehensive overview will help you spot the warning signs and offers tips on involving patients in decision making

**I**n 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 dentists will see more than one or two cases in a lifetime. However, oral cancer is still on the increase in most developed countries and therefore a vigilant approach should be adopted for every patient if malignancies are not to be overlooked. Most importantly, they must be 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 unusual presentation, for example, the loosening of one or two teeth in a mouth where there is no active periodontal disease.

## ASSESSMENT

Whatever the evidence for and against having regular check-ups with respect to periodontal disease and caries, these visits present an ideal opportunity for assessment of the oral mucosa.

Adopting a systematic approach to history taking and dental examinations will enable the dentist 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, is 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 dentists will be familiar with aphthous ulceration, denture trauma, cheek biting etc. Occasionally, dentists 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 dentist to make a referral to a specialist for further investigation even when they are 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 dentist 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 for this.

## 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 dentist'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 be able to demonstrate that over a period of time the clinician has set down 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.

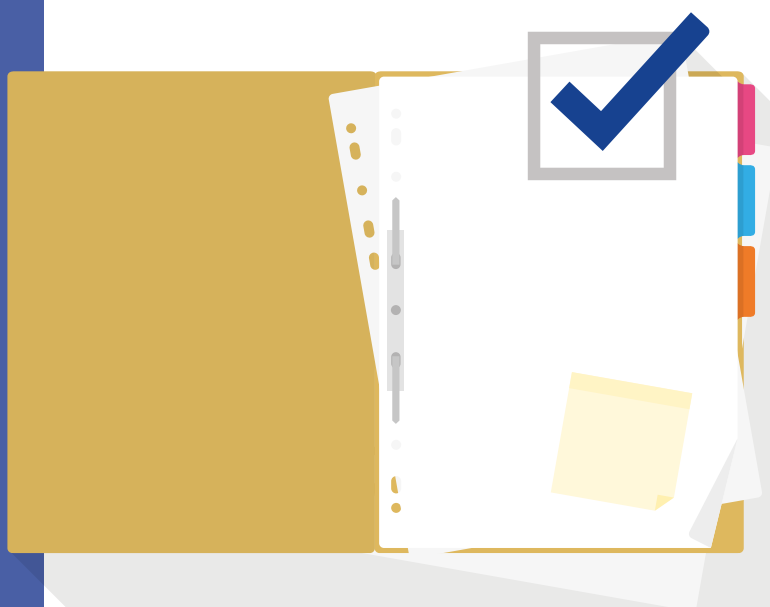
In the situation where a patient alleges negligence concerning an undiagnosed malignancy, or a significant delay in referral, the content of the records becomes particularly important. If the records contain no reference to the mucosa having been examined, it is difficult to disprove the allegation that 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 claim is less likely to be successful.



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## 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.

Dentists 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 co-operated 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 for primary care practitioners to use 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 he/she 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 dentists 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 dentists, 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 dentist consults others who have been involved in the patient's treatment. If the patient would have benefited from a specialist referral, but this was not offered to them, then all those doctors and dentists 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 dentists 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.

# AVOIDING CLAIMS ABOUT CONSENT



**Hilary Steele, Claims Lead for Ireland, shares her top tips to keep the solicitors away**

**I**n Ireland, the number of dental compensation claims has been rising for several years. Although this is an unwelcome trend, members can be reassured about the quality of support provided by our experienced team of claims managers, who have extensive experience in handling dental claims in Ireland. If you are unfortunate enough to experience a claim, you can request support from one of our dentolegal advisers who are fully conversant with the daily challenges of dental practice.

## WHAT IS A DENTAL CLAIM?

A claim is a demand for compensation due to alleged negligence on the part of the treating dentist. Every practitioner owes a duty of care to their patients, and for a claim to succeed the patient must prove that it is more likely than not that there has been a breach of that duty and that it has harmed the patient.

Many of the claims seen by Dental Protection are based on clinical treatment that reflects best practice. None the less, a claim is made because the patient has had unrealistic expectations about the treatment involved or the eventual outcome, for example:

1. Endodontic treatment that failed and the tooth was lost. The patient took the view that had he been warned of the possibility of failure he would have had the tooth extracted at the outset.
2. Orthodontic aligners may straighten teeth but the outcome might not reach patient expectations.
3. Implants do not necessarily last a lifetime and they do require maintenance.

These are only a few examples of the problems that can arise when the patient has not fully understood the procedure or expected outcome, and therefore feels that they have not consented to treatment. These cases are particularly difficult to defend in Ireland where the professional obligations applicable to the consent process are strictly enforced by the courts.

Caring practitioners may well be surprised and upset when the patient makes this assertion even though lengthy discussions had in fact taken place. Unless the discussion was documented in the clinical records the patient has good prospects of succeeding in their claim.

Signed consent forms may be helpful, and indeed in certain scenarios are mandatory, such as treatment under general anesthetic, but such forms have to be specific to the individual treatment planned, and not simply an all-encompassing general consent form.

## SUMMARY

Fully document in the clinical records every discussion to validate the patient's consent. If the discussions are documented, future arguments relating to consent have little chance of succeeding in court. Furthermore, most plaintiff firms will refuse to take the case forward and litigate on behalf of the patient.

If you would like more information on consent download our advice booklet under the Publications tab on our website [dentalprotection.org/ireland](http://dentalprotection.org/ireland)

If you need specific advice on a matter, please contact the advisory team by email: [Ireland@dentalprotection.org](mailto:Ireland@dentalprotection.org)



## TIPS TO AVOID A CLAIM

Discuss and fully document these points in the patient's record:

- The purpose of the procedure.
- The nature of the treatment (what it involves and timescales).
- The likely effects and consequences (taking into account the particular concerns of the individual patient).
- Any risks, limitations and possible side effects (including rare but significant side effects).
- Alternative treatments and how they compare.
- Cost.
- Post-treatment issues including possible time off work or the need for future treatment.

# 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

**H**ave you ordered a takeaway 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 dentist to patient or between members of the dental team.

It's not uncommon to discover a patient, returning after their initial treatment, has not done what was advised because they had misunderstood what was intended. For example, they may have mistakenly stopped their Warfarin before an extraction, against previous advice.

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



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

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.

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. Three percent gave up altogether and went to see another doctor.<sup>1</sup> 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",<sup>2</sup> so reducing the likelihood of misunderstanding or incorrect transfer of information. The process of repeating back words and phrases seems to help recall.<sup>3</sup> 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 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.<sup>4</sup>

It is important that the patient clearly understands the consequences of:

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





## 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<sup>5</sup>, are shown in the box (above right), with the third option being preferred.

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 best – the key aspect being to not make the patient feel bad if they don't understand, what Kemp describes as a “shame-free space”.

### 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

This process obviously takes time and it may not be possible or appropriate to check absolutely everything has been understood. Deciding in advance the most important things that you 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 dentists and their patients, checking understanding is just as important when sharing clinical or administrative information with other members of the dental team, for example, 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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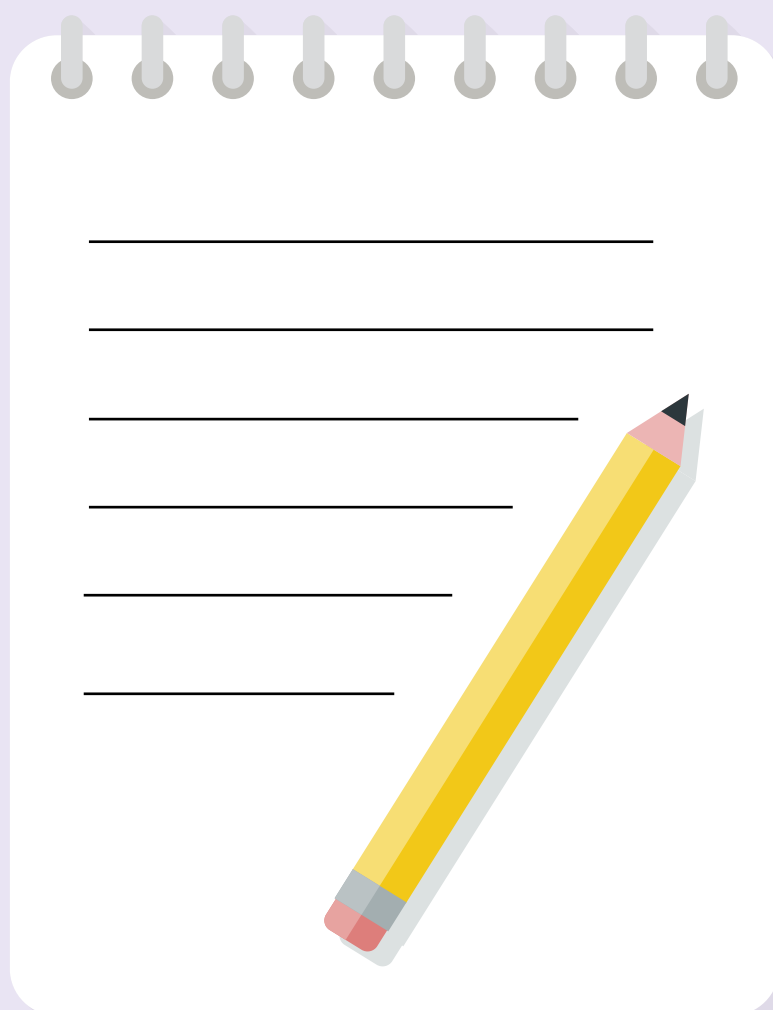
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# **RECORD KEEPING** **AND INFECTION** **CONTROL**



How does the dental team balance the need for contemporaneous records and, at the same time, maintain an effective standard of infection prevention and control?

**V**ery few clinicians have the luxury of dedicated secretarial support at the chairside while they are working on patients. Whatever your approach to record keeping, maintaining an effective standard of infection control should be paramount.

## MAINTAINING THE CHAIN OF STERILITY

Have you ever stopped to think what happens when contaminated fingers touch the paper record card or hit the keys of the computer keyboard? There will certainly be a greater risk of disease transmission if the writing instrument or the writer's fingers had been contaminated when the entry was made.

Operator-to-patient contact is one of the main methods of spreading bacteria but patient records handled by the dental team can also be the cause of cross contamination. Hand hygiene is essential if effective zoning is to be achieved. Periodic review by the dental team of adherence to this protocol is one method to ensure compliance.

## PAPER RECORDS

In order to create effective zoning within a clinical area, paper records need to be kept beyond the area of clinical activity. Since barrier protection is applied to the hands whilst treating patients, it means that additions to the record can only be made before gloving up or after they have been removed and the hands washed. If the need arises to add information to the record during the course of the treatment, there are three ways to deal with this:

- Remove and change the gloves after adding to the notes.
- Create a second barrier (such as a loose fitting bag or disposable 'mitt') placing it over your gloved hand before writing.
- Another member of the team who is not gloved up could make the entry.

## SILVER PAPER

Superbugs, including MRSA and clostridium difficile pose a growing challenge. Items such as patient records and case note folders can now be impregnated with an additive containing silver ions, which instantly kills microbes on contact. This provides a permanent hygienic solution that is active 24 hours a day throughout the lifetime of the product. Clinical research conducted by one manufacturer showed

that 99.9 per cent of bacteria are killed within 24 hours. This approach will possibly become a required standard for the manufacture of record cards in the future, if we do not manage to go paperless.

## COMPUTER RECORDS

In many dental surgeries there has been an attempt to eliminate paper records and to replace them with a computer-based equivalent. From an infection control perspective the use of a computer in the surgery reduces the number of items touched by the clinical team and, with suitable safeguards, it can be utilised within the zone of clinical activity.

The risks arise primarily from direct contact (for example, a contaminated gloved hand/finger) or via aerosols and splatters. The former can be managed by ensuring that there are strict hand hygiene protocols in place, while the latter can be reduced by appropriate surgery design and computer positioning.

Aerosols are inevitably created in the dental surgery when working in the patient's mouth. Aerosols and droplets generated by high-speed dental drills, ultrasonic scalers and air/water syringes are contaminated with blood and bacteria and represent a potential route for transmitting disease. Pathogens can settle onto surfaces anywhere in the clinical environment. Keeping a computer in the surgery means the keyboard, the mouse and the monitor are vulnerable.

## KEY PLAYERS

The average unprotected keyboard is a blackspot for bacteria, each square inch harbouring a staggering 3,295 organisms. One study found potential pathogens cultured from computers included coagulase-negative staphylococci (100% of keyboards), diphtheroids (80%), *Micrococcus* species (72%), and *Bacillus* species (64%). Other pathogens cultured included ORSA (4% of keyboards), OSSA (4%), vancomycin-susceptible *Enterococcus* species (12%), and nonfermentative gram-negative rods (36%). Particular bacteria hotspots are the space bar and vowel keys because they are most often used.

Therefore, computer equipment should be covered with a plastic barrier when contamination is likely. This would apply primarily to the mouse and keyboard. Like any barrier used during patient care, it should be changed between patients. If a reusable form-fitted barrier is used, it should be cleaned and disinfected between

patients. The use of disinfectant wipes has also been advocated, but the potential to damage the plastic keyboard needs to be considered. Infection control keyboards that are capable of being washed are also available.

Strict hand hygiene is also important. Before touching any office equipment wear powder-free gloves or ensure your hands are clean. Computer equipment is an example of a clinical contact surface and the basic principles of cleaning and disinfection used routinely in the dental environment should also apply.

## SCREEN ATTRACTION

The risk posed by the computer screen is slightly different. Bacterial cells possess a negative electrical charge, while the technology used in flat screens generate positively charged static electric fields. Consequently, bacteria dispersed within the aerosols will be attracted to the computer screen. Avoiding contamination of the unit housing the screen is important because it cannot be properly cleaned and disinfected or sterilised. Avoid touching the screen whilst treating patients, be aware of the potential bio-load on the screen and perform hand hygiene if you need to adjust the monitor with ungloved hands.

So in addition to ensuring that your dental records are accurate, complete and contemporaneous, the infection control protocol within the clinical setting is also worthy of further consideration.

The resources listed below are just a few of those used in this article.

## RESOURCES

1. Rutala WA, White MS, Gergen MF, Weber DJ; Bacterial contamination of keyboards: efficacy and functional impact of disinfectants. *Infect Control Hosp Epidemiol* 2006;27:372-377.
2. Bacterial contamination of computer touch screens, *American Journal of Infection Control* 44(3):358-360, March 2016, DOI: 10.1016/j.ajic.2015.10.013
3. Bacterial Contamination of Computer Keyboards in a Teaching Hospital, <https://doi.org/10.1086/502200> Published online: 01 January 2015,
4. Maureen Schultz, Janet Gill, Sabiha Zubairi, Ruth Huber, Microbial contamination of laptop/ keyboards in dental settings, Anjum et al *International Journal of Public Health Dentistry*

# ONLY PART OF THE PICTURE

Have you been contacted by a patient asking you to increase the interproximal spacing between their anterior teeth by removing enamel using a treatment plan that they have brought along to you? Dr Yvonne Shaw and Dr Sue Boynton explain the risks of lending a hand to execute somebody else's treatment plan

**D**ental Protection has received a number of calls from dentists who have been contacted by a company marketing orthodontic aligners directly to patients. Internationally this has been a growing concern with dentists being asked by companies to undertake limited aspects of the treatment plan provided to the patient, including interproximal reduction (IPR) and initial fitting of aligners. This situation raises a number of legal and ethical issues, especially when patients are requesting treatment plans directly from the companies manufacturing the aligners without first having undergone a full clinical assessment. Dentists considering taking on even a limited part of the treatment plan face a number of risks in doing so.

## LEGAL AND ETHICAL ISSUES

Diagnosis, treatment planning and the provision of orthodontic treatment constitute the practice of dentistry and must only be undertaken by appropriately trained, indemnified and registered dental professionals working within their scope of practice. The Dental Council can investigate complaints of professional misconduct made by patients against Irish registered dentists providing remote dentistry for falling seriously below the standards expected of a dentist.

Whilst patients may be tempted to save money and obtain orthodontic aligners directly from a manufacturer, they are likely to be oblivious to the risks they face in doing so. Registered dental professionals have professional and ethical obligations that apply when providing patient care. With regards to planning treatment, this would include carrying out a thorough examination to confirm what treatment options may be suitable, dependent upon the findings of the examination and the patient's wishes. In the absence of this process, a patient may embark on treatment which is simply not suitable, or worse, causes harm.

Patients should also be able to seek compensation if they suffer harm as a result of any failing in the care they receive. If treatment plans and appliances are obtained directly from a third party without appropriate professional registration or indemnity arrangements in place, a patient may find it difficult to obtain any financial redress.

## CONSENT

A dentist, who undertakes even a restricted part of a treatment plan drawn up by another party, may find themselves questioned as to whether the treatment was appropriate and if the patient's consent to treatment was valid. To demonstrate this, a dentist would need to ensure that a patient fully understood all the treatment options, risks and benefits before starting treatment.

Consent also needs to be confirmed at each stage of investigation or treatment, even though a patient may attend with a treatment plan in place.

In order to ensure consent was valid, a dentist would need to identify what clinical problems were present and that orthodontic treatment was appropriate to address the patient's specific concerns. As part of the consent process, the patient would need to not only be made aware of the risks they may face in undergoing the proposed treatment, but also what other treatment options are available to them, what risks there are associated with these other treatments, and what the risks are of doing nothing. It is difficult to see how a dentist could do this without carrying out a full clinical examination of the patient.

Naturally, a patient is likely to believe that the dentist proceeding with IPR and the fitting of any aligners believes that the treatment is suitable. It would not be surprising if they later hold the dentist responsible if any problems arise.

## PROFESSIONAL RISKS

Whilst it is not unusual for different members of the dental team to be involved in a patient's overall treatment plan, dental professionals need to ensure that any dental treatment plan has been drawn up by a registered dental professional with appropriate experience. Dental professionals also need to ensure they are competent themselves to assess and ensure the treatment plan proposed is suitable for a patient. Failure to do so may put the patient at risk and leave the clinician open to challenge.

Similarly, a dentist who chooses to prescribe an appliance without seeing the patient would be likely to find themselves in difficulties if challenged about their diagnosis and treatment planning.

- You risk being challenged if you treat a patient without performing a full clinical examination.
- Patients should be told about the risks of undertaking orthodontic treatment without an examination by a suitably experienced dentist/orthodontist.
- Record any advice given to a patient regarding the risks and the recommendation to seek advice from a suitably experienced dentist/orthodontist.





Naturally, a patient is likely to believe that the dentist proceeding with IPR and the fitting of any aligners endorses that the treatment is suitable

### THE DENTAL COUNCIL HAS ISSUED GUIDANCE TO DENTISTS

*“The Dental Council is aware that some of the manufacturers state that there are dentists involved at various stages of treatment. The Council would like to remind all registered dentists contracted to work for such manufacturers that you still owe the same duty of care to patients opting to have an appliance manufactured as you would to a patient attending your practice, and that you are still obliged to comply with the Dental Council’s Code of Practice regarding Professional Behaviour and Ethical Conduct. This means that you must ensure that:*

- the patient has given full informed consent to the treatment, and is aware of the benefits and risks associated with the treatment plan;
- you maintain full and proper records, and that they are properly protected and are available to you at all times; and
- your indemnity insurance covers you to provide remote dentistry.”

Even where the dentist may not be prescribing the aligner treatment, the Dental Council will almost certainly have concerns about a dentist simply fitting aligners supplied by a third party.

### CONCLUSION

A dental professional risks being challenged if they proceed with a patient’s orthodontic treatment following a treatment plan that has been compiled without a full clinical examination having been undertaken by a registered dental professional. Patients should be made aware of the risks they face in proceeding with treatment in the absence of an examination by a suitably experienced dentist/orthodontist. If patients suggest they are considering this, it would be important to clearly record any advice given to a patient regarding the risks and recommend they seek advice from a suitably experienced dentist or specialist orthodontist.



#### BIOGRAPHY

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worked in general dental practice for 18 years where she developed an interest in orthodontics. She has worked as a clinical assistant in both hospital and orthodontic practice and is now a dentolegal adviser for Dental Protection.



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#### REFERENCES

1. Statement on orthodontic devices provided directly to the public Dental Council 7 April 2017 <http://www.dentalcouncil.ie/files/DC%20Statement%20orthodontic%20devices.pdf>

# BE AWARE



## Susie Sanderson reminds us of the contribution that dentists can make in curbing antibiotic resistance

**E**uropean Antibiotic Awareness Day (EAAD) is held annually on 18 November and is part of World Antibiotic Awareness Week. Huge attention is now given to these campaigns by agencies and organisations throughout Europe

### FLEMING'S FANTASTIC FUTURE

Antibiotics have made the last 100 years a far easier time to live in, but in a cruel twist of Darwinian Theory, drug-sensitive competitors are removed by antibiotics, and resistant bacteria are able to reproduce as a result of natural selection.<sup>1</sup> We are heading to an era in which many life threatening infections cannot be treated.

#### KEY FACTS

- On average, antibiotics add 20 years to each person's life
- Many existing antibiotics and other antimicrobials are becoming ineffective
- 25,000 unnecessary human deaths in the EU annually due to antibiotic resistance
- The ability to treat life threatening infections is at risk
- Antibiotic development pipeline at all-time low

Patients expect antibiotics to "cure" their pain. As early as 1945, Sir Alexander Fleming warned that the "public will demand [the drug and] ... then will begin an era ... of abuses."<sup>2</sup> And he was right. Dentists are equally aware that management of dental infection is something that takes time in terms of proper diagnosis processes and active clinical intervention.

### WHY IS IT DENTISTRY'S PROBLEM?

Primary care dentistry is a significant player, responsible for up to 10% of antibiotic prescribing in Europe. Consequently, dentistry has a duty to view anti-microbial resistance (AMR) with an honest and critical eye. In Ireland, evidence-based guidance developed by the Dental Antibiotic Stewardship Working Group, a subcommittee of HCAI AMR, is available to assist with the indications for the prescribing of antimicrobials.<sup>3</sup> The choice of antibiotic is largely made on empirical terms in dentistry and the first and second line recommendations in published guidance are made with the risks of AMR in mind. Guidelines are there to augment clinical judgment, but a prudent practitioner would make sure that they were able to justify prescribing outside published guidelines, particularly in the event of a subsequently raised concern about their care of a patient.

### "I'VE COME FOR A PRESCRIPTION"

Perhaps one of the biggest challenges is explaining to the public that antibiotics won't cure toothache. It's understandable that an anxious patient will think that a course of tablets is preferable to clinical treatment and that may be their first request of you. Our job is to carefully manage their expectations and act in their best interests. And that sometimes calls for tough love, not only for their own wellbeing, but also for the safe future of the wider society.



### HOW DO WE MEASURE CHANGE?

Clinical audit is a quality improvement process that aims to improve patient care through a systematic review of care against explicit criteria. It is a cyclic and multidisciplinary process which involves a series of steps from planning the audit, through measuring the performance, to implementing and sustaining the change. It can be a prospective audit which allows "real-time" collection of data showing the current and prevalent practice, or a retrospective audit which can serve as a record of what has happened in the past, requirements for change and implementation.

Clinical audit can demonstrate your current pattern of prescribing, as well as recording any changes that are adopted to achieve best practice antimicrobial stewardship. The latest version of antimicrobial prescribing is published on the FGDP website under an open access initiative.<sup>4</sup>



### BIOGRAPHY

**Susie Sanderson OBE BDS FDSRCS(Eng) FFGDP(UK) LLM**

Susie represents the UK at the FDI and Council of European Dentists (CED). She is the Chair of the CED's Amalgam and Other Restorative Materials Working Group and a member of its Antibiotics in Dentistry Task Force. She continues to work to influence European policy makers in their implementation of the globally agreed 2013 Minamata Convention on mercury and mitigate its unintended consequences for dental practice. Susie works for Dental Protection as a Dentolegal Adviser and she will be speaking at the IDA Conference 2017

#### REFERENCES

1. Read AF, Woods RJ. Antibiotic resistance management. *Evol Med Public Health*. 2014;2014(1):147.
2. The future of antibiotics and resistance: a tribute to a career of leadership by John Bartlett.
3. Spellberg B, Gilbert DN *Clin Infect Dis*. 2014 Sep 15; 59 Suppl 2():S71-5. <http://www.hse.ie/eng/services/list/2/gp/Antibiotic-Prescribing/Conditions-and-Treatments/Dental/> Accessed March 2017
4. Clinical audit for prescribing and management of dental infection 2016 [www.fgdp.org.uk](http://www.fgdp.org.uk)

#### Resources

Antimicrobial Prescribing for General Dental Practitioners <http://www.fgdp.org.uk/OSI/open-standards-initiative.aspx>

Scottish Dental Clinical Effectiveness Programme: Drug Prescribing for Dentistry [www.sdcep.org.uk/?o=2334](http://www.sdcep.org.uk/?o=2334)



# MEDICAL HISTORY

A regular review of the patient's medical history and an understanding of its significance improves patient safety

One of the first principles one learns at dental school is 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.

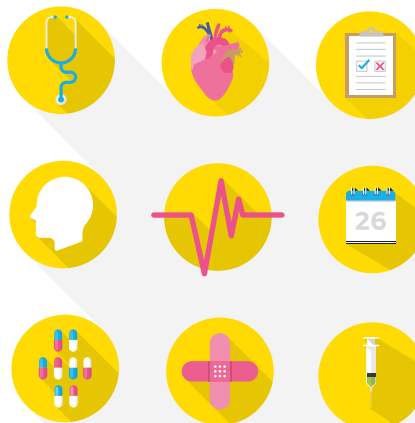
In several recent cases, the patient's medical history has been at the heart of negligence claims brought against dentists and other dental team members. For example, a failure to take into account certain allergies to drugs (especially penicillin and other antibiotics), or to recognise the significance 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 the soft tissue (phenytoin, calcium channel blockers and anti-retrovirals, for example).

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 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.

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.



## 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.

## CONTACTS

You can contact Dental Protection  
for assistance [dentalprotection.org](https://dentalprotection.org)

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