AUSTRALIA

Risk management from Dental Protection

Dental Protection

RISKWISE

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PREVENTIVE DENTISTRY

Dr Andrew Walker explains why the prevention of oral disease may not be entirely risk-free

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NEWS FROM DENTAL PROTECTION

Welcome to the latest edition of *Riskwise*, which I hope you will find enjoyable and interesting. We have an in-depth feature on preventive dentistry, advice on handling the media in the wake of a complaint and an informative look at patient understanding. Whatever your area of practice, there are now more new developments to consider than ever before and we hope Riskwise will continue to help you tackle whatever challenges come your way.

SOURCES OF INFORMATION

Keeping up to date in your areas of practice requires knowledge and understanding derived from a variety of sources. 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. Go to **dentalprotection.org/au** to find out more.

CHANGES TO THE TEAM

Dental Protection's international profile allows us to share the experience of a situation in one country when it subsequently arises elsewhere. The challenge is to ensure that our local presence is sustainable. We recognise that financial security is essential in order to respond to member needs and ensures competitiveness in all the countries where we serve members.

To further enhance our ability to respond to this challenge a new international structure was recently announced and is led by Allison Newell, Executive Director-International. The new international team will work closely with existing teams across the organisation to ensure the best products and services are developed for members worldwide.

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, the Regional General Manager will play a business-wide leadership role in the strategic development, alignment and execution of the business for our dental members.

Rebecca has worked for the MPS Group, of which Dental Protection is part, for six years and prior to that was with the Trans-Tasman law firm DLA Phillips Fox (now DLA Piper) for 13 years in senior financial and operational roles. Rebecca's appointment will support future growth and the continued development of member benefits for Dental Protection members in Australia and New Zealand.

THANKS KEN!

It is with sadness and a great deal of thanks that we say a fond farewell to Ken Parker, who is stepping down from his role as Operations Manager at Dental Protection on 31st March. Many of you will know Ken from his excellent work over the last 16 years, both in the office and out on the road at our seminars and events. He was really at the core of setting up Dental Protection in Australia and making it the organisation it is today. As many of you will have experienced, he has been devoted to the membership, always willing to help with a smile and a warm greeting for all. On behalf of the whole team, I would like to wish him all the very best in his retirement and acknowledge the huge contribution he has made.

FINALLY

As always, I am keen to receive feedback about Riskwise and, in particular, would like to know what subjects you might like to see featured in future issues. Please get in touch and let me know whatyou think.

Best wishes,

James Foster LLM BDS MFGDP(UK)
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NEWS

HANDLING THE MEDIA

What happens when a patient complains to the press?

Raj Pattni, a Dental Protection press officer, looks at the best strategies to adopt if you suddenly find yourself in the local press

While most dental practitioners will have received a complaint from a patient who has taken the trouble to contact them personally, in some cases, unhappy patients are reluctant to complain directly to the surgery – they may go straight to the local press instead.

If the press feels there may be a story worth investigating, they could contact the practice, dentist or staff member at the centre of the complaint.

WHAT SHOULD YOU DO?

The following scenarios are two common examples of situations in which our members find themselves, and where the Dental Protection press office may be able to assist you.

In the first instance, you may only hear that a patient is unhappy with the treatment provided after being contacted by a journalist. If a patient has not previously contacted the practice to formally complain, you may not realise they were not entirely satisfied with the service you provided.

Secondly, you may believe that the story as told to the journalist is a distortion of the facts and wish to give your side in full to set the record straight.

TOP TIPS

If you're contacted by a journalist about a patient complaint

- **Note the outline of the story**
- **Take the journalist's contact details**
- **Check their deadline**
- **Don't feel pressured into giving an immediate answer**
- **Alert Dental Protection**
- **Remember your duty of confidentiality**

SCENARIO 1:

A journalist from a national newspaper contacts you at 10.00 to say they've received an email from an unhappy patient. The journalist wants a response from you about the treatment you provided and your thoughts on what the patient has said by 16.00 as they'll be running the story the following morning.

It is important to know who exactly the journalist is and which patient complained so that you can provide an appropriate response.

Make some notes about the story the journalist is writing – who is involved, what is being alleged by the patient, and whether anyone else is being asked about the story. Ensure you also take contact details for the journalist.

Avoid giving any comments or answers immediately – it is important you take time to consider what you want to say in response. You also need to be mindful of your responsibilities to the patient and the overarching duty of confidentiality you have.

Journalists often work to tight deadlines, so you may find that you have only a short time to write a statement. Nevertheless, it is important that you try and put together a statement by the deadline. You can contact Dental Protection for help and advice with this. In the event that you are unable to provide a statement by the deadline, the story could be published saying you were asked for a comment but did not provide one. It is more beneficial to provide a statement responding to the journalist, even if it's restricted due to patient confidentiality.

Once you have provided a statement, ask the journalist where and when the story will be published. You may find that it is both online and in print. Read the story carefully once published and be on the lookout for any factual inaccuracies.

SCENARIO 2:

Following a complaint from a patient, a journalist has written an article about you in the local paper. Your patients, family and friends are likely to see it and this could impact on your professional reputation. The story is a generally true reflection of the facts of the case, but there are a couple of inaccuracies.

In this scenario, the journalist who has written a story about the treatment you provided has not contacted you for any comment. Instead, they have written the story entirely from the patient's point of view.

It can be quite surprising to open a local paper and see a story mentioning you or your practice, and perhaps even alarming if you are mentioned in a story alleging poor treatment. If you read a story about the treatment you provided, you may find that the story uses very emotive language or perhaps that the story, as written, is a slightly exaggerated account of events.

The temptation might be to phone the journalist to set the record straight and detail what actually happened during treatment, but remember your duty of confidentiality to the patient. Discussing any conversations or treatment provided, without the patient's consent, would be a breach of privacy – even if the journalist has the details of what happened. You can contact Dental Protection for help and advice with this.

However, where there are factual inaccuracies in the account, these can be corrected as long as the inaccuracies do not relate to clinical detail. If you are looking to have something corrected in the press, bear in mind that a number of days may have passed since the article was published. Any corrections issued a few days after the publication may give the story further publicity that keeps it in the paper, or near the top of their website, longer.

If the factual inaccuracies are unlikely to cause you significant distress or reputational damage, there may be greater benefit in letting the story be. News stories do not tend to linger that long and are soon replaced by other news.

WHEN TO CONTACT DENTAL PROTECTION

If you find yourself experiencing either of the scenarios above, or if you receive media attention as a result of clinical practice, Dental Protection's team of dentolegal advisers is available to help you. You can contact the team on 1800 444542. If a journalist approaches you out of hours, an on-call service is also available.

THE DEVICE IN YOUR POCKET

Is it acceptable to use your phone to share dental images with colleagues online? Dentolegal Adviser Dr Philip Johnstone looks at the advantages of digital photography and the potential dentolegal pitfalls in using your own mobile phone

THIS ARTICLE WILL HELP YOU UNDERSTAND:

- Photographs taken in the surgery form part of the clinical record and are subject to state data protection regulations, the Privacy Act, the Dental Board of Australia's Guidelines on Dental Records and AHPRA's Guidelines for Advertising Regulated Health Services
- The importance of obtaining consent to share images online within a closed group
- The alternatives to using the camera on your mobile phone

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ADVANTAGES OF CLINICAL PHOTOGRAPHY

- Creating a "baseline" record of the patient's presenting condition
- Recording progress and development of the above
- Improved usefulness of referral correspondence
- Improved clinical record keeping
- Assistance with the consent process
- Patient education and communication
- Improved laboratory communication
- Self-education
- Gallery of photographs to demonstrate treatment options
- Oral pathology
- Treatment planning

Most people have a mobile phone; sometimes more than one. How often would it be useful to take a photograph of a patient's teeth using our own mobile? Before you start snapping away, here are some considerations to bear in mind.

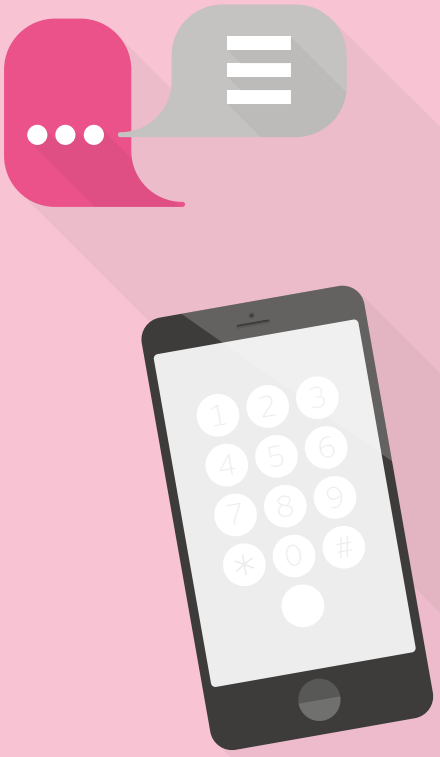
CONSENT

When taking a photograph, you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The photograph should only be taken with appropriate consent, ensuring the patient was under no pressure to give their consent. The patient must be aware what the purpose of the image is and how it will be used. This consent process should be fully recorded in the patient's records. The photograph must not be used for purposes beyond the scope of the original consent, without consulting the patient. Consent gained for baseline recording potential pathology, for example, would not support the use of the images to advertise a practice's services on their website.

CONFIDENTIALITY

Confidentiality is central to trust between clinicians and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to share all the information needed by the clinician in order to provide the most appropriate treatment. But information sharing by medical and dental teams is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.

Photographs taken in the course of the patient's care form part of the clinical record, and should be treated in the same way as written material in terms of security and decisions about disclosures. Therefore, you must follow guidance on confidentiality when taking photographs.



SAFEGUARDING

Individual dentists have a duty to safeguard and promote the welfare of children. You should take into account that mobile camera phones are a potential risk, in that inappropriate photographs could be taken either of them, or of confidential information pertaining to them and could be disseminated further.

STORAGE

Any image, whether it is anonymised or otherwise, forms part of the dental record, so this data must be stored and processed as per the Privacy Act 1988. It is therefore not acceptable to be carrying images of patients on one's mobile phone or electronically sharing them with other devices in your possession (e.g. synchronised via 'the cloud'); there is clearly a risk of the data being lost or stolen. Furthermore, the Privacy Act requires that any offshore storage of data in a cloud must meet the standards required of the Australian Privacy Principles, which underpin the Privacy Act.

More detailed information on this can be found in Dental Protection's advice booklet on the Privacy Act: **dentalprotection.org/australia/publications-resources/dental-advice-booklets**

If there is a clinical need or a desire to take images for diagnosis or education purposes, it is not appropriate to use personal cameras and mobile phones. Agreement by a patient to take a photograph does not negate your obligations to an employer, or your duties of confidentiality.

There are ultimately no circumstances, save for emergencies, when taking patient images on a personal mobile phone, whether or not you have their consent, is justified, so it should not be done. A dedicated digital camera, linked to the practice computer system storing patient details, offers a more secure method. The practice record keeping system should already be compliant with data protection requirements and still allows the sharing of images between colleagues, if the patient has given their consent. But the unintended risks that might arise if a mobile phone is lost or cloud sharing software is engaged, will have been eliminated. It also looks more professional.

BIOGRAPHY

Dr Philip Johnstone BChD MFGDP(UK) DipResDent FFGDP(UK)
Philip is a dentolegal adviser in the London office.

PREVENTIVE DENTISTRY

Dr Andrew Walker assesses the risks associated with attempting to prevent oral disease

LEARN TO

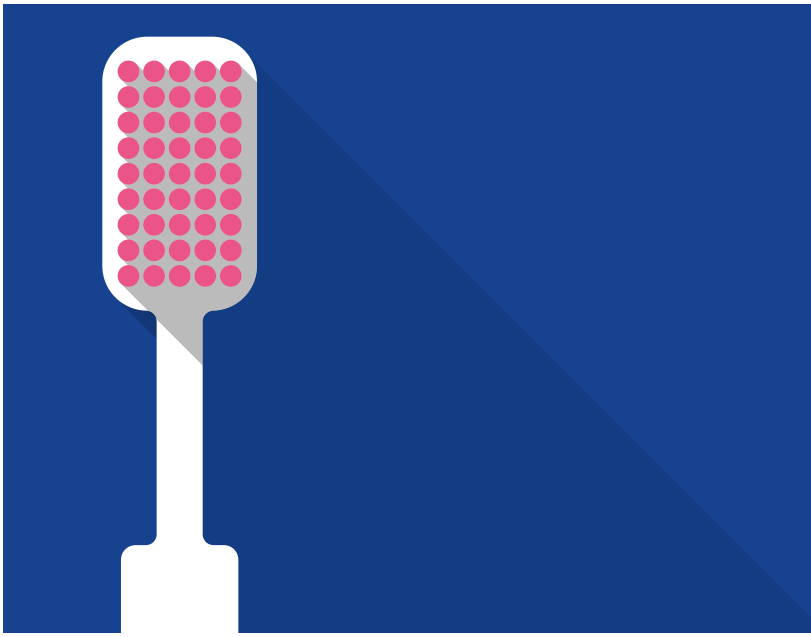
- **Provide preventive advice effectively and how to record this activity**
- **Assess the patient's risk of developing future dental disease**
- **Obtain consent even for the application of fluoride**
- **Understand alternative preventive strategies**
- **Consider a holistic approach**

Over the last two decades there has been a shift in the management of patients towards prevention rather than cure. The associated refocusing of effort can be found in all fields of healthcare, including dentistry. The dental profession continues to invest time and resources in helping patients to achieve and maintain good oral health, rather than concentrating that investment in the treatment of oral disease.

The key elements of this approach include not only patient education, but also helping patients implement any advice given. In this sense, preventive medicine and preventive dentistry not only concentrate on the individual, but also look at communities and populations. Synergy can play a role here, if public health measures are aligned with the commissioning of primary care service providers.

As well as education, there are clinical interventions, such as fluoride application and fissure sealants, which can be implemented as part of an overall preventive approach. The provision of preventive dentistry is not restricted to dentists alone, and the whole dental team can be involved including dental therapists, hygienists, dental nurses and dental health educators.

From a dentolegal perspective, many cases involve criticism of a clinician's failure to give primary preventive advice that would avoid the need for subsequent treatment. The resulting allegation is that the patient has suffered harm that could, and should, have been avoided. Even when there is genuine doubt as to whether or not the patient would have acted upon any advice offered, the alleged breach of a clinician's duty of care often arises from the assertion that the patient was denied opportunity to benefit from an intervention that could have prevented the disease or damage in question.



The criticisms that a clinician might face broadly fall into one of three categories:

- The provision of inappropriate advice and/or treatment.
- The provision of treatment (or the decision not to provide treatment) without adequate consent having been obtained.
- The occurrence of problems which may have been prevented if appropriate action had been taken at an earlier stage.

SCREENING AND RISK ASSESSMENT

There is now greater emphasis on the benefits of performing a risk assessment on patients, which will allow more targeted and focused healthcare. RAG (Red, Amber, Green) scoring is one example of a risk assessment that has already been adopted by many healthcare systems.

All dental patients stand to benefit from a preventive intervention; however, the greatest benefits can be achieved by focusing such measures on those patients who present with a higher risk profile. There are many screening tools which can be employed to identify early problems, potential problems and high-risk patients. The two most commonly used examples of these are the Basic Periodontal Examination (BPE)[1] and bitewing radiographs. Specific guidance on the use of such tools may vary and you should be aware of the standards where you practise and ensure you are acting in the best interests of the patient in front of you.

In Australia, the accepted teaching is that appropriate recall intervals be based not on a set interval, but on the original diagnosis, the extent of the disease, the nature of any treatment carried out, patient response to treatment, and the need for long term review and maintenance. As dental caries and periodontal disease are essentially chronic diseases, this means that any treatment plan must account for and manage aetiological risk factors and treatment risks. Any individual treatment plan must include ongoing and long term reassessment and management. Failure to do so may mean inadequate patient care.

The importance of adequate dental patient records is an important part of patient management.[2]

ARPANSA outlines the Code of Practice and Safety Guide for radiation protection in Dentistry. The Australian Dental Association has additional guidelines for dental radiography.

The American Academy of Periodontology and the American Dental Association have extensive articles relating to guidelines and suggested requirements in managing periodontal disease from diagnosis to long-term maintenance.

FLUORIDE

There is overwhelming evidence that fluoride has a significant impact on the prevalence of caries. The use of fluoride can take one of two forms: topical application and systemic supplements. The introduction of fluoridated toothpaste is one example of how mass access to fluoride has improved oral health by reducing the incidence of dental caries.

Other forms of readily available fluoride can be found in varnishes, mouth-rinses and fluoridated additives, such as fluoridated salt. As already mentioned, specific guidance may vary from country to country and each practitioner should check their own local recommendations. This is important, as the information may vary depending on factors such as whether the water supply is fluoridated.

Regardless of location, the consent process for the patient is a key issue when using fluoride, especially in topical agents. As with many areas of healthcare, there is some controversy surrounding the issue. A small number of research articles, and a commensurately small number of clinicians, have linked fluoride to serious side effects, including cancer, in some instances. Such negative connotations have been reported in the media and, understandably, caused some concern for the general public.

Whilst the overwhelming body of evidence suggests fluoride is beneficial and safe, when used in the recommended dose, some patients or parents may not wish to have such treatment. Of course, it is their right not to do so and it is critical, if you are undertaking such treatment, that the patient or their parent fully understands what you are proposing, what materials you are using, the intended benefits and any associated risks.

Dental Protection is not the arbiter of clinical opinion; so when deciding on treatment approaches, each clinician must carefully weigh up the evidence and guidance for themselves and act accordingly. They must also be willing to justify all of these decisions in the event they are challenged at a later date.

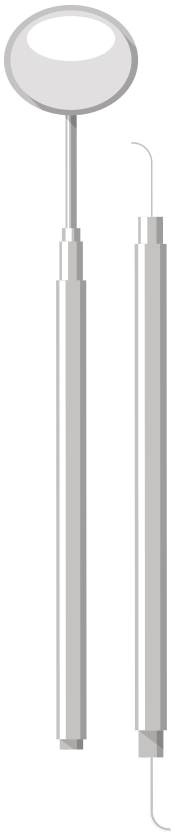
DIET AND ORAL HYGIENE INSTRUCTION

These are two pivotal, patient-centred issues that are basic to promoting better oral health. Any assessment and advice needs constant re-enforcement, as they can both involve lifestyle changes that are often difficult for patients to implement.

It is simply not enough to provide patients with information. Clinicians also need to consider how they can help their patients use that information. This might involve looking specifically at the diet and helping the patient identify practical ways in which they can make positive changes. This aspect of care does not need to be performed by the dentist and is an opportunity for the whole dental team to be involved. Hygienists, therapists and oral health educators can all have a role in delivering the educational component of patient care.

ADDITIONAL RESOURCES

It is well-known that patients can only absorb a small amount of the total information presented to them at any one time in the clinical setting. This is one reason why it is so important to provide continual, positive re-enforcement of the information. One way to enhance the message you want to give is by providing written factsheets. There are many downloadable information sheets, which are published by recognised authorities, and those published by the ADA provide an excellent source of patient education.



1. Council of the British Society of Periodontology. Basic Periodontal Examination (BPE). British Society of Periodontology 2016. http://www.bsperio.org.uk/publications/downloads/94_154250_bpe-2016-po-v5-final-002.pdf
2. Guidelines are available at Dental Board of Australia (dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx)

SIMPLE CONSERVATION

Clinicians will be familiar with the dilemma of having to decide whether or not an early carious lesion can be re-mineralised and reversed, whether it can be kept under observation and reviewed, or whether immediate active intervention is required. With the benefit of hindsight, one can be criticised for any wrong decision. However, it is equally possible to defend a decision which turns out to have been misguided, if it was based on justifiable reasons at the time. This is dependent on an appropriate history, examination and investigations to support the decision are properly recorded in the patient's clinical notes.

A particular dilemma exists when treating early pit and fissure lesions, because in addition to the 'to treat or not to treat' decision that exists with interproximal or smooth surface lesions, there is the added problem that it is not always easy to detect developing lesions radiographically.

Transillumination is a useful diagnostic adjunct both for occlusal and interproximal lesions, but here again it is important to record the use of this investigation, and any conclusions reached, in the clinical notes.

When fissure sealants are recommended as primary preventive procedures (or when sealant restorations are advised in circumstances where any part of an enamel pit or a fissure system is thought to be actively carious) it is important not to give the impression to the patient (or possibly, their parents) that this provides any kind of guarantee of long-term protection against subsequent caries.

Allegations have been known to be made that fissure sealants were recommended and provided on the assurance by the clinician that the teeth would thereby be protected forever from becoming carious. Any such assurances or guarantees are misplaced, and should be avoided.

Checking the marginal integrity of fissure sealants, once placed, noting and acting upon any reported sensitivity from the teeth involved and their periodic monitoring by means of radiographs where appropriate, is an important aspect of preventive dentistry. Fissure sealants can, and do, 'leak' and they can then obscure the development and progression of caries in the depths of the fissures that they are designed to protect, sometimes leading to extensive caries occurring before the problem is detected.

COMPLEX CONSERVATION

The provision of restorative treatment for patients where caries are not controlled carries the ever-present risk of further caries at the margins of the restorations, or elsewhere in the same tooth. The provision of complex or expensive treatment, when the primary disease has not been controlled, could leave the clinician open to challenge regarding the appropriateness of the treatment plan. This may be a particular issue if there is premature failure of any treatment provided. To mitigate any criticism of the clinician, a careful discussion of all the treatment options is required and should be recorded before treatment starts, together with the reason for the patient's preferred option, if this does not coincide with the recommendations of the clinician. Treatment should not be undertaken unless it is considered to be in the patient's best interests.

Some patients are at a higher than average risk of caries or tooth erosion because of impaired salivary function due to systemic disease or medication. In a similar fashion, a patient's susceptibility to both caries and periodontal disease can be affected by the introduction of fixed or removable prostheses, or orthodontic appliances. Acknowledging these factors, and acting appropriately, is another example of risk assessment and good patient management.

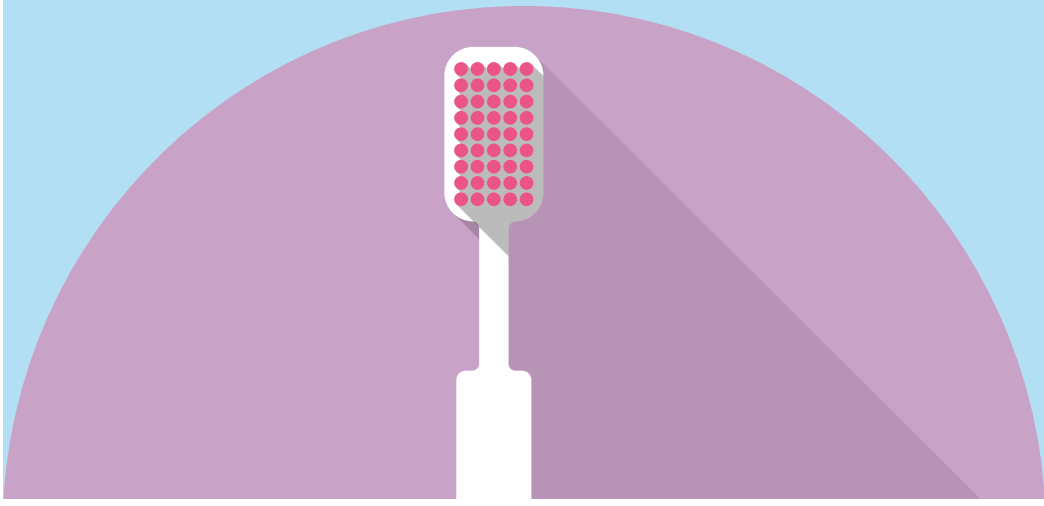
The provision of treatment without any necessary preventive advice, designed to maximise prospects for success and longevity, can lead to early failure. If this results in the patient being worse off than if the situation had no treatment been provided at all, which is often the case, complaints or claims may ensue.

SMOKING CESSATION AND ALCOHOL USE

Scientific research has clearly established smoking as a major risk factor for both periodontal disease and oral cancer; this has changed the standards expected of dental professionals. It is no longer acceptable for clinicians to ignore tobacco use and a failure to inform the patient of the risks it has on their oral health, or failing to advise smoking cessation, could be viewed as a breach of duty.

All patients should be asked specifically about the nature and extent of any tobacco use habit, including chewing tobacco or other carcinogenic chewing materials such as paan, and they should be made unambiguously aware of the adverse effect that this can have upon their oral and general health. These enquiries, and any necessary follow-up advice, should be repeated at appropriate intervals. It would also be prudent to offer referral to a local professional smoking cessation service.

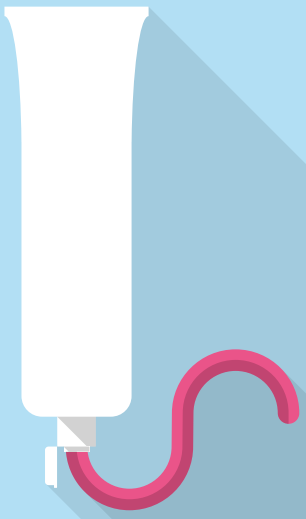
Most medical history forms used by dentists also enquire about alcohol use. If it transpires that a dentist had information about the patient's habits that could impact on their health at a later date, but had not acted upon this information, they may be open to criticism. Although it may be a subject that dentists feel uncomfortable discussing with patients, high alcohol consumption is known to increase the risk of oral cancer. The patient should be made aware of this fact along with the synergistic effect of smoking and alcohol. There is plenty of educational material online that can be used to raise patient awareness. In addition, there are public health campaigns which provide an opportunity to start a conversation with a patient that might otherwise be difficult to initiate.



HOLISTIC CARE

The following concepts encapsulate the idea of considering all aspects for patient care and there may be other areas of concern where the dental team may be able to implement a preventive strategy. Such areas include, but are not limited to:

- Dry mouth – there may be many reasons why patients have a lack of saliva and this can predispose them to a high caries rate. If this is recognised early, appropriate management can help reduce the impact of the condition.
- Acid erosion – this is a growing problem, especially in younger adults and teenagers. The restoration of severely affected teeth can also present a difficult challenge for the dentist. Again, early detection and prevention can prevent a lifetime of difficult problems for both the patient and dentist.
- Oral sex and the risk of HPV – although a sensitive subject, it still falls within the remit of dental care. It may not always be appropriate to directly ask or discuss this with patients and so it can be useful to use other forms of communication. Factsheets and posters subtly displayed in the practice can inform patients without causing embarrassment and offer them the opportunity to ask further questions if they so desire.



RECORD KEEPING

As with all complaints and claims, your clinical records are your best line of defence. Therefore, it is critical that they accurately reflect advice, warnings and treatment given.

Detailed records should be kept of all occasions when preventive advice is given to patients, or parents. It should be clear from any such entries:

- who gave the advice
- what form the advice took (for example, whether verbal or supplemented by advice sheets or visual aids of any kind)
- how the patient responded to the advice.

It is particularly important to note instances where a patient appears apathetic or disinterested in the preventive advice being offered to them, or when the patient indicates that they are unlikely to follow such advice. Here, any entries should be sufficient to demonstrate that the patient was appropriately warned of the likely consequences of not acting upon the advice given.

It is sometimes conceded on a patient's behalf, especially when confronted with good contemporaneous records, that certain advice was indeed given, but then argued that it had been given in such a way as to attach no great importance to the advice.

When the advice given to a patient is likely to have a direct bearing upon their future oral health (or general health), it is advisable to ensure that the record entry properly reflects any emphasis given to the advice and also that the subject was re-explored with the patient at subsequent visits. If a preventive message is important enough to give to a patient, it follows that it is important enough to reinforce at regular intervals.

A patient who may not be receptive to the advice on one occasion may well be more receptive to the same advice when it is subsequently repeated, often for reasons of which the clinician may never be aware.

In the case of oral hygiene instruction, it is helpful if records provide sufficient detail of any specific preventive techniques that the patient is advised to use. If these techniques are demonstrated to the patient (e.g. on a model, or in the patient's own mouth) and/or if the patient is encouraged to practice the technique(s) under the supervision and guidance of a dentist, hygienist or therapist, then this similarly needs to be described clearly in the clinical notes. Vague entries such as 'OHI' are better than nothing at all, but are still of relatively limited value in confirming precisely what advice was given.

Similarly, a note should be made of any educational material, videos, leaflets or advice sheets that are given to patients (or parents) to supplement any preventive advice given verbally. Additional resources, such as clinical photographs and study models can help demonstrate not only the clinical situation, for example at first presentation, but can demonstrate appropriate monitoring and education.

"It is particularly important to note instances where a patient appears apathetic or disinterested in the preventive advice being offered to them, or when the patient indicates that they are unlikely to follow such advice"

SUMMARY

Any member of the dental team who is involved in the provision of dental care, advice and treatment to patients, whether to specific patients or more generally, needs to be aware of current thinking in the field of preventive dentistry and to take steps to keep their knowledge and skills up-to-date. Preventive dentistry needs to be seen as an integral part of the care provided for all patients, rather than being reserved for specific patients in specific situations. This is reflected in The Dental Board's *Code of Conduct*, which states that healthcare professionals should encourage "patients or clients to take interest in, and responsibility for, the management of their health and supporting them in this".

Communication and documentation are key aspects to successful practice. For the right messages to be given and received, communication is essential, not only between the clinician and the patients, but also between all the members of the dental team. Advice is more likely to be acted upon if communicated effectively; consideration should be given to how, when, where and by whom this advice is given, and also to the need for training and personal development of the dental team in the areas of behavioural psychology and communication skills.

When the team has worked hard on promoting oral health and providing high quality preventive dentistry, this should be reflected in the clinical records with excellent documentation. The critical aspect of record keeping is that a third party needs to be able to read and understand the records and subsequently know exactly what has happened, and when.

When there is nothing abnormal to be seen with the oral tissues and a fee is charged for achieving this highly desirable condition, a clear record of how this was achieved is the only way of proving that the outcome was due to professional nurture (a chargeable activity) and not a gift from nature (no charge).

BIOGRAPHY

Dr Andrew Walker BDS MFDS M Clin Dent (Perio)

Andy is based in the UK and worked as an SHO in maxillofacial surgery before undertaking specialist training in periodontology. He now works in a specialist referral practice and as a clinical tutor at The University of Liverpool Dental School and is a part-time associate dentolegal adviser to Dental Protection.

YOU'RE IN THIS TOGETHER

Dr Raj D K Dhaliwal explains why it is important to balance the patient's needs and preferences with your own knowledge before deciding on a treatment plan

The Dental Board of Australia has said: "Making decisions about healthcare is the shared responsibility of the treating practitioner and the patient or client who may wish to involve their family, carer(s) and/or others. Practitioners have the responsibility to create and foster conditions for this to occur."

PATIENTS' INTERESTS FIRST

It is not surprising that the Dental Board, which promotes high standards of professional conduct, expects the dental profession to act in patients' best interests at all times.

To mitigate the risks, it is important to reassess the clinical decision process to ensure patients are fully informed, knowledgeable and wholly involved in their care. This is achieved through a process of shared decision making.

POSITIVE EFFECT

In general terms, the more complex the intervention, the more in-depth the discussions required to be sure a patient is able to give valid consent. The benefits of shared decision making are the opportunities of discussing evidence around certain procedures, along with the patient's preferences.

This patient–clinician communication improves patient knowledge and risk perception accuracy and so leads to a reduction in decisional conflict as well as the patient feeling uninformed. The positive effect on satisfaction and the perceived quality of outcomes is shown in Figure 1 (right).

WE ARE NOT MACHINES

Complexity – in the clinical sense – relies on known interventions that mostly lead to known outcomes. That said, experience tells us that the biological response to treatment is not always predictable and so things do not work out as we may have hoped. A dentist today has to manage the clinical complexity associated with caring for the patient and the complex adaptive elements within the environment, all of which are interconnected.

A review of our past cases reveals that the existence of so-called predisposing factors (such as rudeness, poor interpersonal relationships, inadequate communication and inattentiveness) will often motivate patients to sue or complain when there are precipitating events (such as patient harm, adverse outcomes or iatrogenic injury during clinical procedures).

IDENTIFY

Providing high-quality dentistry for a patient can be simple or complicated, but both take place in a complex environment that has a significant impact on clinical decision-making. Patient involvement in the process is important to ensure care is delivered in a way patients know to be in their best interests.

The shared decision-making process should also address the cost of the treatment options available. It is a common finding in complaints – or claims for compensation – that an intervention is questioned or challenged by a patient on grounds of cost rather than clinical effectiveness. Further inquiry or investigation may then reveal ethical breaches in the decision-making process.

Figure 1. Shared decision making

FIVE KEY COMPONENTS OF SHARED DECISION MAKING

1. **The use of professional judgement**
2. **The use of current information sources (evidence)**
3. **Choices are made about what, who, where, when and why things are done (options), evaluating the choices that are made (selection)**
4. **Accountability for those decisions**
5. **Cost of treatment**

BIOGRAPHY

Dr Raj Dhaliwal BDS MDentSci MFGDPRCS LLM

After graduating from Birmingham Dental School, Raj undertook research into dental public health before moving to general dental practice. Raj worked as a clinical dental adviser to NHS England and as a dentolegal adviser for Dental Protection. She recently moved to Australia and is now working in the Melbourne office.

MINIMALIST APPROACH

Dr 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"

WHAT IS MINIMAL INTERVENTION (MI) DENTISTRY?

An approach 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 MI 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 MI 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[1] 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.

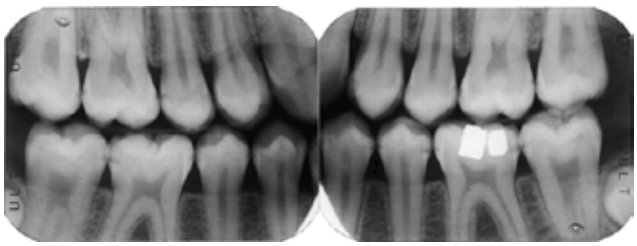


Figure 1 (radiographs © of Dr Louis Mackenzie)

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 no-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 dentist.

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.

> There have also been a number of publications and conferences on this issue, such that it is becoming increasingly mainstream

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.[2]

There have also been a number of publications[3] and conferences on this issue, such that it is becoming increasingly mainstream. The Dental Board of Australia sets out its expectations of a professional in the *Code of Conduct*.[4] This states that "underpinning this code is the assumption that the practitioner will exercise their professional judgement to deliver the best possible outcome for their patients".

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).

The MI 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 communicating this philosophy to the patients they should understand their ongoing commitment and duty to inform future dentists that a non-interventive approach has been adopted. Without this information, the philosophy is squandered through ignorance.

RISK TRANSFER

The MI approach to caries has the need for patient compliance in common with the management of periodontal disease. But unlike periodontal disease, where the patient can see an improvement in gum health and reduction in measured pockets, the signs of improvement in caries stabilisation are not so obvious. These developments help to reinforce behaviour change and compliance, but for the patient whose early lesions are being 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 dentist undertaking this approach could effectively be transferring the risk 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, 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 dentist 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 should be taken into consideration. It should also be explained, 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. *Rogers v Whitaker* [5] has long enshrined the need for the communication of risks to a specific patient in contemporary Australian practice 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 will be largely ameliorated.

BIOGRAPHY

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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.

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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 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, who 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.

> "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

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.

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.[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. 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 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 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[5] 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.

BIOGRAPHY

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Dr Mark Dinwoodie is the director of educational services for Dental Protection.

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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. 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.

> "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"

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 certainly a key part of a dentist'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.

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/au

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