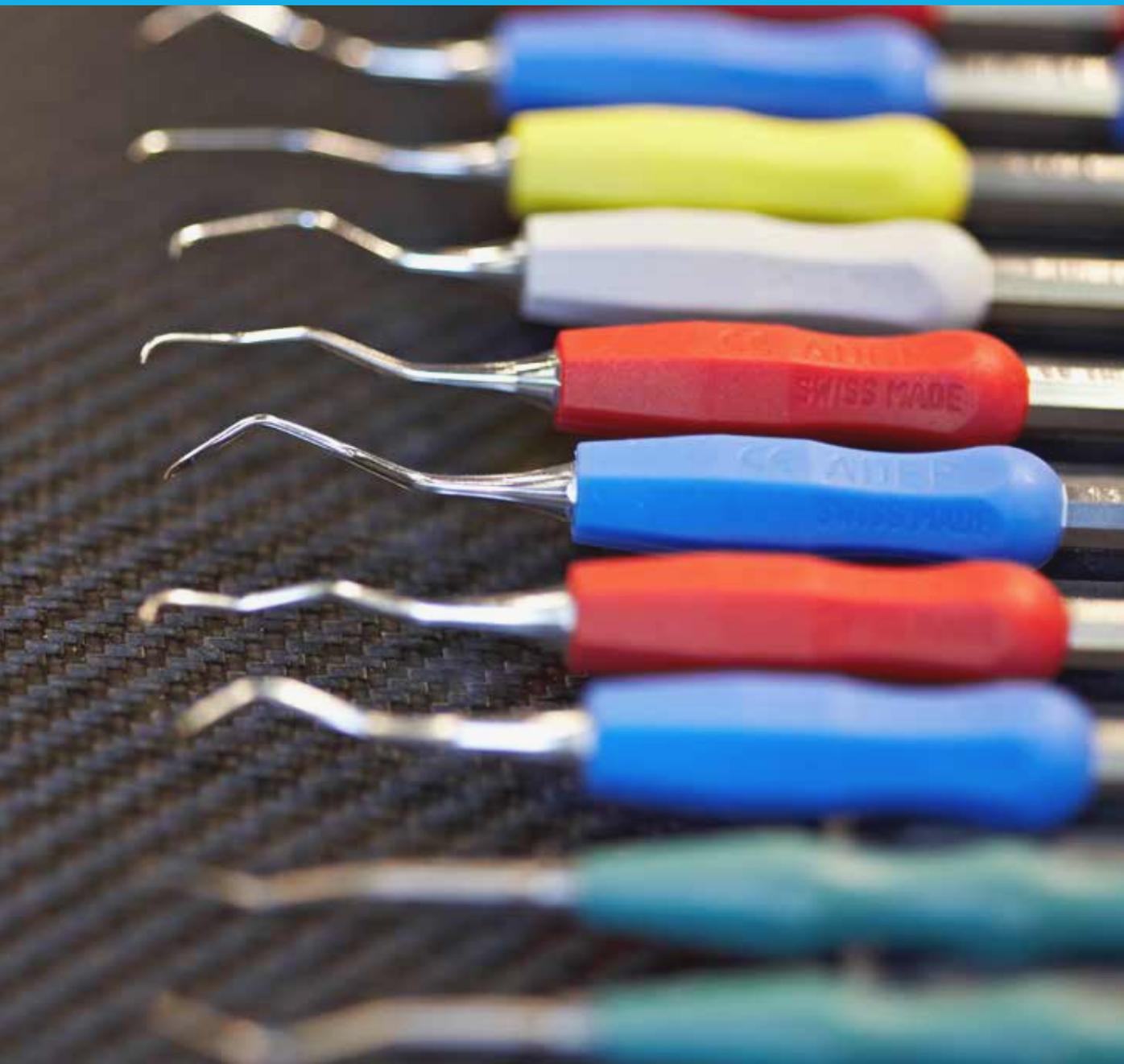


RISKWISE

ISSUE 16 | DECEMBER 2016



PERIODONTAL DISEASE

Allegations of failure to diagnose the disease are on the increase.
Read the report on page 9

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Pictures in this publication should not be relied upon as accurate representations of clinical situations

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NEWS FROM DENTAL PROTECTION

This November, my colleague, Dr Stephen Henderson, and I met up with some of the dental members to discuss the cases in which they are currently involved to ensure that they were happy with the service that was being provided. There was also an opportunity to meet with our colleagues at the Singapore Dental Association.

AT YOUR REQUEST

Stephen and I had the pleasure of delivering a lecture to Singaporean members which explained how good records can help to safeguard a professional reputation. In addition, we discussed the risks associated with aesthetic dentistry and short-term orthodontic treatment. There was also an opportunity to demonstrate a worldwide trend identified by Dental Protection that has resulted in an increase in the number of claims relating to periodontal treatment and how this risk could be reduced. You can read more about this subject on pages 9-13 in this issue of *Riskwise*.

COMMUNITY HEALTH ASSIST SCHEME

We had a productive meeting with the Chief Dental Officer, A/Professor Patrick Tseng where we discussed his letter of 28 October 2016 to dentists operating under the Community Health Assist Scheme (CHAS). We would urge our members to be aware of the strict record card audit the Government is implementing from 1 January 2017. There will be a requirement to ensure that the fee claims match charting and clinical records and all dentists need to be mindful that any false claims identified would be passed to the Police and their Commercial Affairs Department for investigation. In the event that a criminal prosecution is not brought, the papers may well be passed to the Dental Council for investigation as an issue of professional misconduct.

We were also delighted to meet representatives from the Association for Oral Health Therapists, to hear about their work and initiatives and to assure them of Dental Protection's support for their role in the wider dental team. Dental Protection has a long record of supporting the team approach to oral healthcare.

COMING UP

We are looking forward to the launch of our new Record Keeping small group workshop, the revision of our Risk Management and Ethics Modules which will soon be available on our web-based e-learning platform dentalprotection.org/Prism.

GOOD NEWS

In an ever changing world I am sure that members will be pleased to know that no new subscription categories are being introduced in 2017 however, you need to ensure you are in the correct membership category and hence paying the right subscription for the work you are carrying out.

As always I am keen to receive feedback about our publications and in particular would like to know what subjects you might like to see featured in future issues.

Please feel free to contact me at the email address below.



Dr Jane Merivale

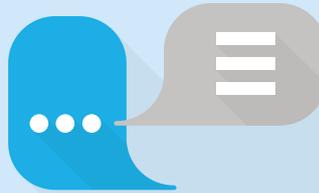
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THE NEW DENTAL DIRECTOR

Dr Raj Rattan MBE was appointed as the new Dental Director to succeed Dr Kevin Lewis who stepped down from the post earlier this year.

Dr Rattan has over 30 years' experience in dental practice and has been associated with Dental Protection for more than 20 years, first as a dentolegal adviser and more recently as a senior dentolegal consultant. Indeed he only left clinical practice last year.

Dental members will probably be familiar with his articles in our publications and some of you may have had an opportunity to hear him speak.



**RAJ
RATTAN**

It is a huge privilege to be given the opportunity to lead a very talented team who are dedicated to dentistry. Within the organisation we have an enormous breadth of expertise and experience that serves the needs of dental members in Singapore.

You should be reassured to know that if a difficult situation arises, our members have access to the largest team of dentolegal advisers anywhere in the world, with a wide range of skills and expertise in every aspect of clinical and professional life. I look forward to working closely with my colleagues in helping to shape a better future for all our dental members and for the profession, by listening to their concerns, working closely with key stakeholders and continuing to provide courses and events that address their particular needs.

I also want to take this opportunity to thank Dr Kevin Lewis for not only his strong leadership, but also his sense of purpose that has made Dental Protection what it is today.



IS IT ME?

Dr Susie Sanderson looks at the positive benefits of being asked a potentially difficult question

'CAN I JUST HAVE A QUIET WORD WITH YOU?'

Guaranteed to create a surge of adrenaline in even the least insightful of us, those words mean that it is likely that someone has given a huge amount of consideration to what they are about to say.

In the category of "information I never want to receive" is the conversation with a colleague who thinks you are underperforming as a dentist. Unless the communication is inappropriately driven by malice or personal gain, the approach will not have been taken lightly. Nor should it be dismissed lightly although an immediate reaction of denial, anger, hurt, betrayal and bewilderment is entirely understandable.

If you are the messenger delivering such news, you will have carefully examined all the available facts beforehand, but then things are never as simple as they seem.

A CRITICAL MOMENT

Such conversations are extremely uncomfortable for both parties. The good news is that one colleague has discharged an ethical obligation by alerting the other one to their concerns. The exchange between colleagues has been done quietly, in confidence at this stage, and deserves respect and professional courtesy. This is also a valuable opportunity for the other registrant to listen calmly to the concerns, explore why they have been raised and address them swiftly if that becomes necessary.

This episode could be an opportunity for the same colleague to suspend frustration, delay denial and take an honest look at themselves to see if there could possibly be some shortfalls in their professional development. A far riskier situation lies in not recognising the possibility.

IS IT ME?

Although it's hard to believe in this age of digital connectivity, it is entirely possible for a practising dentist to be effectively isolated. Life events can sometimes overwhelm us and may last many years; relationships, home making, a growing family, responsibilities outside work feel as though they deserve our close attention.

During that time, it's easy to function on autopilot in our working hours and before we know it, everything has moved on without us. Dentistry is a dynamic area of healthcare moving at an astonishing pace.

Is it appropriate to continue using outdated procedures in automatic mode simply because we didn't question or even realise that there may be something better? Is it appropriate to rely on the comfort of "it's always worked for me" to justify a procedure that has a more effective or safer alternative?

Even in a large multi-chair practice, a clinician can come and go on a daily basis with no professional interaction with peers. If that is coupled with little or no engagement with professional development or peer networking, the opportunity to see what is currently considered best practice might be lost.

AWARENESS

In dentistry, our awareness of an associated risk of harm to those people, who put their trust in us to look after them and their best interests, should be a constant niggle in our minds. Poor performance is not a calculated behaviour in anyone other than those with criminal or psychopathic tendencies.

More commonly, when accepted standards are not maintained, an underlying pattern can often be identified in retrospect. Burnout drives disinterest, poor motivation, isolation and ill health. Hubris can create

an aura of unchallengeable confidence, particularly in situations in a small community where dentists can develop a self-perception of indispensability.

How many times do we hear our patients say to us, "I just don't know what I would do if you weren't here?" Such affirmations need to be heard with an understanding of the fickle nature of being indispensable.



There are no mistakes, save one. The failure to learn from a mistake

Robert Fripp

One risk is that a dismissive culture develops where small mistakes and minor complaints are ignored as unimportant or blamed on staff members or patients themselves. Early warning beacons can be missed, especially in an environment where there is an autocratic communication and governance style.

Unfortunately, it may be that the first "light bulb" moment follows the raising of a concern about the practitioner to the Dental Board or Council. The process of investigating a dentist's fitness to practise can, in some cases, be lengthy, intrusive, demoralising and personally devastating in its outcome.

Surely it is far better to employ a healthy, honest and energetic degree of insight and to do everything possible to demonstrate current knowledge, well-practised skills, continual use of self-audit and an openness to constructive criticism.



You see a person when you look in the mirror that no one sees but you. Other people see a person when they look at you, but you're not that person, either

Roy H. Williams

Dental Protection works with dentists in many countries, who find themselves under investigation, to assist them in planning and extending their professional development. A first step on the part of the practitioner is an honest reflection about the issues that have triggered the concerns. The process can provide powerful reassurance that there is light at the end of the tunnel.

ASK YOURSELF

“Would anyone feel it necessary to raise concerns about me at the moment?”

In taking the first brave step to ask such a question, the wise and insightful practitioner is looking for a reality check to provide reassurance one way or another. There is absolutely no shame in asking for help to consider this from a trusted critical friend, colleague or professional mentor. Even an informal chat in a safe place over a cup of coffee can be a valuable experience.

The only way to mitigate the risk of unconscious incompetence is to put yourself in a position to know what you didn't know before. We are naturally curious and intelligent beings. In Dental Protection's experience, the re-awakening of the joy of learning is an unexpected pleasure described by members who have taken advantage of feedback from a colleague to reflect and improve their knowledge or behaviour.

It may be that a discussion with a mentor (formally or informally) will reassure you that it is simply a lack of confidence in your own skills and breadth of knowledge that has led you to question your own competence and safety. Or it may be that the realisation that there really is a problem provides you with the incentive to sort it out.

Getting to the bottom of the reasons for your concerns about yourself may be harder to achieve. If they involve health issues, then it would be wise to discuss these with your

GP or an adviser from a confidential agency that supports the wellbeing of healthcare workers. In any event, taking time to reflect and plan your actions will pay dividends.

ADVICE AND ASSISTANCE FROM DENTAL PROTECTION

Dental Protection can offer advice and support and access to confidential counselling for members in any of these situations:

If you find yourself in receipt of information that may lead you to think that another registrant is repeatedly underperforming or is a risk to patients, you may wish to call and discuss the situation in confidence with one of our dentolegal advisers.

For members who have been alerted to concerns about their own professional performance, a conversation with one of our dentolegal advisers may help to give some direction to your next actions.

If you are concerned about your own professional performance, please take advantage of this benefit of membership, or perhaps discuss the issue with your own doctor.

For more information go to: dentalprotection.org

RESOURCES

Dental Protection's risk management courses and learning material are available at: dentalprotection.org/prism

For a range of advice booklets look under the Advice tab at: dentalprotection.org



BIOGRAPHY

Dr Susie Sanderson
OBE BDS FDSRCS(Eng)
FFGDP(UK) LLM. Susie was a partner in a mixed family general practice for most of her career. She was Chair of the Executive Board of the British Dental Association (BDA) and continues to represent the BDA internationally. Susie is also a Dentolegal Adviser for Dental Protection.





REFLECTIVE PRACTICE

Dr Mark Dinwoodie explains how you can learn from a bad experience by changing your behaviour, either consciously or subconsciously

Reflecting on what we do in everyday clinical practice is a good way of considering whether how we treat our patients is as effective as we would like it to be and identifies ways that we can improve. As the saying goes, "if we don't reflect on what we do, we will carry on doing what we have always done". While it may be that we are practising optimally it is likely that there are areas of our practice that could be improved. Reflection is an important part of maintaining competence. It helps identify learning needs, contributes to quality improvement and provides a way of self-monitoring our performance.

Many regulators require their registrants to undertake Continuing Professional Education (CPE) and reflective practice is seen as an essential component of this process. One way of understanding our current standard of practice is to actively think about what we do, question how we do it, and ask ourselves if we are fulfilling the modern dental patient's expectations and the requirements or standards of our regulators.

SO WHY BOTHER TO THINK MORE DEEPLY ABOUT WHAT WE DO OR REFLECT?

There are a number of reasons why you might reflect:

- When things go wrong, or just simply don't go to plan, often causing considerable stress to ourselves and other members of the dental team which could have been avoided.
- Equally we may reflect on positive events – what went well and why, so that we can repeat the process and benefits in similar situations.
- Following a CPE course when we want to introduce new ideas and change into our practices; how will we do this?

We are likely to reflect on the events of the working day as they happen, but sometimes we also take them home at the end of the day - still thinking about a conversation, a treatment, or an interaction.

However, some events remain unresolved. For many events, this may not be significant, but for others, when a similar situation arises again in the future, a repeating pattern of behaviours may arise if the initial events weren't fully reflected on at the time.

WHAT IS REFLECTION?

Most models of reflective practice incorporate the elements of critical analysis and learning to achieve deeper understanding of a personal experience and our actions as well as the impact of these on others. The process of reflection is often triggered by a particular event or experience allowing a new understanding, which can then be applied to a similar situation in the future. Reflection can occur at a fairly superficial level or involve a much deeper level of analysis and understanding.

Reflection should not be a passive activity, but should be a proactive process for the dentist. It should be structured, asking specific questions, encouraging self-assessment, analysis and critique of our practice.

Reflection should challenge our beliefs, integrity, and ethical values, but, in its deepest form, demands some soul searching. This is not always an easy, quick or one-off process.

The endpoint should bring about learning by changing knowledge, skills or attitudes or all three, resulting in a change in behaviour or practice. Our goal should be to encourage the habit of reflection into day-to-day practice and as part of ongoing lifelong learning.

Experience gained through life, education and work plays a central role in what is termed experiential learning. The most popular theory of learning from experience is Kolb's¹ learning cycle. Reflection is an essential component of this. Experiential learning is based on the notion that ideas and understanding constantly change, are not static and are reformed through the experiences we have every day.



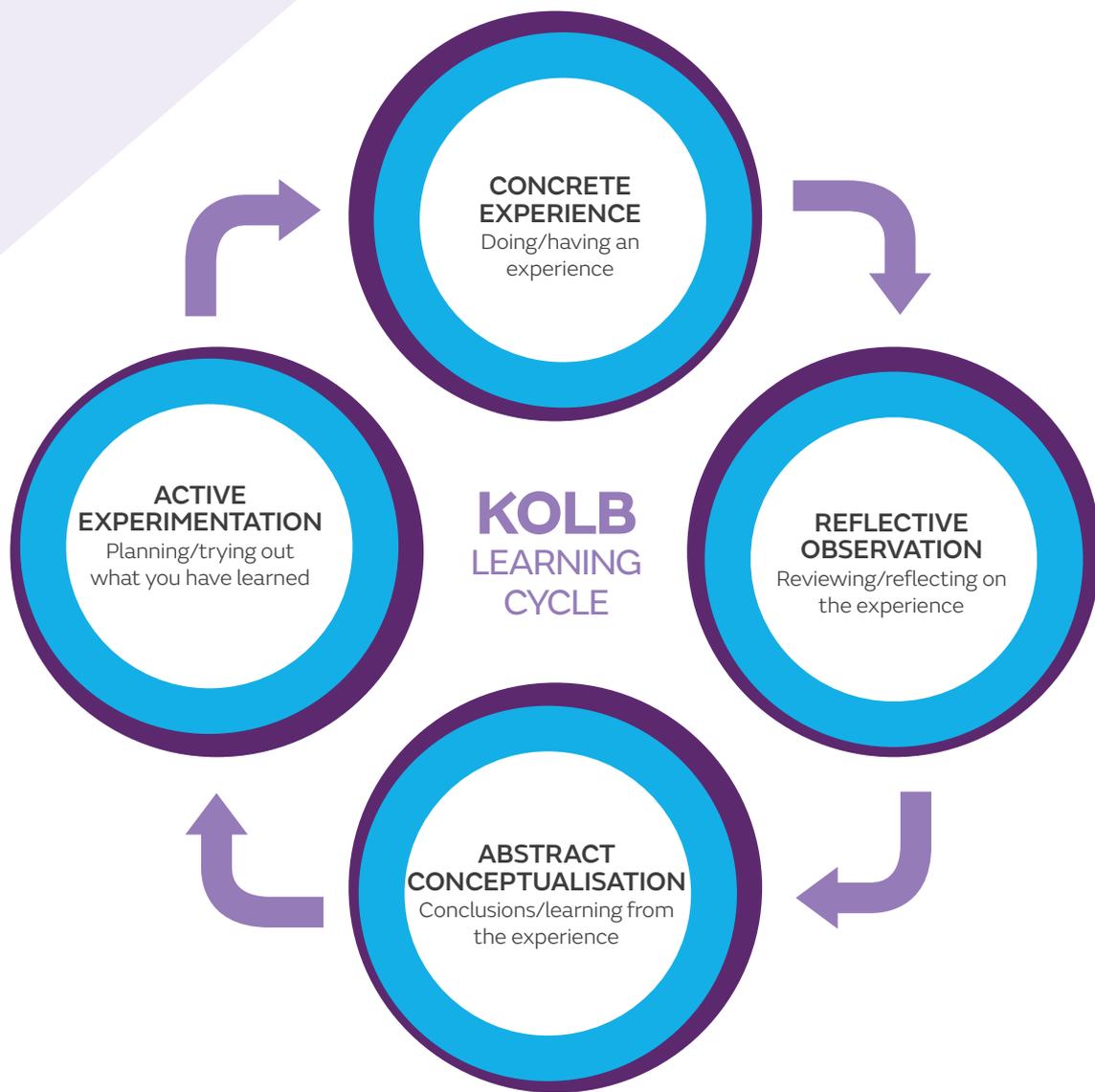
Often reflection takes place after an event. However, to make a greater difference to the way we practice, this should be viewed more broadly and considered in three ways:

Before we act, while we act and after we act.

Areas to reflect on:

- **Clinical events**
- **Patient experience**
- **Personal performance**
- **Communication**
- **Professionalism**
- **Leadership**
- **Management**
- **Teamwork**
- **Learning activities**

For self-reflection to be effective, it needs to be relevant, recorded and revisited.



WHAT ARE THE BENEFITS FOR DENTISTS PERSONALLY AND PROFESSIONALLY?

- To gain greater insight into how we think and act
- A new way to tackle problems and explore them in a structured meaningful way. This may reduce risks for the future, or provide a better way to tackle a similar problem next time
- Dentists who reflect themselves are more likely to encourage other staff and team members to engage in the same process
- Dentists using the skills of reflection in their everyday practice will reflect on incidents, good or bad, to make changes for safer practice
- Dentists using the skills of reflection are likely to question the CPD activities they participate in - asking questions such as: are they relevant, or do they change our way of practising?
- Reflection will make it more likely that a potential learning experience will result in it influencing and impacting on everyday clinical practice.

ANY REFLECTION SHOULD INCLUDE

- A statement of observations –
“the patient came in to complain about me”
- A comment on personal behaviour –
“I was very defensive with the patient and didn’t apologise”
- Comments on reaction or feelings –
“I feel very guilty about my approach”
- Comment on context –
“that always happens when my nurse is off.”

IT MAY ALSO SHOW:

- The ability to see an event from different points of view
- An ability to step back from a situation or consider alternative interpretations.

SO HOW DO I START BECOMING A REFLECTIVE DENTIST?

For many dentists this is a difficult and challenging task. However, this may be made easier by considering a framework to consolidate your thoughts. As in all adult learning, everyone has their own style and there are a number of frameworks for reflective thinking and writing.

One framework to consider when reflecting on an event good or bad, is Driscoll's reflective framework. Consider the three questions of Driscoll's² reflective framework below:

- What? - This explores what really happened
- So what? - This explores how you felt as a result of this event
- Now what? - This explores what you are going to do about this for the future.

Although this can be done by a dentist individually, there can be enormous benefits in doing this with a colleague, mentor, or collaboratively with a group of colleagues or staff members.

Across the spectrum of incidents and learning opportunities, it is only with experience and professional judgment that you can discern what depth of reflection will be appropriate to each situation. Reflection is likely to have greater impact if it is documented and your notes and comments are revisited at a future date.



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IN CONCLUSION

A statement is made showing that something has been learned from the experience and there is a feeling of development.

This should be done with honesty and integrity.

Lack of reflection may indicate that an individual is unable or unwilling to self-evaluate and take responsibility, and may instead blame others when things haven't gone well.

To participate in verifiable CPE using an interactive e-learning version of this article, please visit Dental Protection's online learning – PRISM at:
dentalprotection.org/singapore/events-e-learning



BIOGRAPHY

Dr Mark Dinwoodie is the Head of Educational Services for Dental Protection. Mark would also like to acknowledge the assistance of Anne Budenberg BDS, DGDP(UK), PGCTLCP, DipMed Ed in the preparation of this article.

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PERIODONTAL DISEASE

Why is periodontitis a
problem for general dental
practitioners?

Dr Andrew Walker BDS MFDS M Clin Dent (Perio)



Periodontitis affects around 10% of the adult population and, if left untreated, can result in tooth loss. The long-term nature of the disease, and the fact it remains largely asymptomatic until the degree of attachment loss causes mobility, means it may remain undiagnosed and untreated unless the dental team and the patient are proactive in this respect. A failure to diagnose and a failure to treat periodontitis is one of the fastest growing allegations in the dentolegal field.

It is not uncommon for such allegations to arise when a patient who has regularly attended the same dental practitioner over many years, for one reason or another, sees a second dentist. This may be due to the patient seeking emergency care, or following their original dentist either retiring or moving practice.

Patients who are unmotivated or simply unable to attend a dentist regularly may also find themselves with an established periodontal condition when they eventually see a dentist or dental hygienist.

Either way, success in controlling the disease needs the active participation of both the clinician and the patient. It can also help if the patient understands that periodontal disease is their problem which the dental team can only successfully control with their active participation (carrying out home care and attending appointments for any necessary treatment and monitoring).

The YouTube video called “Sound of Periodontitis” offers an extremely high level of patient motivation to engage with the risk of periodontal disease and establishes that anyone can develop a periodontal condition.

The video is easily shared with any patient <http://tinyurl.com/z6uvy43> - perhaps email it to them to watch at home when reminding them of their appointment and discuss it when they attend the surgery.

If you note this procedure in the patient’s record and link the discussion to their latest periodontal examination, you can establish a documented point of engagement for the future management of their periodontal tissues. By demonstrating a high level of care you also build patient loyalty.

Not every patient can return to the same clinical team indefinitely. A new job or a house move will often cause the patient to seek out a new dentist.

INADVERTENT CRITICISM

Sometimes the second dentist simply describes the periodontal condition in terms that the patient has not heard previously. Often the cause for the patient’s dissatisfaction arises from statements made to the effect that the condition has not appeared overnight.

“It must have been present for years.”

“This is very deep pocketing and a lot of bone has been lost.”

“More teeth might well be lost in the foreseeable future.”

Currently, there is a level of expectation that tooth loss is avoidable and certainly many of our patients retain more of their teeth into later life. There can be strong emotional implications associated with tooth loss and, if it comes as an unexpected surprise, can lead to the patient asking questions.

It is therefore vital that dental professionals can demonstrate they have provided appropriate advice, treatment and care.

SCREENING AND ASSESSMENT

In any branch of medicine or dentistry, it is important to follow the established steps of investigation, diagnosis and treatment planning. In periodontics, this must start with a basic periodontal examination and pocket depth measurement, where indicated, in accordance with clinical guidelines. An example of which is the Basic Periodontal Exam, BPE.

As in all situations, when a clinician chooses to deviate from recognised guidelines, they must be prepared to justify their reasons for this with reference to their clinical records. A common example in periodontology is not taking pocket and bleeding charts, or appropriate radiographs, as described in the clinical guidelines recognised in Singapore.

TREATMENT AND REVIEW

Once a diagnosis of periodontitis has been made, it is essential to formulate an appropriate treatment plan. Part of this may include assessing any relevant risk factors and acting accordingly. The most common of these would be the smoking status.



Easy to miss without regular periodontal screening

Once treatment has been provided, typically non-surgical periodontal therapy, some form of assessment of the outcome should be made and documented. In most cases, a decision then needs to be made as to how the patient moves forward. In some instances, further treatment in practice is warranted and in other cases a referral may be necessary. In most cases, after completion of active treatment, the patient is likely to end up in a long-term maintenance programme. It is crucial these decisions are made and discussed with the patient and that the process of, and justification for, decision making is reflected in the notes.

LONG-TERM MAINTENANCE AND MONITORING

As periodontitis is a long-term disease, the patient needs long-term treatment planning. Once active periodontal treatment has been completed, or exhausted, this often takes the form of periodontal maintenance care, also referred to as supportive periodontal therapy.

The exact nature of maintenance care depends on a risk assessment of each individual patient and is tailored to suit their specific needs. Regardless of the specific details of their recall, it is crucial to reassess the periodontal status at regular intervals. This will help determine if the patient is still stable, or whether further intensive treatment is required. When these assessments are made, it is equally crucial to inform the patient of any findings and involve them in the relevant decision making. Patient motivation is beyond the scope of this module but there are plenty of online resources to support your own discussion about the importance of the patient accepting that they have a disease and that they have to be part of the solution if it is to be successfully controlled.



For successful outcomes, both short and long-term, there must be patient cooperation. To achieve this, the patient not only needs to be made aware of the diagnosis, but also the nature of the disease process and, therefore, their input with regard to managing their own condition.



In spite of the clinician's best efforts when dealing with the periodontal patient, it is not uncommon for the treatment outcomes to be limited by the patient's oral hygiene. In such cases, the patient may never reach stability and so the dentist, or hygienist, is simply maintaining the situation as best as is possible. If this is the case, the patient must be informed and any discussions relating to this documented. It is equally vital to reassess the patient motivation periodically, as changes in their circumstances may result in them becoming more engaged in the treatment process.

The key concept of these assessments is that both the dentist and the patient are fully aware of the current status of the disease, what treatment options are available and how they will impact on the prognosis. It also means that, ultimately, the plan of action has been agreed by all parties.

RECORD KEEPING

A high standard of record keeping is imperative for all aspects of dentistry. Good clinical notes are essential in mounting a defence against any complaint or claim of negligence. As has been previously highlighted in earlier sections, the patient should be involved in the decision making and treatment planning of their care and this involvement should be apparent in the records. They should also be forewarned of the long term nature of the disease and the potential need for further treatment after initial therapy.

For successful outcomes, both short and long term, there must be patient cooperation. To achieve this, the patient not only needs to be made aware of the diagnosis, but also the nature of the disease process and, therefore, their input with regard to managing their own condition.

Two obvious examples of the patient's role in managing the disease are smoking cessation and personal plaque control. Smoking cessation advice should always be given and documented, along with offering a referral to a local smoking cessation service. With regard to patient education, it is not sufficient to simply record 'Oral Hygiene Advice Given' or 'OHIG'. The clinician must record the specific details of what has been advised, such as the size and

frequency of any inter-dental brushes which may have been demonstrated.

In most periodontal cases radiographs will have been taken. It is a legal requirement to report on all radiographs and the salient features should be noted. The degree and nature of the bone loss may be examples of what you would comment on.

As in any treatment, there are potential risks in providing periodontal therapy. Notable risks include recession and sensitivity and this may be a particular concern in the aesthetic zone. It is prudent to warn patients of these prior to treatment, as informing them after the event will only be seen as an excuse.



DEALING WITH DIFFICULT CONVERSATIONS

The potential for complaints and claims can increase when a patient sees a new dentist for the first time. This has already been discussed and referred to as "inadvertent criticism". Such conversations can be very uncomfortable for the new dentist, as the patient may ask awkward questions.

These interactions are never easy and there are no hard and fast rules in managing such situations. There are, however, two principles that should be borne in mind:

- Always give an honest account of your clinical findings
- Try not to criticise another dental professional.

Your duty is always to the patient. When confronted with a patient with treatment needs, you must give your honest opinion as to the extent of the problem and what



A record of the management of this case including all the appointments and advice offered, as well as follow up conversations with the patient can help counter any subsequent complaint if their teeth are lost

treatment you advise. This will not only ensure that the patient is offered the treatment they need but, critically, if a complaint were to arise, you have been shown to act appropriately and in the patient's best interests. When presenting this information, you must remember not to pass judgment on, or be critical of, any other clinicians. Without reference to the previous records, it is impossible to say what treatment they have had or been offered. Any criticism you make of previous care could subsequently turn out to be erroneous and create a difficult situation even more problematic.



The increasing popularity of implant dentistry has brought about new challenges for dentists and dental hygienists in general practice

Of course, the balance between giving the patient an honest opinion, without being critical, is a difficult and fine line to tread. It may be useful to have certain phrases that can be used to help answer difficult queries:

- "It is true that you may have had this problem for some time, but it is impossible for me to know how things have progressed over the last few years."
- "I cannot comment on what your previous dentist has done, as I do not know what treatment they have provided, how they have assessed, monitored and managed the condition. All I can do is recommend how I would treat this condition."
- "It is very difficult for me to comment on how this has been managed previously, but the important issue is that we can identify your problems today and discuss the best way to move forward."
- "Without knowing exactly what your previous dentist has advised and done, it would be unfair and unprofessional of me to comment."

As in all aspects of medicine and dentistry, there are differences in opinion as to how to manage a condition, when to take x-rays etc.

IMPLANTS

The increasing popularity of implant dentistry has brought about new challenges for dentists and dental hygienists in general practice. Many feel that they do not have adequate training to deal with implants and so there is a temptation to avoid monitoring and maintaining them. These situations may arise when a new patient arrives who has implants, or when the practice refers to an external practitioner to provide implant treatment.

If this scenario does occur, it is the dentist/hygienist's duty of care to either access appropriate training or refer the patient to someone who is comfortable with implant maintenance. This may mean the regular dentist contacts the implant dentist to ask for guidance as to how they prefer their implants being maintained, or refer back to the implant dentist for them to take responsibility for the maintenance.

Whichever route is taken, it must be established from the outset who is taking the lead for the implant care. All concerned should be clear as to who the lead is and what their individual responsibilities are. Again, this should be clearly documented and, as always, the patient informed.

REFERRAL

After initial periodontal treatment - or in some cases, from the outset - it may become clear that specialist advice or treatment would be in the patient's best interests. Record carefully any discussions with the patient along these lines and always keep copies of all referral correspondence and replies. Bear in mind that in cases of severe periodontitis, it is much easier for patients to allege, after the event, that they would have preferred a referral for specialist care. Similarly, it is important to remain aware of the perils of any delay in a referral, especially where early referral is clearly indicated.

CONSENT AND HOLISTIC CARE

Another aspect of periodontal care is its relationship to the other restorative disciplines and within the broader context of treatment planning. Particular care should be taken in the assessment of periodontal health prior to any other aspects of treatment. The sub-optimal results of restorative work, or its premature failure, which follows on from an inadequate preoperative assessment of the periodontal support, may invite a claim of negligence. Implant dentistry is a growing area where complaints or claims follow from complications related to inadequately treated periodontal disease. If in doubt, it is always worth seeking a specialist opinion on the periodontal status prior to complex or costly treatment.

Other allegations of negligence often relate to shortfalls in the consent process and dentists undertaking treatment of this nature should take care to explain the prognosis, discuss possible treatment alternatives and the advantages and limitations of each. As always, be careful to fully document all discussions.

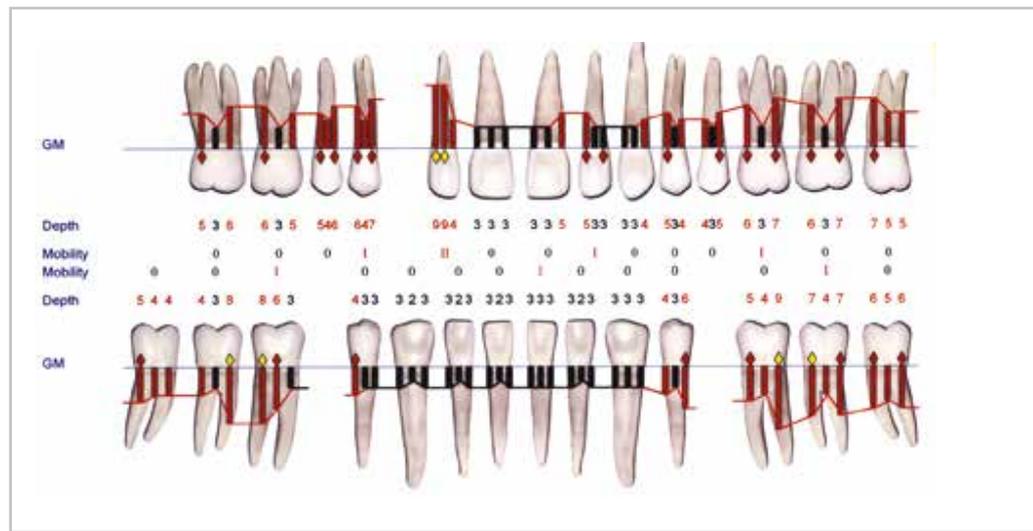


DESPITE BEST EFFORTS

An important consideration in periodontal cases arises from the fact that the dentist has usually not directly caused the patient's periodontal disease. In addition to this, periodontitis sometimes progresses despite a dentist's best efforts, as opposed to substandard care. Even in well maintained, compliant patients treated in specialist practice, teeth can still be lost. Good baseline records of the periodontal condition at the first presentation are essential in showing how, if at all, the condition has deteriorated whilst under the care of the dentist. This strategy can be strengthened by any educational activity which you have provided for the patient along with their documented feedback.

Some patients decline, or fail to attend, appointments. It is important to note these occurrences, just as it is important to record any lack of cooperation in oral hygiene and resistance/apathy towards treatment in general. In many cases, this helps to demonstrate that the periodontal disease has arisen or progressed because of failings on the part of the patient, rather than the dentist.

With patients living longer, and retaining more of their teeth into later life, periodontal problems are likely to present an ever-increasing challenge for dentists in the years ahead, both clinically and dento-legally.



Is your periodontal monitoring sufficiently frequent and detailed?
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BIOGRAPHY

Dr Andrew Walker BDS MFDS M Clin Dent (Perio). Andy 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 at Dental Protection.

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EDUCATION

SIX THEMES THAT MAKE A DIFFERENCE



Dr John Tiernan BA BDent Sc DGDP(UK) shares the best strategies to adopt in order to keep out of trouble

One of the first questions that colleagues from Dental Protection are likely to ask a delegate when they are delivering education is “why are you here?” and the response is frequently, “I want to avoid being sued or avoid complaints”.

It is hardly surprising that one of the most challenging events in a dental career is to be the subject of a patient complaint or a claim. For most dentists, this distressing event might arise once or twice in a career. Unfortunately, for some the frequency is significantly more. The key to reducing or avoiding patient complaints or claims is, in my view, education and training. Otherwise we are unlikely to acquire the necessary skills to manage this risk.

When deciding what to include in your professional development plan to help you reduce risk, the variety of education programmes can be daunting. Should you choose those areas where you have acknowledged weaknesses or those areas that interest you most? When it comes to risk, a broader approach is required because it will bring into focus a more comprehensive understanding of the various areas where such challenges arise.

WHAT REALLY CREATES RISK?

Clinical competence is a key prerequisite to successful dentistry; however, the real drivers of risk, as far as litigation is concerned, are frequently referred to as predisposing factors. These will often arise from the interpersonal relationship between the healthcare provider and the patient. The relationship between negligence outcomes and litigation are poorly documented. There is, however, evidence to suggest that those dentists with poorer interpersonal and risk management skills get more complaints or claims.

In a way, this is good news because these are skills that can be learned by most people. That is the approach taken by Dental Protection in designing its current educational programmes.

WHAT ARE THE MOST EFFECTIVE STRATEGIES?

There are six key areas for professional development that support the educational foundation built up through undergraduate training.

1 PREDISPOSING FACTORS

From a preventative point of view it is important to develop the knowledge of what really drives a patient to complain or litigate. These can include poor communication, lack of empathy, poor listening, unmet expectations and issues around manner and attitude among others. This is the focus of the Mastering Your Risk workshops. The objective is to give colleagues the skillset to reduce risk before events occur.

2 ADVERSE OUTCOME MANAGEMENT

Realistically most of healthcare is in the disappointment business. We provide care and treatments that patients would probably prefer not to have. Even patient-led care areas such as cosmetic dentistry can lead to profound disappointment when their expectations are neither understood nor met.

3 CHALLENGING INTERACTIONS

The world would be a great place if everyone agreed all of the time. Nevertheless, on a day-to-day basis, we have to manage differences of opinion and approach. Challenging interactions can result in complaints and claims if they are not managed. We are not the only industry that has to do this, however the stakes are high in healthcare.

4 SHARED DECISION MAKING

Shared decision making is yet to feature heavily in the dental literature. However, it is logical to assume that patient might want to be involved in decision making. When patients are involved, they make better decisions for themselves and are happy with the outcomes. In some cases, not all, it leads to better outcomes. Whilst most of the studies are in medical situations, there is no reason to believe that dental and medical patients are different or behave differently. It is a skill to be able to balance your own therapeutic knowledge and desire to help a patient and ensure that the patient feels that they have had full autonomy over their decision. The patient should feel that their balance and preferences have helped them arrive at their decision.

5 RISK MANAGEMENT

Good systems and processes are an essential part of risk management. Such knowledge can be acquired through educational programmes even if many working within the profession do not have day-to-day control of their systems and processes. A thorough knowledge of how to tell good from bad allows a healthcare professional the opportunity to consider the risk of the environment they are working in. Armed with this information, strategies can be put into place.

6 SELF-MANAGEMENT

Dentistry is a tough profession physically and psychologically. You are working with patients who have varying levels of anxiety at different times. It is important to understand that the human is not a machine and the right work-life balance needs to be struck in order to ensure that you are best placed to provide care for your patients. A common feature of those with high risk of claims and complaints is that their work-life balance has been poor and burn out ensues.

SUMMARY

In summary, these six key areas of education and training can make a very significant difference to your risk profile. Education after qualification is part of professional development. Most of the subjects above are optional but my suggestion is that if you are going to take a holistic approach to risk, they are all an important part of that professional development cycle.

Dental Protection offers FREE risk management workshops to members, that cover these key areas of professional development. Book your place today: dentalprotection.org.singapore/eventsandlearning



BIOGRAPHY

Dr John Tiernan BA BDent Sc DGDP(UK).

John qualified from Trinity College, Dublin in 1980, and worked in dental practice before joining MPS in 1994. He has worked as Head of Practitioner Services and subsequently Assistant Dental Director before being appointed as Director of Educational Services in 2007. John stepped down from his role with Dental Protection and MPS this summer.



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FOR PROFESSIONALS AS WELL AS PATIENTS



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to help keep you informed, educated and connected. Many of these events and resources are also accredited for continuing professional development.

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