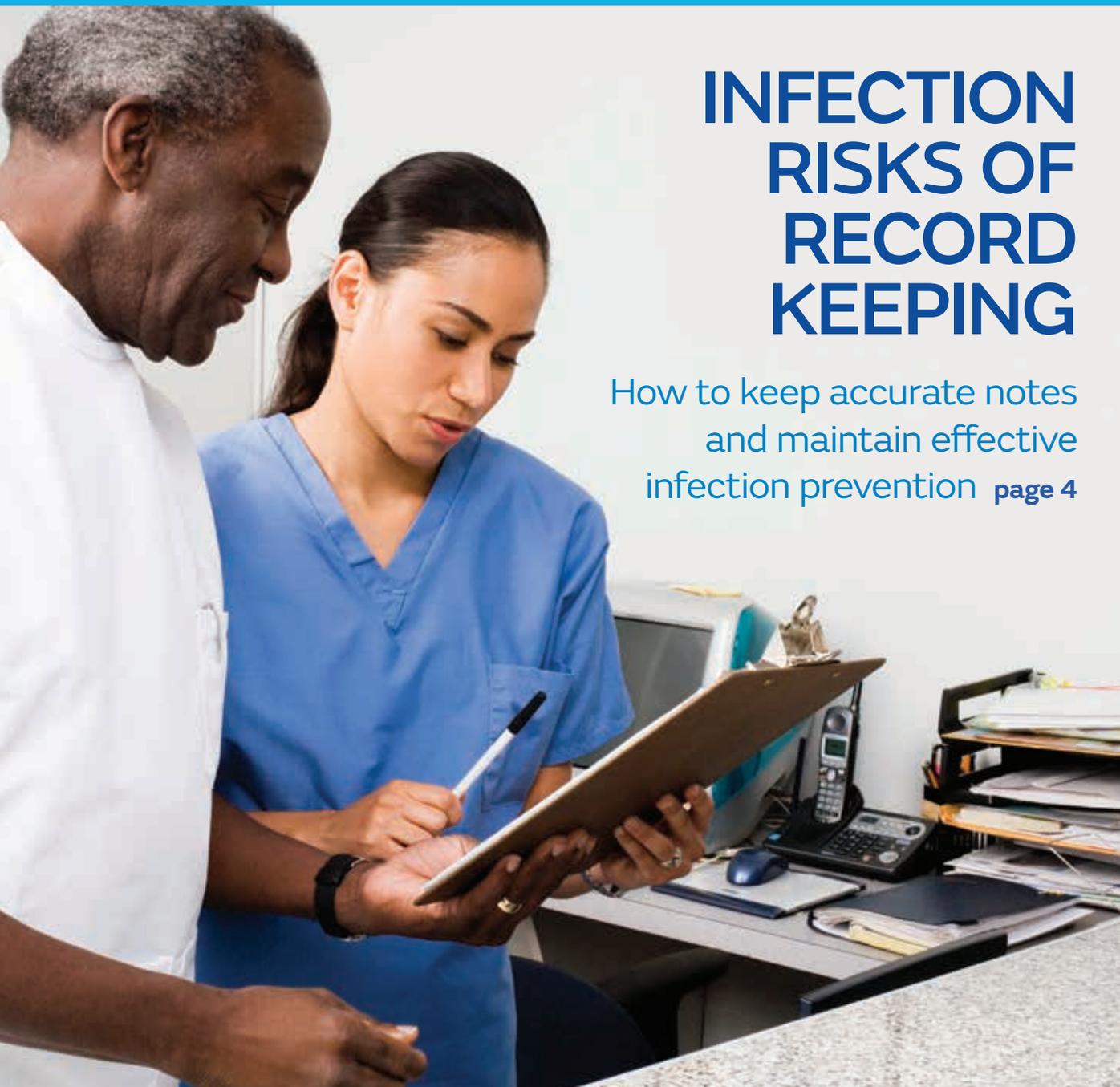




RISKWISE

ISSUE 26 | MAY 2018



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and maintain effective
infection prevention **page 4**

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DID THEY UNDERSTAND?

Has the patient understood everything you said?

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EDITORIAL



Alasdair McKelvie BDS, LLM
Head of Dental Services, South Africa

Hello and welcome to this edition of *Riskwise*. As Dental Protection's flagship publication, *Riskwise* offers the latest information on dentolegal topics and advice from our dentolegal advisers and professional experts.

IN THIS ISSUE

In this edition, Dr Len D'Cruz offers an introduction to minimalist intervention dentistry and explains what risks are associated with this approach. We also provide a comprehensive overview of how to maintain an effective standard of infection prevention and control in your approach to record keeping.

Meanwhile, on page 6, Dr Mark Dinwoodie explains the importance of checking that a patient has fully understood everything you have told them about their treatment. I'd also like to draw your attention to the article on page 10, which was written by Dental Protection's Dental Director Dr Raj Rattan. He has created a detailed and interesting feature on patient interaction and the management of patient expectations. Perhaps you are at the stage in your career where you are considering retirement? On page 12 you will find some tips to help you make preparations for this next stage.

CASE STUDIES

We're always looking for new ways to support members so, starting in this edition, *Riskwise* will now always feature a selection of case studies. These are practical examples of challenging situations and complaints that have been faced by members, and we offer learning points and guidance for you based on these situations. Not only can our members seek assistance for professional indemnity and world-class legal representation in times of trouble, but they can also access expert training and medicolegal or dentolegal advice to help them reduce the threat and impact of a complaint, claim or investigation.

WEBINARS AND ROADSHOWS 2018

This year, we have already delivered two webinars to members in South Africa looking at current best practice in record keeping and consent. The same themes will be discussed at our roadshow events this year:

9 May - Gauteng South / PPS Offices

10 May - Algoa Midlands / Radisson Blu Hotel

12 May - Western Cape / Ashanti

14 May - Limpopo / Pietersburg Club Polokwane

16 May - Pretoria / Pretoria Country Club

17 May - Free State / Cure Day Clinic Bloemfontein

More roadshow branch visits are planned for August. For more details of each roadshow and an event near you, please contact Marilize van der Linde on mvdlinde@sada.co.za or **022 715 1543**.

If you would like more information about any of the topics that have been discussed in this edition, or you have another query for which you are seeking advice, then please contact one of dentolegal advisers on **+44 207 399 1400** or enquiries@dentalprotection.org, or contact us via SADA on **+27 11 484 5288**.

I would also encourage you to access and use the education materials which are available on the website through Prism (dentalprotection.org/prism).

I hope you find this edition informative and useful. If there are other topics you'd like to see covered, then please get in touch and let us know. We're always happy to hear feedback.

Best wishes

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INFECTION RISKS OF RECORD KEEPING

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

READ THIS ARTICLE TO :

- ✓ Learn how to maintain an effective standard of infection control in your approach to record keeping
- ✓ Discover where major infection risks can occur in paper and computer records

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

MAINTAINING THE CHAIN OF STERILITY

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

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

PAPER RECORDS

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

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

SILVER PAPER

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

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

COMPUTER RECORDS

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

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

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

KEY PLAYERS

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

Therefore, computer equipment should be covered with a plastic barrier when contamination is likely. This would apply primarily to the mouse and keyboard.

Like any barrier used during patient care, it should be changed between patients. If a reusable form-fitted barrier is used, it should be cleaned and disinfected between patients. The use of disinfectant wipes has also been advocated, but the potential to damage the plastic keyboard needs to be considered. Infection control keyboards that are capable of being washed are also available.

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

SCREEN ATTRACTION

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

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

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

RESOURCES

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

MINIMALIST APPROACH

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



READ THIS ARTICLE TO :

- ✓ Understand what minimal intervention dentistry is
- ✓ Discover the risks associated with this approach



TOP TIPS

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

Whilst a minimally invasive (MI) approach to dentistry is not entirely new, its evidence base and popularity amongst forward-thinking practitioners is gaining momentum in a number of countries across the world, including South Africa.

WHAT IS MINIMAL INTERVENTION (MI) DENTISTRY?

Based on all the factors that affect the onset and progression of disease, minimal intervention dentistry integrates the concepts of prevention, control and treatment. The field of MI dentistry is wide, and includes the early detection of lesions, the identification of risk factors (risk assessment) and the implementation of preventive strategies and health education for the patient.

When the effects of disease are present, in the form of a carious lesion, other therapeutic strategies may be required, but MI dentistry looks to the least invasive solutions, for example remineralisation, therapeutic sealants and restorative care aimed at conserving the maximum amount of sound tissue.

STOP DESTROYING TISSUE

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

Why does this conservative way of thinking warrant an article in a risk management publication? The first and most obvious reason is that it is new. When something is new it has its innovators and early adopters, before the majority come on board sometime later. 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 clinical records indicate otherwise.



Figure 1 (radiographs © of Dr Louis Mackenzie)

If we look at the radiographs in Figure 1, it is clear there are lesions in several teeth. This is a young patient and the shared decision made with them was to adopt a non-interventive approach. The only evidence that this has worked will be based on a series of radiographs which will show no further progression of the caries. The radiolucent areas won’t miraculously disappear, so there is every danger another practitioner may intervene, either because they do not subscribe to the MI philosophy or they have not taken the opportunity of obtaining and reviewing the radiographs taken by the previous dentist.



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

CONSENT

Where the patient is young, such as in this case, it is important that the patient and their parents agree to the approach being taken based upon an understanding of the purpose, nature and likely effects and risks of the treatment, including the likelihood of its success, and also discuss any alternative to the MI approach.

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

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

There have also been a number of publications and conferences on this issue, such that it is becoming increasingly mainstream. The HPCSA would expect all dental healthcare professionals to provide good-quality care based on current evidence and authoritative guidance. It further advises that if you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

RECORDS

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

A minimally invasive approach helps to preserve pulpal health when there are deep cavities. By isolating a lesion and incarcerating the bacteria under a restoration, the clinician will be judged by some to have adopted an effective approach, but to the uninitiated, it may appear to resemble recurrent caries or a failure to remove all the caries.

When communicating this philosophy to the patient, 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. Legal and ethical standards for consent have made the communication of the risks to the specific patient in your chair very relevant.

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 careful and thoughtful communication with the patient will mean that these risks will be largely ameliorated.

RESOURCES

1. Everett Rogers, Diffusion of Innovations 2003
2. Pickard's Guide to Minimally invasive dentistry 10th Edition Banerjee A Watson

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, has not done what was advised because they had misunderstood what was intended. For example, they may have mistakenly

stopped their Warfarin before an extraction, against previous advice.

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

A 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



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

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. For example, 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



READ THIS ARTICLE TO :

- ✓ Understand the consequences of poor communication
- ✓ Learn how to eliminate patient misunderstanding
- ✓ Discover techniques to ensure patients understand what you say

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 Kemp⁵, 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,

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

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".

This process obviously takes time and it may not be possible or appropriate to check absolutely everything has been understood. Deciding in advance the most important things that you want the patient to

understand will focus your efforts on those things which you need to check.

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

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3. MacLeod C, Gopie N, Hourihan K, et al. The production effect: delineation of a phenomenon. *J Exp Psychol* 2010;36:671–85
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GREAT EXPECTATIONS

Dental Director Dr Raj Rattan discusses the need to manage patient expectations and interactions

READ THIS ARTICLE TO:

- ✓ [Learn how to manage patient expectations and interactions](#)
- ✓ [Discover what the “expectation disconfirmation” theory is](#)
- ✓ [Learn from a case study](#)

Our lives are enriched by our daily experiences. Our response to these experiences is largely determined by our expectations – a “surprise” is only a surprise because we have no expectation about the event or occurrence. Other responses, such as making a complaint, arise when expectations are not met. The “expectation disconfirmation” theory can help the dental team to understand patient satisfaction in relation to expectations and outcomes.

The concept is best illustrated by the following sequence:

1. When a patient visits a practice or a dentist, they do so with a pre-set level of expectation. In the case of existing patients, prior experience of the service will influence these expectations. In the case of new patients, the experience of friends and family (or whoever else has recommended the service) will play a part. For others, the expectations may be set by words and images that appear on websites and marketing literature.
2. These expectations are the standard against which the dental team and the practice will be judged.
3. When expectations are met, confirmation occurs.
4. Disconfirmation arises when there is a difference between expectation and outcome.

5. If the outcome is better than expected, there is positive disconfirmation and this leads to satisfaction. Negative disconfirmation arises when the outcome is below the pre-set level of expectation and may lead to a complaint. Simple disconfirmation is the term used to describe a situation where the expectation meets the outcome; it is neither better nor worse.
6. Complimenting and complaining behaviours are determined by this outcome. Clinical practice continues to advance and improvements in techniques and materials allow clinicians to raise the bar when it comes to setting standards. Where there is competition in the market amongst providers of services, advertising and marketing materials are one method of differentiation. It is all too easy to over-promote the benefits of care and influence expectation levels such that they cannot be met.

The adage that “first impressions count” is also relevant here. The practice environment itself contributes to expectation levels. It has been described as the “servicescape” of business. It also impacts on the perceptions of quality, expectations and performance. (Interestingly, cleanliness is cited as the area of the “servicescape” that received the most complaints in the wider business world.)

CASE STUDY

A patient attended for the removal of lower impacted third molars. After the removal of one tooth, his dentist called him in the evening to make sure he was comfortable and that there were no postoperative issues. The call was not expected and the patient expressed his gratitude for the care he was shown. Two weeks later, the same dentist removed a molar on the other side and, on this occasion, did not call the patient as a local postgraduate meeting had overrun and there was no opportunity to telephone. On his return to the practice some days later for a review appointment, the patient commented that he was surprised not to have received a call on the second occasion.

In a matter of two weeks, the patient's baseline expectations had changed and he had crossed from the positive to the negative side of the disconfirmation continuum. It is a reminder of the importance of setting realistic expectations that can be met consistently. At first glance, the mantra of under-promise and over-deliver offers a solution. But lowering expectations also potentially lowers the appeal of the service or product, especially in a competitive market. It is a matter of striking a balance.

Some leading researchers in the field suggest that there are three types of expectation.

1. The desired service – a level that the patient hopes to receive.
2. Adequate service – this is the minimum tolerable level, because patients will have recognised that the desired service is not always achievable.
3. Predicted service – the level of service a patient thinks they are likely to receive on the basis of probability.

The gap between one and two is the so-called “zone of tolerance” and the predicted service is likely to lie within that zone. It is a zone in which the dental team can perform in comfort. It is only when the experience falls outside the zone of comfort that a patient demonstrates complaint behaviours. The extent of the tolerance is contextual. It varies amongst patients and may vary at different times in the same patient, depending on what else is happening in their life.

THE POWER OF EXPECTATION

PATIENT SATISFACTION

Patient satisfaction is a mental state and is a multi-dimensional construct affected by many variables. It influences positive patient behaviours such as loyalty.

Dissatisfaction has the opposite effect. Many studies have shown that patient satisfaction is determined by subjective and objective experiences and their dentist's interpersonal and communication skills, and the “communication of care and attention” has been cited as the most influential in maintaining patient loyalty (Holt and McHugh).

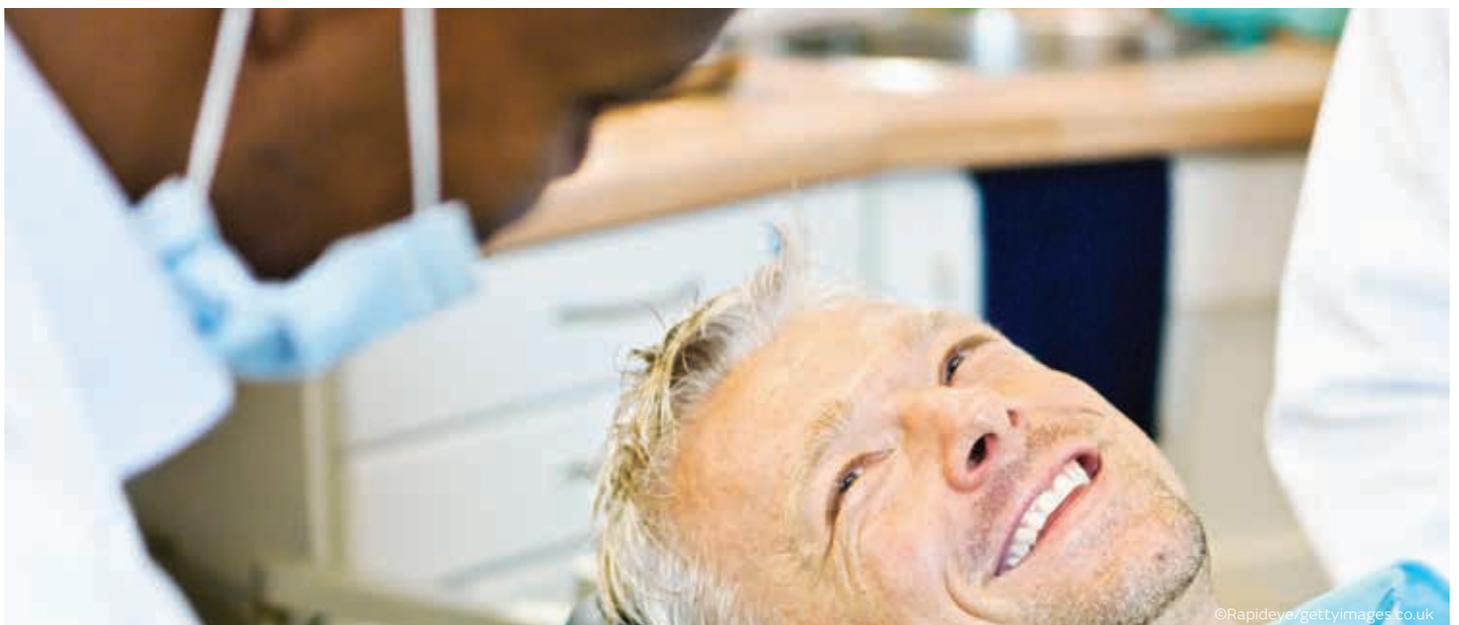
Dentists should focus on and develop effective communication skills before, during and after treatment sessions by involving patients in treatment decisions. For example, according to one study, patients who received more preparatory information and knowledge had superior postoperative pain control and satisfaction after undergoing third-molar extraction than patients who did not.

To avoid complaints, we must focus on the human and psychological aspects of the dentist/patient relationship, and adapt our communications to better manage patient expectations within the expectancy-

disconfirmation paradigm. It is also worth paying attention to the “servicescape”, as it is the antecedent to the experience itself and can mould patient perceptions.

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ARE YOU READY FOR RETIREMENT?

Dr David Croser offers help and guidance on planning for retirement

READ THIS ARTICLE TO :

- ✓ Understand the essential things to consider when thinking about retiring
- ✓ Discover tips to help you prepare for retirement

Retirement is a period of change that every professional has to face and prepare for as their career begins to wind down. No longer is there a rigid division between an active professional life and being pensioned off to inactivity. An increase in life span and the current performance of pension schemes have conspired to make retirement a transitional process. Before retirement begins, there needs to be an opportunity for the clinician to take stock and make changes that can often be for the better.

Retirement usually means that a new income stream will be called down from pensions that are either employer or self-funded. The financial changes that happen towards the end of a career allow the older dentist to review their pattern of working and lifestyle, before rearranging them to create a new way of living.

PLANNING

Some will want to continue as they did before. They have no inclination to slow down or move to other fields. Others will have had enough of their present situation, having sat in the same spot for long enough; they now have plans to develop other interests that had been dropped because of a lack of time.

The one thing a dentist does not want to do is stagnate in retirement. It is a stage of one's career that should be carefully considered and planned for – and the earlier the better! Take professional advice if necessary.

The financial aspects of retirement should be considered and planned for at the very outset of a dental career. It is sometimes a little difficult to think that far ahead having just started out on a professional career, but accountants and financial advisers are there to help you.

CONTINUITY

Nearer to the planned time of retirement, it is important to consider how the change in professional life will be made. Those in a salaried service will need to discuss with their management how the process can be facilitated with least patient disruption. Patient records should be carefully worded so that your successor will know what has been done, and what is intended or agreed with the patient for future treatment.

Many years in the same job may mean that you are using abbreviated notes. Whilst such notes may be perfectly understood by you and your dental assistant, they are likely to be meaningless to others. Similarly, any 'mental notes' about the patient's next appointment are best put into written form.

SELLING UP

Dentists in general practice will usually want to transfer the patient's goodwill to another colleague or sell the whole practice. To avoid any problems in handing over care, it is imperative that all the records are complete. It is not only the clinical records,



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however. Buyers of practices will usually want to see all relevant documentation. This might include financial records for previous years, relevant validation and service reports for equipment, autoclave logs, waste transfer forms, staff training logs, audit reports and pressure vessel tests. It is therefore important that these are available and in a form that can be easily analysed.

It is sensible to consider whether the practice can be run at full capacity until the time of the sale, as this will necessarily increase its value. The sale price of the practice may be a vital part of your financial plan for retirement. Practitioners are sometimes reluctant to invest in the practice in the years up to retirement. This is a mistake that occurs when you fail to think about the end of your career soon enough. Good planning can produce an investment plan that continues to run throughout the later years. This is important, since a practice that looks run down can be more difficult to sell.

EXCLUDING THE SELLER

When selling the practice, there will be a legal contract. It is usual for the contract to contain a clause to prevent the seller from working in the area after the sale. If you do intend to continue working as a dentist, then make sure that this clause allows you to do so. Some practitioners continue working in their own practices under the new ownership, as an associate or assistant. Ensure that the appropriate contracts for this are negotiated at the same time as the sale.

The new owner will be paying for the goodwill and will want to protect that purchase. If the former owner begins working nearby in new premises, it is certain to be noticed by your former patients and could possibly be a source of friction with the new owner. If you are not going to continue working as a dentist, then an exclusion clause is quite reasonable.

CAPITATION

With capitation schemes or third party benefit restrictions there has been a growing number of disputes involving accusations of supervised neglect. Patients are understandably upset if they receive an estimate for a large amount of treatment soon after you have left.

It is not that unusual then for prospective buyers to include in the contract of sale a sum of money to be retained as a withholding. This fund is ring fenced for situations where remedial or replacement

treatment that would ordinarily have been provided by you for no fee is now needed. If the fund is not used or partly used it can then be returned to the seller after a nominated period of time. There will always be differences of opinion between dentists on individual treatment plans, but these are less likely to result in problems if communication and record keeping is good and the new dentist is not left feeling disadvantaged by what they have inherited.

CLAIMS AFTER RETIREMENT

Whatever type of practice you have, there is always the possibility of a complaint or a claim for negligence arriving after the retirement date. They may result from a dispute with a new owner or when a problem arises after the treatment was provided. In these situations, clinicians who have had Dental Protection membership throughout their professional career can rest assured that they can still request access to indemnity, provided they were in benefit at the time of the alleged incident. It does not matter if the claim arrives many years later. Indeed, the majority of claims never surface in the same year of the incident. It is therefore important to keep in touch with Dental Protection after retirement and keep us informed of any changes of address.

THE RECORDS

To help you in retirement, it is imperative that if at all possible you should have access to past patient records. If you are simply closing down a practice, then find safe storage for your records and keep them as long as you did in practice (you are welcome to contact Dental Protection if you need more advice about that).

If you are selling the goodwill or the practice, it is advisable to build a clause into the contract that binds the new owner to look after and keep the records for a similar time, and also allows you reasonable access to any that you might need. The HPCSA guidelines for good practice suggest that all records should be retained for a minimum of six years after the last treatment was completed.

COMPUTERS

Computer records provide the opportunity to take a complete back-up away with you. If you do so you should be mindful of protection of personal information (POPI) requirements. Your financial records will also remain on the computer, unless you choose to save them elsewhere before you leave

STAFF

Existing staff can become unsettled in the period leading up to you finishing work. Although they may be aware that you are drawing near to retirement age, they may not know of your actual arrangements until the deal has been struck to sell the practice.

In most jurisdictions, the staff have continuing employment rights and may well be valued highly by the incoming owner. It is important to remember that however well you may have got on with them, their loyalty must switch over to the new owner who will become their employer. Dentists and other fee earners in the practice will also have to switch their loyalty and contracts when you leave.

With the increased length of active life expected today, retirement can be a period almost as long as your working life. Start planning for the financial consequences as early as possible, and think what you want to do in the next stage of your life as retirement approaches. Get involved, gain the knowledge, plan how to use the time to do what you want. Use the time to do what you want, and remember, Dental Protection can tailor its support to every stage of your career, including retirement.



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A DIFFICULT PATIENT INTERACTION

A young male patient attended a local dental practice with toothache. The dentist diagnosed the source of the pain as irreversible pulpitis from an extensively carious tooth, the upper right first molar (16), which had a large fractured amalgam restoration. The patient did not wish to have an extraction and, as there was sufficient tooth left to restore, the dentist carried out a root canal treatment and placed a gold shell crown.

All was well for many years, tooth 16 remained symptom and pathology free. The dentist subsequently sold the practice. The patient then returned after some years suffering from a periapical abscess on the same tooth and the new owner advised the patient to have a re-treatment of the root, which would cost more than the sum originally paid ten years earlier.

The first dentist received a letter of complaint, alleging negligent care and demanding full reimbursement for the subsequent treatment costs. The patient also alleged that he had been informed, at the time of the original treatment, that it would be 100% successful.

The dentist contacted Dental Protection, feeling aggrieved because the tooth he had treated had remained functional and

symptom free for more than ten years. The root treatment had been carried out using a standard technique, and the radiographs demonstrated a well obturated root canal filling with sound crown margins.

However, the clinical records made by the member only contained information about the actual treatment provided and had no documented record of the consent process to help him challenge the allegations made by the patient. On the other hand there was sufficient information and evidence to demonstrate that the actual treatment had been provided to an appropriate standard. It clearly helped that the tooth had been free of pathology and symptoms for over ten years.

With Dental Protection's help, the original dentist responded to the patient, explaining that no 'medical' intervention has a 100% guarantee and that the clinical care provided was in line with standard procedure and protocols.

This approach clearly contradicted the position taken by the patient around the guarantee. Had the patient also suggested that he should have been made aware of the consequences of failure from a financial perspective, and if so, would have taken a different treatment decision at the time by seeing an endodontist, then our approach

to the resolution of this matter might have involved a refund.

Fortunately the patient accepted an empathic response and took the matter no further. Had that not been the case, then our strategy would have turned on our member's recollections and his usual practice when providing information to patients about predicting success in endodontic procedures. Such an approach carries risk and without documented evidence of the consent process it is entirely possible for a Court or the HPCSA to prefer the patient's version of events. It makes sense then to manage expectations around treatment outcomes and record the salient points of those discussions. The unpredictable nature of healthcare interventions may be obvious to us as practitioners, but may not be to some patients.

LEARNING POINTS

- Be aware of the unrealistic expectations of some patients and their persistence in pursuing dentists many years after treatment. You can help protect yourself from this by carefully documenting all relevant discussions with the patient.
- Patients should be given advice regarding the long-term prognosis of proposed treatment, and this should be documented in the clinical records.
- Clinical records are vital in detailing discussions about consent.
- Even when the clinical care is satisfactory, if there is a flaw in the consent process dentists can be vulnerable.



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LONGSTANDING PERIODONTAL DISEASE



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A patient had attended the same general dental practitioner for more than 20 years, and had undergone regular treatment by a dental hygienist during that time.

The treating dentist retired and a new dentist purchased the practice. He examined the patient and advised her that she had periodontal disease. Full-mouth radiographs were taken, and the patient was given a vigorous course of oral hygiene instruction, scaling and root planing. The new practitioner handed the patient a report that included a charting of the teeth, the radiographs and notes about the bone loss around the roots of the teeth.

The new dentist also recommended a referral to a periodontal specialist because of the advanced state of her periodontal condition. The patient was horrified that this condition had not been discussed with her in the past, and was upset by the cost quoted by the periodontist for ongoing treatment to manage the situation.

A letter of complaint was received by the retired dentist, in which the patient asked about compensation and mentioned legal action. The retired dentist then contacted Dental Protection for assistance.

A dentolegal adviser reviewed a copy of the original treatment records, which simply recorded the dates of the patient's

examination appointment and occasionally noted when scaling and polishing had been performed. There were no radiographs or evidence of any periodontal screening, such as a periodontal pocket charting.

The situation was discussed with the retired dentist. Seemingly, he had regularly and persistently advised the patient about her periodontal condition, and sent her to the hygienist for oral hygiene instruction and scaling, but this treatment and the discussions supporting the diagnosis and treatment were not recorded in any detail. The dentist also mentioned that he had frequently spoken to the patient about her periodontal condition over the early years of her treatment. More recently he had not further discussed the matter because the patient seemed disinterested.

The lack of detail demonstrating how the disease had been identified and monitored left the original dentist in an uncomfortable position simply because he could not provide sufficient evidence to show that the patient had been correctly informed of her condition and had been made aware how the condition had been deteriorating over time. A quantitative analysis of attachment loss at each visit would have reduced the obvious discomfort the dentist was feeling upon receipt of the complaint and Dental Protection's considered views on how the matter could be concluded. Fortunately, the matter was settled by reimbursing

the fees paid to the new dentist and the periodontal specialist for the patient's recent periodontal treatment.

LEARNING POINTS

- Keep detailed records of all discussions with patients regarding advice and treatment.
- Ensure that patients clearly understand the significance of periodontal disease and the likely outcomes should treatment advice be ignored.
- Use every appointment as an opportunity to remind patients with periodontal disease of the need to maintain good oral hygiene.
- Keep adequate notes of home care advice given to patients and the importance of flossing, brushing and smoking cessation.
- Patients should be actively involved in their care, rather than just being a passive receiver of treatment.
- Ensure periodontal disease is identified, recorded and monitored appropriately in accordance with current guidelines.



ARE YOUR DENTURES FIT FOR PURPOSE?

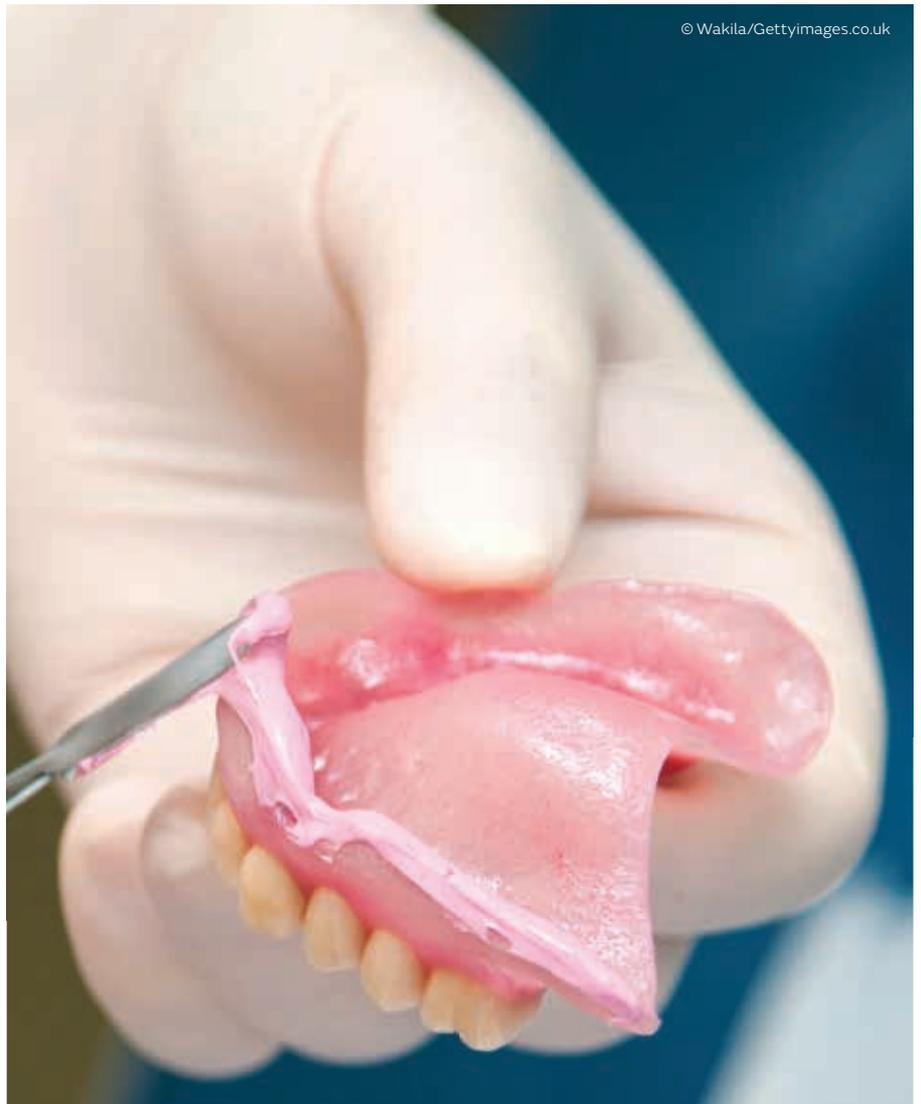
When supplying dentures for a patient, there is an expectation that they will be of “satisfactory quality” and be “fit for purpose”. These broad terms are captured within the verbal contract that exists between the clinician providing the treatment and the patient who will pay to receive this treatment. It is a contract that can be unwittingly breached.

A clinician made a patient three sets of dentures over a 12-month period. The patient just “couldn’t get on with any of them”. They were “too big”, “too small”, “too loose”, “too tight”, “too straight”, and then “too crooked”. Both the patient and the provider were exasperated.

The clinician felt he had made every effort to meet the patient’s high level of expectation. But the patient still requested a refund for the first set of dentures that had been supplied, the only set they had actually paid for. The clinician was reluctant to refund the fees; after all he had used up a lot of clinical time with the patient and also incurred additional laboratory costs. The risk of not doing so potentially left the patient with the option of seeking redress through consumer protection legislation or through the Small Claims Court for a breach of contract.

To succeed in such a claim, the patient would not need to show that there had been any negligence on the dentist’s part. In pursuing a claim, the Court would look to be sympathetic to a patient who cannot use the prescribed denture for the functions it was provided to restore. It is also difficult to obtain a fully supportive expert opinion in relation to dentures.

In view of the potential difficulty in defending a claim for breach of contract in respect of the dentures, the clinician was advised by Dental Protection to make a business decision to offer a refund to the patient as a gesture of goodwill. Ultimately the clinician was relieved that the patient was now free to approach another dentist.



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LEARNING POINTS

- It is important to gain insight into the expectations of the patient before embarking on treatment.
- If in doubt, speak to one of the dentolegal advisers at Dental Protection.



COMMUNICATION AND CHANGE OF DENTIST

A patient received a letter from his dental practice explaining that his care would need to be transferred to a new dentist. Later, the practice owner received a complaint from this patient. No concerns had been raised about the clinical care, so the letter came as something of a surprise. However, the letter did raise a concern about the lack of information provided to the patient over the changeover. He later said that he had felt pressured into choosing a new dentist at short notice and this had motivated the complaint.

In his letter the patient confirmed he had no previous knowledge that a change of dentist would be necessary and there was no mention of the name of the new treating practitioner. The letter was generic and had been sent to all the patients previously seen by the associate; however, it did not provide any details, other than a suggestion to call the practice to arrange an examination appointment.

The practice owner requested assistance from Dental Protection as to how he might manage the complaint and a way forward was suggested. Assistance was provided drafting a letter which was sent by the member to the patient apologising for his dissatisfaction, with an explanation that the practice felt it was in the best interest of the patient to discuss the change in staff when they attended for their routine check-up. It was explained that whilst most patients had been informed that their dentist was leaving, this was not known at the time of the last check-up with this particular patient.

The new dentist was introduced to the patient and was able to provide reassurance that his experience would complement the range of the other services available within the practice.

An apology was offered to the patient for the earlier poor communication. The practice advised that the concerns would

be discussed at a team meeting where ideas and opportunities would be identified to drive an improvement in the way the practice communicated with its' staff and patient base.

The patient accepted the letter of apology and subsequently booked an examination appointment with the practice principal.

LEARNING POINTS

- It is always useful to consider and identify beforehand where a generic message may be misunderstood and the impact of this on a small minority may be negative.
- Choice is as much part of dentistry as in any other retail/service industry and it is important to make this clear where choice exists.



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A PATIENT COMPLAINS AND LEAVES THE PRACTICE



A patient made a complaint regarding aspects of the treatment they had received at a practice. The complaint was resolved; however the patient advised the practice they would not be returning for any further treatment.

Some weeks later, the daughter of this former patient attended an appointment, accompanied by the parent who had made the complaint. Upon arrival, they were informed that this appointment had been cancelled and the dentist would be unable to see the daughter. The practice had assumed the whole family would not be returning to the practice and the child was declined a further appointment.

Clearly the assumption made by the practice was incorrect and as a result of the cancelled appointment, the mother made a further complaint.

LEARNING POINTS

- It would be difficult from a contractual and ethical perspective to justify withdrawing treatment of a child because of a breakdown in the professional relationship with one of their parents. Whilst it could leave everyone feeling a little more uncomfortable, it is important other family members should not be disadvantaged in their choice of clinician.
- In such circumstances, if there is any doubt as to whether the children will be returning to the practice, it seems reasonable to ask the parent if they would feel comfortable with their children attending for future appointments with the clinician who was the subject of the original complaint, and if not, it might be helpful to offer them the opportunity to see an alternative clinician.

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