Successful Practice – Stay out of Trouble


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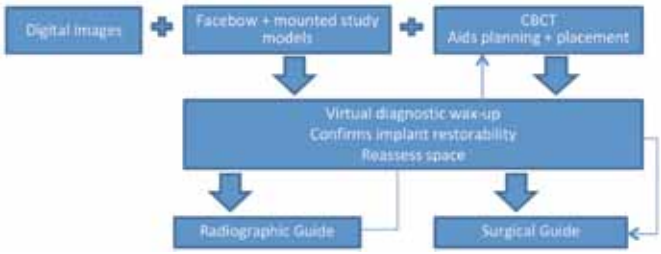
Successful clinical practice inherently requires the clinician to evaluate and treat patients comprehensively and, where possible, to best practice standards. A thorough knowledge of the current evidence for, and efficacy of, treatment interventions can promote clinical success (http://www.ada.org/en/science-research/evidence-based-dentistry).

To stay out of trouble, the modern day clinician needs to manage both the clinical delivery of patient care and the patient's behavioural and psychosocial needs to ensure expectations are met or (if possible) exceeded. A careful analysis of the patient's oral and systemic health and the residual supporting tissues must be considered. Various health history and examination forms are available: *www.dentistry.utotoronto.ca./dpes/diagnostic/patients/extraoral-and-intraoral-soft-tissue-examination-patient).* Underlying medical conditions will influence treatment plans. *(https://sydney.edu.au/dentistry/documents/give/dentistry-development-brochure.pdf).*

Visual inspection, occlusal assessment and periodontal assessment with full periodontal charting and vitality testing should be performed. The colour of the adjacent teeth and the condition of existing restorations should be noted. Clinical records should include all relevant radiographs (e.g. bitewings, periapicals, OPG), scans (CBCT), images, models, correspondence and documentation (De Kok, I.J., et al., 2014). Where anterior aesthetics are to be modified, a digital wax-up should be done to show the patient and assist in determining aesthetic considerations.

Planning the surgical and restorative stages for implants is summarised below.

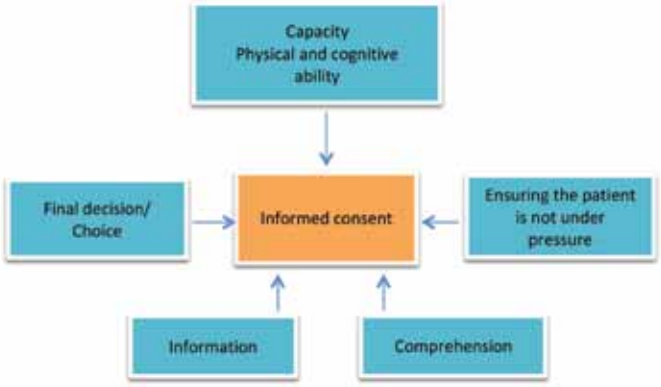


The identification of underlying conditions and caries risk factors in a patient can be achieved by CAMBRA (caries management by risk assessment). CAMBRA targets the aetiology of caries, periodontal disease and xerostomia to prevent tooth loss for the primary and secondary dentition (Yanase, R.T. and Le, H.H., 2014). Initial treatment should address control of active disease - exodontia for non-viable teeth, replacement of failed restorations, relevant interdisciplinary consultations and provisionalisation (if appropriate). Re-evaluation for comprehensive definitive treatment will require the integration of interdisciplinary and multidisciplinary consultation findings. Dental care must be directed through a system that identifies health and disease as well as the potential risks to a patient undergoing treatment or refusing it *(Chart 1).*

INFORMED CONSENT

Informed consent for any and all possible procedures should be obtained before any treatment starts. A proper consent process should occur between dentist and patient (Reid, K.I., 2017). The benefits of shared-decision making in the informed consent process should occur. Use written documentation for most informed consents (Curley, A.W., 2011). The goal is to ensure that patients fully understand all of the clinical treatments that will be performed, including the expected risks, benefits, costs and alternatives that are available to them. The patient should be able to ask questions, discuss their choices and have reflection time (http://osp.od.nih.gov/sites/default/files/resources/IC2013.pdf). Present options. "Treatment should always mitigate future risk and improve prognoses of the teeth and therefore decrease tooth mortality (Kois, D.E. and Kois, J.C., 2015)".

Informed consent should include 5 basic elements which are summarised below.

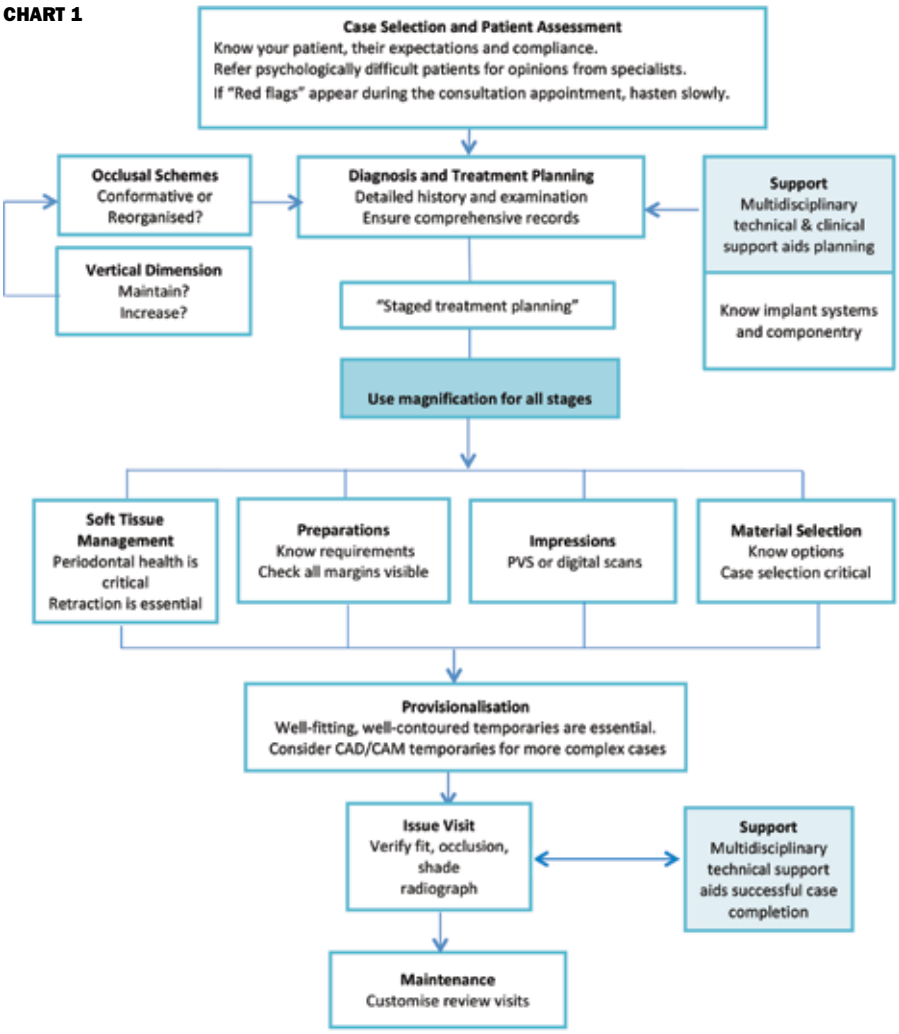


People have the right to self-determination through the informed consent process *(http://www.ada.org/~/media/ADA/About%20the%20ADA/Files/statements_ethics_patient_rights.pdf).* Educating patients is an essential part of the informed consent process. This initial investment of education time with the patient implies their value as an equal partner in the decision-making process (Fried, T.R., 2016). Clinicians should aim to include adjunct resources when sharing important treatment information with patients. Historically, the courts and higher courts considered the professional-patient relationship to be the core of informed consent (Mazur, D.J., 2009).

"A diagnosis and provisional treatment plan should be formulated and discussed with the patient. All treatment options should be explained and considered as part of the consent process and only then should treatment proceed (D'cruz, L., 2010)". It is wise to include a discussion of the risks and benefits of no treatment.

Treatment decisions can be taken by the dentist who may be under pressure from the patient's demands *(www.medicalprotection.org).* A dentist should not feel pressured to

CHART 1



provide treatment if it would be wiser to postpone treatment or to carry out only minimal 'first-aid' treatment initially, until further, information is obtained. A clinician is likely to stay out of trouble if patients are referred for another opinion or treatment postponed until a mutually agreed plan is reached.

With regard to implants, the patient should be informed very early in the consultation phase and prior to any commencement of treatment that despite favourable long-term outcomes achieved, biological and technical complications are frequent (Pjetursson, B.E., 2004). Embarking upon irreversible treatment too soon can be a recipe for premature failure of any restorative treatment (Maglad, A.S., et al., 2010).

Previous research results show that 40% to 80% of research participants who initially were judged to be capable of giving consent did not recall one or more required elements of the consent information (Wendler, D., 2004). Comprehensive literature reviews point to an overall unsatisfactory patient understanding and recollection (Sherlock, A. and Brownie, S., 2014) of information presented during informed-consent processes.

COMPLEX CASES

Patient motivation is often the key to the successful completion of complex and protracted treatment (Gurrea, J. and Bollain, I.G., 2016).

Prior to definitive treatment the dentist should ensure that patients should have an understanding of the following (www.dentalprotection.org):

- The number of appointments
- The likely period of temporisation
- The likely biological damage delivered to the prepared teeth and
- The probable survival time of the planned restorations

FAILED DENTISTRY AND RETREATMENT

All patients should accept and understand that the initial phase of dealing with failed restorations is an investigation of the supporting teeth, occlusion and surrounding structures. This will involve initial removal of the failed restoration(s), assessment of the quality and quantity of remaining tooth structure and implant integrity. Then an appropriate suggestion of long-term treatment options can be outlined.

At the time of failure, a patient should be aware of what they "bring-to-the table"in terms of the risk to future replacement restorations. If a dentist inherits a case, it is important to emphasise as part of the consent process that:

a. Issues of warranty etc. reside with the original treating dentist. The patient should take all reasonable steps to contact the dentist who provided the original treatment before treatment commences.
b. Any treatment to follow may involve undoing the failed treatment of the past before proceeding with the reparative treatment i.e. it may be more complex and more expensive than starting a case from the beginning and may take longer to fix.
c. There are compromises inherent to taking on other's treatment. This may mean not being able to guarantee a successful outcome in the first instance and mishaps may occur in the process of sorting it out.
d. A contingency plan must exist especially where complex treatment is required, as this can often be like opening a proverbial "can of worms."

Unexpected problems arise in dentistry particularly in previously restored cases. The plan should factor into account the required temporary situation for the patient.

Successfully staying out of trouble may also involve clarity in both the clinician's and patient's mind as to what constitutes clinical success. Reviews of trials and studies on the success of implant single crowns range from 57.5-100% (Papaspyridakos, P., et al., 2012). Is an implant successful in the patient's mind if it remains integrated despite some bone loss? What aesthetic expectations are also applicable to define if such a case is successful?

With root treated teeth, a similar issue may arise. Is the retention of a pain-free tooth without clinical swelling or other symptoms a successful outcome, irrespective of the full resolution of an apical radiolucency? The clinician has to evaluate carefully what constitutes a failing tooth. "The end-stage failing tooth is one that is in a pathological or structural deficient state that cannot be successfully repaired with reconstructive therapies, including root canal treatment and/or retreatment and continues to exhibit progressive pathologic changes and clinical dysfunction of the tooth"(Iqbal, M.K. and Kim, S., 2008). Retreatment

of root treated teeth has a success rate from 74-86% (Ng, Y.L., et al., 2011). It may at times be prudent to not proceed with retreatment of asymptomatic teeth with chronic periapical lesions until the clinician is confident that the aetiology of the lesion is understood and that there is a reasonable chance of clinical success. If not, referral to a specialist should be considered if the patient wishes to proceed with treatment.

Ultimately, the clinician will need to focus on working with a patient to achieve mutually agreed outcomes that meet clinically acceptable standards of care. Thorough treatment planning giving attention to underlying causes of presenting conditions, informed consent and competent treatment delivery can all assist in keeping a clinician medico-legally safer and also build rapport and patient loyalty. ◆

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