

Exercise in risk management

Patient information

In case after case, the question arises of what information a patient was given in advance of their treatment. Obviously, this is material to the quality of the consent obtained from the patient, and yet dentists, hygienists and therapists often find themselves unable to demonstrate with any certainty, exactly what the patient was told, when, and in what terms

Some of the ways in which we communicate this information become so routine to us that in many cases no one appreciates the need to confirm the detail of what is said or done. But it need not take much additional time and effort, especially if a dental nurse or receptionist is involved in this process - and the enhanced quality of the resulting records may spare you months or years of worry and inconvenience.

Verbal

Get into the habit of recording conversations with patients; what information/warnings/explanations did we give, when, and in what terms? What (if any) questions did the patient ask and what was our reply?

Visual aids

If you use models, photographs, diagrams/drawings, computer programmes or the patient's own mouth (with the help of an intra-oral camera or hand mirror), or any other commercial aid, make a note of this. Try to make the record in a way which leaves you in no doubt as to which model or other visual aid you used.

Information leaflets

If you give the patient an information leaflet to take away, to support and complement your discussions and explanations, make a note about this. Ideally, specify which leaflet(s) or information sheets and/or which version of them, you used. This has on many occasions proved to be critical in cases managed by Dental Protection, especially when the content of an information sheet changed at or around the time when a dentist treated a particular patient.

Computer programmes

There are some dental health education programmes of outstanding quality available commercially that can be used to provide patients with information about their oral health and proposed treatment. It is also true, however, that some of them - especially those created by the manufacturers or suppliers of particular products - can be somewhat one-sided in the way in which they present the information. In a legal or investigative process, it is quite possible that you will be required to supply a copy of the programme in question. You may choose to introduce this into the evidence yourself, in order to demonstrate what information was given to the patient during the communication process. It so, your records will need to be sufficient to demonstrate with reasonable confidence, what specific programme(s) the patient saw.

If, on the other hand, the patient is arguing that the programme was biased in some way, and this influenced them towards a particular decision, then it could be said that this amounted to a form of coercion or manipulation that was sufficient to invalidate any consent that the patient subsequently gave.

It is therefore important not only to record exactly what the patient saw and when, but also to satisfy yourself that any such visual aids or patient information material is fair and balanced in terms of the information it conveys. Risks and limitations must be given the same degree of emphasis as the advantages and benefits.

Correspondence

Some clinicians prefer to summarise the key points of a discussion in a letter to the patient and/or in information provided alongside such a letter. Wherever possible, letters such as this should:

- Summarise what has been discussed.
- Identify the fact that certain information has been provided to the patient.
- Detail any information sheets/leaflets that have been given to the patient, or that are being enclosed with the letter.
- Invite the patient to raise any further queries they have, after reading the letter and enclosures.

This would be an excellent approach and letters such as this become an integral part of the overall clinical records. Coupled with good records of the treatment provided during each visit, the clinician can provide a seamless summary of the information that has been given to the patient. The letters add value because they help to demonstrate the precise terms in which the information has been conveyed and the clinician's commitment to ensuring that the patient properly understood what was being proposed for them and why, before proceeding with the treatment.

Is the patient listening?

Although a visit to a lawyer's office when subsequently considering legal proceedings can often be sufficient to provoke an acute attack of selective amnesia as to the information and warnings that they were given in advance of treatment, we also have to accept the fact that many patients genuinely don't remember everything we tell them. This is particularly likely when a person is nervous or apprehensive, but it can also happen for a variety of other reasons.

It is worth checking a patient's understanding of important information that you have given them and an understanding of non-verbal communication (body language) can provide a clue as to whether a patient really is listening to, concentrating upon and understanding what you are saying. There is a particular need to keep meticulous records of the information you have provided if you have the slightest doubt as to any of the above.

Practical exercise and audit

- 1) Involve your dental nurse and reception staff in the process of recording in as much detail as possible, the information you have given to the patient.
- 2) Use the above headings as a checklist for the type(s) of information you may need to record, and work as a team to ensure that no important detail is left out.
- 3) If you regularly use certain visual aids, photographs, information sheets, computer programmes or other commercial aids, you may find it helpful to agree a consistent way of describing and recording them (eg. information sheet 3, demonstration model B, and/or the name of a computerised programme). It then becomes much easier to piece together exactly what was said, when and how rather than relying upon the somewhat less satisfactory (but all too familiar) 'I would normally have done xxx', or 'my nurse would usually have shown the patient yyy', or 'we have some leaflets in the waiting area and my receptionist would generally give one to patients who are contemplating this kind of treatment'.
- 4) Review a representative sample of clinical records of patients for whom you have provided information - especially in advance of complex treatment - and assess how much of the above information you have actually recorded. Repeat the exercise after implementing some of the above suggestions and measure any improvement that you have achieved.