



How to Limit Unintended Outcomes

Taking Action and Promoting Ethical Communication

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Dental practice professionalism is a matter of both competent practice and proper interactions with patients. Both aspects require the dentist to work hard to prevent unplanned and bad outcomes—both in the oral cavity and in patient relationships.

Every dentist knows that there is a difference between an unplanned outcome and poor clinical work. This is partly because every procedure comes with risk. Every piece of technology, every dental material, every medication, and every patient communication has a success rate short of 100 percent. Additionally, there are variations in patients' biochemistry, physiology, anatomy, and psychology that reveal themselves only when the treatment outcome falls short of expectations.

But another reason there is a difference between an unplanned outcome and bad work is that no general dentist, no matter how skilled, can reasonably expect to foresee every circumstance that might impact the outcome of a patient encounter.

But this does not mean there is nothing a dentist can do to limit unplanned and/or bad outcomes. The key, though, is not simply paying close attention to details and exercising great caution, as dentists already do. Instead, the key is in understanding that all dental care is provided by a team.

The proper question is not, "What can a dentist do to limit unplanned and/or bad outcomes?" It's, "What can a dental office—the dentist working

closely with his or her staff—do to limit unplanned and/or bad outcomes?" Let's look at some examples to show why the team-oriented question is so important.

Keeping an eye out

In our first example, your assistant has seated George McClutchen, a long-standing patient of record, in Operator No. 1. Scanning his record, you note his excellent oral hygiene, as well as a written reminder from your receptionist indicating that he is there for a regular cleaning and checkup. But, before you enter the operatory, the receptionist touches your arm, pulls you away from the door, and says quietly, "George does not look very good to me. He usually looks vigorous and energetic, but not today."

So when you begin talking to George, you ask him how he is feeling—not just orally, but overall. He says that, as a matter of fact, he is feeling some indigestion. "Anything else unusual?" you ask. He says that this morning he started feeling some pain in his left shoulder and arm, even though he has not been physically exerting himself lately.

A few more questions and answers, and you ask him to let you walk him across the street to the local hospital's outpatient clinic. "It will only take a few minutes to have someone check this out, George, and I think that it's more important right now than cleaning your teeth," you say.

When you check on George later in the day, a family member confirms that he was indeed having a heart attack and he is receiving care. When George contacts your office several weeks later to make a new appointment, he thanks you again. He has since received an angiogram and angioplasty and is doing quite well.

In our next example, you are preparing to meet with a patient when the dental assistant from Operator No. 1 leaves you a note saying "Ext. upper molar—Op. 1." As you enter Operator No. 1, you hurriedly glance at the chart and X-rays for your patient, Jane Jones, before greeting her.

"So, it looks like you're ready to remove that upper third molar that's been bothering you," you clarify, and Jane agrees. You get ready to anesthetize tooth No. 1 (upper right). However, your assistant says, "There's a watch on tooth No. 1, but Mrs. Jones just said it wasn't bothering her anymore and was only concerned about the pain on her upper left." You stop your attempt to provide a maxillary right block, thank your assistant, and say, "We still want to look at No. 1 to be sure it is OK. Let's do that, Mrs. Jones, before we anesthetize for the extraction."

You then re-examine your notes. Tooth No. 1 is indeed under a "watch," and tooth No. 16 on the upper left has the extensive internal decay that you had discussed with Jane a week before. In your haste not to delay her appointment even further, when you first saw No. 1 on the X-rays, you concluded it was the molar to be extracted. With that oversight corrected, the extraction of No. 16 goes smoothly, and everyone is happy.

In both of these stories, some significant bad or unplanned outcomes were avoided not only because the dentist performed a procedure correctly, but also because

the patients' overall care and the prevention of poor outcomes were treated as team responsibilities. There are three principal characteristics of dental offices where the prevention of bad outcomes is truly a team effort. All of these characteristics require staff—and dentist—training, as well as self-conscious practice and regular team self-assessment. The first of these characteristics is a particular shared attitude toward communication about the team's patient care. The second is the establishment of a concrete procedure for an explicit preventive or "premortem" discussion about each patient, in which the whole staff participates. The third is maintaining an attitude of shared responsibility and remaining united as a team even if bad and unplanned outcomes occur.

Fostering open communication

Neither of these two stories would have had a positive outcome if the staff had been afraid or hesitant about stopping the dentist to point out something important about the patient or the procedure. At a minimum, every staff member needs to know that the dentist wants to be stopped when there is potentially important information of which he or she may not be aware.

This will not happen, however, unless the dentist believes it is important and makes it clear that such open communication is the office's normal routine. The dentist also needs to affirm such communications whenever staff offers them. The dentist's expertise must not be taken, by either side, as a reason why staff should not communicate something about a patient or a procedure.

This will require a reinforcement of a mutual respect among all parties. It also will require everyone to become so enabled that every team member can freely offer valuable insights to anyone, at any time. In many office settings, this will take time and require self-conscious effort by all parties. In some offices, this will require a significant learning curve for both dentist and staff. However, it's important that this open communication becomes ingrained in the office's organizational culture to ensure that bad outcomes are minimized.

It is not enough that staff members learn to set aside fear, moods, and hesitation, and feel comfortable communicating with the dentist when they notice something. They need to become proactive, looking for ways that bad outcomes might arise. This means—particularly if the dentist and staff are just learning how to communicate in this open, trusting, and mutually respectful way—that everyone needs to be willing to speak, and hear, "too much" and "too often" until the habit of being on the lookout is well-established and natural.

Establishing a "premortem" procedure

Does this mean that, in order to limit poor outcomes, patient care must be interrupted constantly because something might be missed? No. It simply means there are a habitual procedure and a natural manner in place so the whole team can identify potential problems in advance. That is, once such a pattern of teamwork is established,

interruptions will become infrequent and, more importantly, every office team member will know what he or she needs to watch out for.

In order to achieve this, the whole office team needs to participate in a formal procedure that asks, in advance, "What might go wrong here—with relating in the best way possible with this patient, with properly diagnosing this patient, with providing the best treatment for this patient's needs, with the procedures likely to be used, with after-care and patient education?" and so forth. In the world of organizational quality improvement, this question is often given the name of the "premortem" question.

Whereas postmortem questions ask why and how something went wrong, premortem or preventive ethics questions, on the other hand, are asked ahead of time. The working team gathers before beginning a task and asks itself, "Suppose that, down the line, we found out that things went wrong with this? What are all of the possible ways in which things might go off track?"

Some dental office teams huddle and discuss these questions at the beginning of each day, before any patients have been seen. They review key aspects of their upcoming patient interactions for that day—not only those with appointments, but also those who will be contacted by phone and those who may show up with urgent needs.

And, for each scenario, the team should identify what ought to be done and by whom. For example, who will do what if: Patient A breaks down in tears in the chair or reception area, as she did on the phone with the receptionist when she was making the appointment two weeks ago; or when Patient B's child acts out in the chair; or when Patient C again asks you to "adjust" the diagnosis you report to his insurance company to save him some money? Consciously planning ahead for what might happen (even if it never does) is the best way to make sure that it will be noticed and dealt with based on an underlying system of careful planning rather than by ad hoc solutions that often don't lead to improved resolutions.

Before very long, these preventive conversations will take less time because patterns will emerge, and the team's shared experience will grow. Mental and perhaps even written checklists can be created to help handle circumstances that previously were addressed in an ad hoc manner.

According to a 2013 article from the *Journal of the Canadian Dental Association*, "Optimizing Patient Safety: Can We Learn From the Airline Industry?" aviation crews have been using this advance preparation technique for a number of years, and there is solid evidence that it has significantly reduced the number of bad outcomes. In the aviation industry, this procedure is called crew resource management (CRM).

CRM should have a place in the routine practice of every dental office that wants to reduce bad outcomes. It will not work, though, unless the attitude of mutual, respectful, and team-based communication described above is in place as the basis of the office's organizational culture.

Sharing responsibility on unplanned outcomes

As a subtle result of active team efforts to reduce bad outcomes, when something does, somehow, "slip through the cracks," finding someone to blame is not the correct thing to do. If this much team effort doesn't prevent something untoward from happening, the relevant question is: "How did it slip through so much effort on the part of all of us?"

In other words, the relevant question is a systems question: "What is it about our preventive thinking ahead of time, and our constant shared effort at being on the lookout, that let this circumstance slip through?" And, of course: "How can we fix the system so this kind of circumstance does not slip through again?"

In many other environments (e.g., auto insurance), "no fault" means something different from this notion of "no blame." No fault is a strategic system designed primarily for saving money and human resources by setting aside individual responsibility, thus reducing the legal costs of arguing out an acceptable answer. In such settings, individuals can either ignore or remain aware of their contributing faults, but in any case they are not discussed. And when a bad outcome does occur, the rest of those involved do not have a sense of shared responsibility for what happened.

But when a team accepts the reality that limiting bad outcomes in their work together is a shared responsibility, then bad outcomes are viewed as multifactorial in terms of both potential fault and blame. In this situation, the question should then be: "What can we do as a team to fix our system of preventive conversations ahead of time and our vigilance during the day so this does not happen again?"

However, most of us ask the "Who is at fault?" question so habitually that when bad things happen it takes a conscious effort on everyone's part to ask the systems question and set aside the "Who is at fault?" and the "Whom can we blame?" questions. In other words, a dental office that wants to limit bad outcomes needs to learn how to ask the systems question.

Given that health care liability insurance in the U.S. is built around "establishing fault," this will require extra professional commitment. While nurturing the no-blame approach within the office enhances care and patient interactions, it will not guarantee a reduction in the legal risks and consequences of the fault-based approach to liability in health care.

Being professional

And this takes us back to the theme of professionalism with which we began. Every profession takes pride—and justly so—in the mastery of its expertise and its service to the community. But no member of any profession has mastered all of its technical and relationship skills, much less invented them personally from whole cloth.

To be a professional is to be part of a group of people that has developed its expertise over time and now practices together as a team, no matter how physically separated its members are day in and day out. This is why,

in an important sense, when any dentist falls short of professionalism in practice, every dentist ought to ask, "Do we, the profession, share any responsibility here? What systems have failed here? Why didn't anyone see this as a possibility and intervene? Have we, the co-professionals of this person, not done our collective part to prevent this bad outcome?"

This means that the communication style and attitude of shared responsibility among the whole dental office team that has been described here should be embraced by the professionals themselves toward one another. Although this article is focused on a practical aspect of professionalism—limiting unexpected and bad outcomes—it also is a natural sequel to our previous articles on "Professionalism in the Dental Office" (*AGD Impact*, September 2012 and April 2013).

Paradoxically, a dental office that puts this article's suggestions in place almost certainly will discover at first that its daily work is leading to many more bad or unplanned outcomes than anyone on the team had realized. In any environment in which communication about bad outcomes involves a cost to the communicator (especially one in which blame is readily assigned to particular individuals), most bad/unplanned outcomes (especially bad relationship outcomes) will not get talked about, much less addressed. And in the case of matters that the observer considers serious, remaining unwillingly silent also may cause moral

distress ("Moral Distress," *AGD Impact*, August 2013).

A dental office that is proactive in limiting bad outcomes in the ways suggested here will reduce not only the bad outcomes of which a dentist is currently aware, but also many more that previously had not been brought to the dentist's attention. There are many good reasons, then, for changing the culture of communication and fault-finding in the dental office and establishing a preventive ethics or CMR procedure and a no-blame team culture like the practices described here. ♦

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