Aim for a ‘Blameless’ Environment

What I can do to help my DF trainee?

Oxfordshire and Thames Valley HEE - Joint DF Trainers / DF Trainees study day - 29th September 2015

Lake Vyrnwy Hotel and Spa

Education or Training a Dentist – which is best?

Aim for a ‘Blameless’ Environment
Current Clinical Concepts in Restorative Dentistry and Implications for DF Trainers

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Handout – hodsollhousedental.co.uk/education & training /course downloads
DF trainee – A Pain or a Joy?

Handout – hodsollhousedental.co.uk/education & training /course downloads
• Aim high – Deep-learning with high clinical aspiration
• Information-rich – Know & understand what we are all doing
• Appropriate technical execution – Repetitive Practice of skills on patients, practice on skills in simulation, human contact learning to aid clinical application
• Professionalism – Care for all people with Wisdom, Respect, Empathy together with a Human and develop a clinical conscience
• Awareness and reflection on own limitations – blame self before others for problems
• Compromise from a position of strength

Education or Training a Dentist
– which is best -?

Aim for a ‘Blameless’ Environment
You are a select group - you have put your hands up to a commitment to train the young dentists of tomorrow

- Why did I do it?
- What do I have to give?
- Am I doing it well?
- Am I giving DFs what they need for their future?
- Are they teaching me new things?
What is your training style?
I can think back to my ambitions – can you and have they changed?
The Learning Environment for DFs and DF trainers

• The average UK general dental practitioner is 3-3½ times more likely to be sued than the average UK general medical practitioner.

• Indeed, more than twice as often as the average dentist in the US, and 60% more often than dentists in California, Florida and New York State.
2015 Risk

• The likelihood of a UK dentist facing some kind of regulatory challenge is much greater than for:
  • Any other kind of registered healthcare professional in the UK
  • Any other dentists, anywhere else in the world
Where are the risks for trainers / trainees?

If we ask ourselves what kind of procedures leads to claims in the UK - the league table in 2015 looks something like this:
Let’s start with emergency pain control

1. Trusting the dentist 92%
2. Ensuring healthy teeth and gums 82%
3. General cleanliness and hygiene 80%
4. Treatments to solve dental problems 79%
5. Being seen quickly in an emergency 78%
6. Sterilisation and patient protection 74%
7. Special skills of dentist 71%
8. Screening for oral cancer 63%
High Risk - Acute Infection Management

What is your diagnosis and what should the patient trust to be done?

Never let the sun go down on pus – knowing what antibiotics will and will not do?
Systemically unwell? - need to find out with a thermometer
Inflammatory Endodontic Risk:
We need to teach DFs what antibiotics will and will not do and knowing how to use LA to get ‘hot’ pulps numb in the lower jaw – so that they can be extirpated

Only 50-60% of IDBs will fully work with hyperaemic mandibular molars – all will need top up
Inflammatory Endodontic Risk:
We need to teach DFs what antibiotics will and will not do and knowing how to use LA to get 'hot' pulps numb – so that they can be extirpated.
Two tools to help DFs more safety and effectively Rx dental emergency
Anatomical Knowledge – reducing Endodontic Risk

Our dental anatomy knowledge should be comparable to a surgeon’s
Our dental anatomy knowledge should be comparable to a surgeon’s – how can we help?
Where are the risks with C & B?

- Planning & Execution
- Abutment condition and prognosis
- Static Jaw Registration / Occlusion
- Impression quality & fit
- Posts / Cores – as abutments
- Aesthetics / shade / shape / margin etc
Early identification of Partial De-Cementation

Managing Failure of Conventional Bridges (Briggs et al 2013)
75% of dentists questioned used porcelain on the occlusal surfaces of premolars and molars most or all the time for their patients.

Christensen, G. J. J.

Honest thinking – on biological tariff
73% of the same dentists would use metal occlusal surfaces for their own teeth or those of their family – the friends or family test has been around for a long time!

Figure 4A. Preoperative view of the combined abrasive-erosive defects on the posterior teeth on the right side of the mandible. The vertical dimension of occlusion (VDO) was affected significantly by severe loss of enamel. B. After fabrication of an analytic wax-up and three months' successful therapy with a modified Michigan splint for reconstruction of the VDO, onlays with a minimum thickness of 1 millimeter were fabricated (IPS e.max Press HT, Ivoclar Vivadent, Amherst, N.Y, with the staining technique). C. Postoperative view of the final onlays after adhesive placement with a light-curing low-viscosity resin cement (Variolink II Base, transparent, Ivoclar Vivadent). The onlays exhibited an enamellike appearance and the color adapted well to the surrounding tissues owing to a high degree of translucency.

Honest thinking – use modern technology where better than old

My suggestion: mix and match – where is in the best interest of patient
Team Standards – Impression quality
The Use of Gingival Retraction Cord

Seems that we struggle
Storey and Coward (2013)
We must all know and be able to get a good impression 2015 – many C&B complaints relate to poor marginal fit – time = money so electro-surgery skills important for DFs to learn
The significant things to note about the UK picture compared to other countries at present are the prominence of:

- Allegations of a failure to diagnose and adequately treat periodontal disease
- Implant cases of all kinds
- Implant cases have larger quantum than the average dental case
- Luckily DFs will not be doing implants - but they will need to receive sensible advice from you on how they can best start to build OI training blocks
- They need to start to understand where implants sit against natural teeth – so in the future they have both games to offer
So if we put ourselves into the shoes of a DF - what does this all mean?

• How do I learn and make my mistakes in clinical practice in the UK without running into trouble?
• If I accept that I will have my share of cock ups then - how can I minimize the chance of my patients making a complaint against me?
• Is there any non-clinical things that I and my trainer can do to help?
As we all know, the UK population is living longer and retaining more of their teeth into later life. The ‘baby boomer’ generation is the ‘heavy metal’ generation – they will require most dentistry.

For patients under the age of 45 - I will need to develop biological / prevention skills (biological)

For older patients I need to learn and skill-up in the CRAFT (technical) dentistry and be able provide predictable quality – particularly for strategically important teeth.
So in an environment of risk is there any good news about how I can learn to do contemporary restorative dentistry and make my mistakes without trotting up and down Wimpole Street to the GDC FTP panels?

Yes
We must help DFs learn to live with RISK – It is always in the background
This happened to me on Friday!
• Professor John Adams of the Adam Smith Institute (in his 1999 book “Risky Business” - ISBN 1902737067, 9781902737065) suggests that we all have a “default” approach to risk
• The two groups on the left are essentially problem solvers and see no need to do anything until a problem arises.

Groups on right are basically cautious:
- Very organised
- Processed
- Default is against taking risks
- Look for the less risk option
- Can only make a decision after considering and re-considering their options and supporting information.

Fatalists / Individualists – Hierarchists / Egalitarians
Adventurous Souls on the left

Risk taker

Dangers:

• *May be a little overconfident on occasions*

• *Too dismissive of the risks – I can always re-do it*

• *The challenge - as always - is to find the right balance*

• *Achieve balance that serves the best interests of the individual practitioner as well as that of the patient*
Adventurous Souls – Risk taker
- What’s the problem I can always re-do it and sort out the problem -

Foundation (perio / endo), core design, preparation, impression, static jaw registration, temporisation, crown construction, try-in, cementation and polish
• So much so that they are so confident of their *problem solvers* skills they will give anything a go as they can mechanically repair any complication - *what will be will be!*

• The two groups on the right anticipate and plan to avoid risks and complications (*problem finders*).
What does this mean to DF trainers?

• Firstly you need to understand where you sit
• Then you need to observe & understand where your new DF sits
• Then you can work out how you can help them to develop skills to work across both sides (PDP)
What has this to do with risk and learning environment for DFs Peter?

Deviation / Perforation – 20% of posts deviate

Good or Bad?
Grieve & McAndrew (1993)

- Radiographic examination of 327 post-retained crowns
- 20% had deviated posts
- 10% had no root filling
- 50% inadequate RCT
- 47% had radiolucent areas
- 74% of posts tapered

Fatalists / Individualists – Hierarchists / Egalitarians
Drilling a post channel is a high risk procedure – particularly for a DF under your supervision.
Bunting and others, have found that most complaints are triggered not just by the actual event – **perforation of root** ("predisposing factors"). It will be triggered where the patient is tipped over the edge by a succession of "precipitating factors" – because other things had already happened to create doubts and concerns at the time of the **predisposing incident**
Predisposing factors included: poor communication, a perceived lack of interest, rushing and not listening, rudeness, financial or a lack of respect. You will note that these are “people” issues that have little or nothing to do with clinical dentistry.
Post-op pain

Predisposing factors included: poor communication, a perceived lack of interest, rushing and not listening, rudeness, financial or a lack of respect. You will note that these are “people” issues that have little or nothing to do with clinical dentistry.
Controlling Predisposing factors:  
Post treatment / instrumentation pain - how big is the problem? 

*A good subject for a tutorial I would suggest*


- The prevalence of post-obturation pain within 48 h after treatment was **40.2%**
- Less than **12% of patients experienced severe pain (VAS 4 or 5)** on either day 1 or day 2.
- **Gender, tooth type, size of periapical lesion, history of post-preparation pain or generalised swelling and number of treatment visits**
Controlling Predisposing factors

Evaluation of NSAIDs for treating post-endodontic pain
A systematic review
ANDREA HOLSTEIN, KENNETH M. HARGREAVES & RICHARD NIEDERMAN
Endodontic Topics 2002, 3, 3–13

• Ibuprofen 800mgs is the gold standard against which others should be tested

• NSAIDs are most effective for treating acute endodontic pain
DF STEP ONE: Develop and hone the skills on the right

• If only a precipitating factor is present (e.g. a perforated root) - with no major predisposing factors beforehand

• **Then only 2% of patients will make a complaint to the practice, NHS, GDC or litigate when you have made a significant clinical mistake (e.g. post perforation)**

Fatalists / Individualists – Hierarchists / Egalitarians
......on its own can this be managed?...
Then it is for the DF and trainer(s) to make sure that the mistake does not happen again (craft skills training)

Post / Crowns
Never use the post drill first – always start with ‘measured’ non-end cutting - Gates Glidden Burs

In a multi-rooted tooth use only one root canal

Parapost burs create significantly greater deviations from the centre of canals than Gates Glidden (Gegauff et al 1988) Therefore safest to use the GGs first to remove (mostly by heat) the GP and then prepare / cut a post channel within the root
Professionalism - predisposing factors

- Be careful calling people by their Christian name – it may not go down well with some
- Do not get too chummy with patients – they want you to be their dentist (professional) not a chummy friend
- Be careful how you look, dress and behave
- Remember the 90 year old war veteran test
DFs - what are their responsibilities?

• At start of career - STEP ONE - learn the communication skills and professional approaches of the people on the right so patients trust you and know that you have done your best & that you have been kind to them. Understand what patients expect of you as a medical professional

• Create few predisposing factors

• My trainer must observe and feedback to me my progress on right-sided skills

• Bear this in mind before telling me to speed up and speak less to patients

Fatalists / Individualists – Hierarchists / Egalitarians
As DFs what are their responsibilities?

• When I make a mistake – I must be able to look the patient, my trainer, my nurse, my mother & father in the eye and admit it, apologise and vow to learn from it

• Believe the patient - they are usually right

• Aesthetics – the patient has the last word – I will not argue with them – if they do not like it then it is not right for them

• Do not argue about money in the case of sub-optimal outcome work – it only makes things worse – you will need to help them with this
DF STEP TWO - Careful and Informed Decision-Making – followed by technical execution

(learned from repetitive skill experience)

Fatalists / Individualists – Hierarchists / Egalitarians
As trainers - we need to change

• The craft of dentistry is / has changed
• We need to reflect on this and not dismiss newer ideas

We need to get the palatal chamfer margin right and note how it slides round the outer aspect of the ‘wing’!
The most successful dentists treat people - not teeth! – and they realise that patient interests come before their own.
• If you remain only on the left without developing skills from the right – you are dangerous (you have no insight)
• If you remain only on the right you are a public dental health dentist
Many dentists believe that they are in the dentistry business, or the tooth business, the implant or the veneer business.

But they are not – we are all in the people business, and people buy people (i.e. you) - before they buy any implants, bridges or veneers.
MATTHEW SYED

• Syed believes that innate talent is not always necessary if you are prepared to put in the work and the hours

• This should be a very empowering prospect for anyone at the start of their dental career
Luckily, we need hard work and grunt not GGT
Developing competence

MATTHEW SYED

• Sign up to the mission and criticism
• Learn from mistakes (reflective learning)
• Learn from others better than you

[Diagram showing stages of competence development]

- Early UG years
- Late UG / DF / DCT years
- DCT 2/3 and early Practice years
- 5-10 years of experience and training
DAVID DUNNING and JUSTIN KRUGER

Their work published in 1999 demonstrated that less skilled and less competent people tend to overestimate their level of competence and expertise, while those who are truly expert sometimes underestimate their true level of expertise.
So your bar of competence will increase the better you get

- True experts (10,000 hours of training) soon learn not to ‘charge in’ – because they better understand what is in the best interest of their patient
- They will want to ‘buy time for the patient’ – using less aggressive and cheaper treatment plans – as they understand the implications of complications (as they are trained to deal with them)
• I am naturally scientific and cautious – I know what can go wrong – and realise the sense of buying time

• Something has to make overwhelming logical sense for me to do it

• I naturally occupy ground to the right but when I have made a decision can move with commitment to the left

• If things do not go as planned – I return to the right to think – Why?
Successful dentists will treat people - not teeth! – they firstly must learn the skills of the right – and then start to wok in the face of risk on the left.
I hope that this was helpful

The End

Thanks for your attention and I hope you all enjoy the rest of the conference