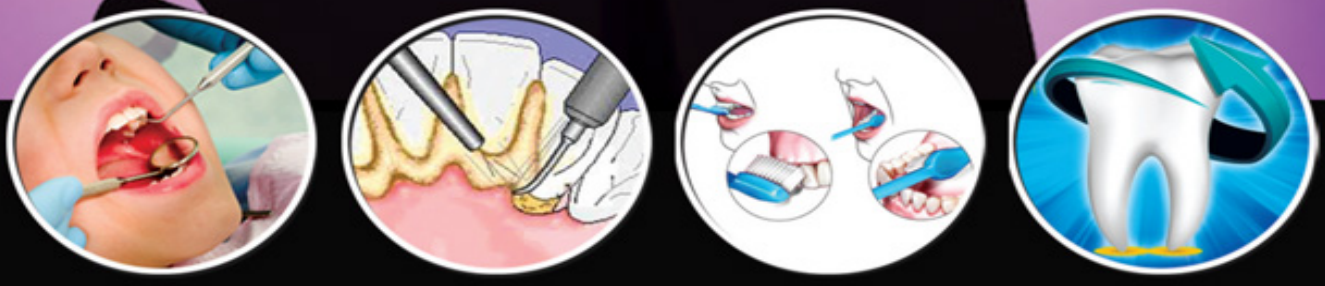
A PRACTICAL MANUAL OF PEDIATRIC DENTISTRY



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INTRODUCTION

The distinguished Canadian Physician Sir William Osler wrote, *"Never treat a stranger*." His words underscore the need for a thorough patient history; experienced Dentists learn everything they can bring about their patients before beginning treatment. Obtaining a complete and accurate patient history is part of the art of being a Doctor.

In the past, Dentistry was considered a division of the Department of Surgery and thus a department constituent rather than a discrete department. Because of this, Hospital Dentistry experienced limitations in exposure, staffing, privileges, care of patients, and care associated with the performance of routine and major extra oral Surgery. The overall effect was that it lacked the recognition that it rightfully deserved. Currently, this concept has been changed.

The Dental department is now organized as a separate and independent department as the Department of Surgery or the Department of Medicine. This gives the opportunity and responsibility to exercise judgment in staffing, generating protocols for operations, and establish training programs.

The organization of a Dental department requires the same approach and structure as those used for surgery or Medicine and other independent clinical departments in the hospital. This means that staff of the Dental Department has to comply with rules, regulations as that of all other clinical departments.

Possessing the same authority and responsibilities as members of other departments, staff members of the Dental Department are required to obtain Medical support for admission history, physical examination, and management of Medical problems during the hospital stay.

The availability of an experienced Oral and Maxillofacial Surgeon in the Dental department is mandatory in managing casualty and inpatients.

MAJOR SERVICE UNITS OF THE DENTAL DEPARTMENT

Within the departmental organization, there are four major service units:

a) Admitting service.
b) Outpatient service.
c) Casualty service (emergency service).
d) Consultation service.

a) Admitting Service

The admitting service allows the general Dentist or the specialist in the faculty to admit patients and care for them in the operating room of the Institution. Dentists who use the hospital for inpatient and ambulatory surgical care are usually general Dentists treating disabled or mentally challenged patients, Oral and Maxillofacial Surgeons who require Operating Theatre because of the nature of surgery; Periodontists and Pedodontists whose patient's age and disease require general Anesthesia in a hospital setting.

The admitting service is responsible for the care of the inpatients as well as their discharge and follow-up.

b) Outpatient Service

In most hospitals, the outpatient service performs the outpatient treatment, follow up of discharged patients. In smaller hospitals, this service performs the consultation also.

The team consists of general Dentists, Oral and Maxillofacial surgeons, Pedodontists, Orthodontist, Periodontist, Prosthodontist, an Endodontist, and Conservative Dentist. While the first three are essential as full-time faculty, the other specialists may be considered either for full time or part-time consultants depending on the nature of the work and needs of the community.

c) Casualty Service

This service, otherwise known as Emergency service is prepared to care for patients requiring immediate and emergency care. Patients seldom seek emergency care for routine Dental complaints such as Dental pain and

mild infections.

Those reporting to hospital casualty who needs Dental procedures require the services of an Oral and maxillofacial surgeon for the management of Faciomaxillary injuries or severe Dental infections.

Very often, the Oral and Maxillofacial surgeon is called for the emergency management of polytrauma cases along with other Medical specialists. These opportunities should be considered as one of the best opportunities to serve the community as well as to demonstrate the mettle of the Dental profession.

d) Consultation Service

The necessity for Dental consultation in hospitals was first accepted when it was noted that patients with major diseases also had Orofacial and intraoral complaints. Such diseases conditions often have the potential to influence the outcomes of required surgical and Medical therapy.

Bleeding gums, loose and carious teeth, unexplained facial pain, ulcerations of the oral cavity, and oral manifestations of systemic diseases intraoral infections limitation of mouth opening and oral metastatic disease contribute to the need for Dental consultation.

Currently, the Dental department responds to consultation requests from the following departments:

1. ***Cardiology:*** The Dental department provides service for patients undergoing major Cardiac surgery who require presurgical Dental extraction, Oral prophylaxis, and restorative and periodontal therapy. Patients with a history of Ischemic Heart Diseases, those with
   a pacemaker or valve replacements, after bypass surgery (CABG) and with Rheumatic heart disease or Congenital Heart Diseases are referred for the Dental department for treatment, which requires special attention.
2. ***Dermatology:*** Patients are often referred to the Dental department to rule out the oral focus of infection, an oral manifestation of Dermatological diseases, and for biopsy of oral lesions.
3. ***ENT:*** To rule out oral focus in the management of unexplained facial pain or in the management of sinusitis very often, Dental consultation is sought. Similarly, for the fabrication of surgical Obturators and final Obturators following Maxillectomy, the service of the Dental department is essential.
4. ***General Medicine:*** The Dental department helps to identify the focus of infection and the oral manifestation of systemic diseases.
5. ***Intensive care unit:*** Patients in an intensive care unit who require diagnosis and treatment of Orofacial and Dental diseases that are associated or exacerbate acute diseases conditions need Dental consultation.
6. ***Oncology department:*** Dental consultation and treatment therapy forms an integral part of the preparation of patients scheduled for chemotherapy and radiotherapy of patients. These patients require removal of focal infection, restoration of carious lesions, and maintenance before, during, and after therapy.
7. ***Plastic surgery:*** The Dental department helps care for patients requiring the construction of Obturators and similar maxillofacial prosthesis. They work closely with the plastic surgeons for the management and rehabilitation of cleft palate patients.
8. ***Sleep apnea syndrome laboratory:*** This service, which has gained wide acceptance in western countries, had not gained due recognition in India. The Dental department aids in the preparation and construction of anti-snoring devices and helps in the preparation
   of patients for surgical correction of skeletal deformities influencing the condition. Thus, by providing the necessary services to the above category of patients, the Dental department forms an integral member of the multidisciplinary health care team.

The staff of the Dental department should always be on the lookout for the opportunity to provide additional services to the patients by taking an active part in clinical discussions and case presentations.

Recent advances in Dentistry, which have implications in the Dental management of hospital patients, should be conveyed to the Medical staff whenever an opportunity arises.

Referrals from General Dental Practitioners a positive relationship between the Dental department and general Dental practitioners are vital to both areas of practice.

Very often, the general Dental practitioner hesitates to manage patients with moderate and severe systemic disease in Dental office because of the possibility of the development of emergency situations while treating

such patients.

Hospital Dentistry benefits those patients who need specialized Dental care.

ADMISSION AND MEDICAL RECORD

Each hospital will have its own procedures and protocols for admission, and it should be followed from admission until discharge. These are intended to arrive at a working diagnosis, order appropriate investigations, and record the progress of the patient in the hospital.

Admission Process

A patient may be admitted to the hospital in either of the following ways:

A. Elective admission.
B. Non-elective admission.

Elective Admission

These are instances where admission is made when the patient has been given an appointment for the surgical procedure or specialized investigations that must take place in the hospital.

By utilizing the facilities in the hospital, the patient can be closely monitored and the best possible treatment are given to the patient. Conditions that require hospital Dental care are:

1. Emotionally or mentally challenged patients or Pediatric cases incapable of tolerating Dental procedures in conventional settings.
2. Major maxillofacial surgical procedures which requires treatment under General Anesthesia.
3. Management of difficult impactions.
4. Other Medical conditions that may require transfusions or parenteral medications.
5. Patients with complex Medical problems that require Oral Surgical or Dental procedures. For example, patients who had undergone valve replacement and are on anticoagulant therapy requiring Dental extraction.
6. Procedures that may cause localized swelling and airway compromise.

Non-elective Admissions

Admissions from casualty constitute non-elective admissions which mainly include maxillofacial trauma cases and severe Odontogenic infections.

Patients with maxillofacial trauma who are unconscious or those who have sustained polytrauma are generally admitted in a trauma unit or under general surgery unit. These units then consult with the Dental service regarding the care of the patient.

A patient suffering from Odontogenic infection that severely has diabetes may be admitted under the Medical unit and then requests a Dental consultation.

If the patient has no other injuries and does not have serious systemic disease requiring immediate Medical management, the Dental service may admit the patient. Conditions requiring non-elective admission to the Dental unit are:

1. Conditions requiring administration of intravenous fluids or parenteral antibiotics.
2. Extensive soft tissue injuries that require wound care and observation.
3. Fractures of the facial bone requiring reduction and fixation in the Operation Theater.
4. Infection or injury those are likely to compromise the airway.
5. Rapidly spreading Odontogenic infections requiring incision and drainage.

The Medical Record

The Medical record is the document that charts the patient's stay in the hospital from admission until discharge. All members of the health care team involved in the management of patient participation in the writing of the

Medical record.

The purposes of the Medical record are:

1. A means of communication between the members of the health care team.
2. Abbreviations should be kept to the minimum possible.
3. All entries must be signed and show the date and time they were made.
4. Any corrections made should be signed.
5. The Medical record should be written legibly with utmost care avoiding errors and omissions. This is important not only for the proper management of the patient but also from the viewpoint of Medico-legal aspect.
6. To record all the relevant information regarding the patient.

The following are the seven major parts of the Medical record are:

1. Admission notes.
2. Progress notes and Doctor's orders.
3. Laboratory results.
4. Preoperative, operative and postoperative notes.
5. Consultations.
6. Nursing notes.
7. Discharge summary.

Admission Note

This explains in detail the reasons for the patient's admission to the hospital. This includes the following:

1. Chief complaint.
2. History of Illness.
3. Past history—Medical and Dental.
4. Personal history—Habits.
5. Family history.
6. Physical examination.
7. Tentative diagnosis.

While admitting patients who have drug allergy, uncontrolled systemic disease, bleeding diathesis, anticoagulant therapy, head injury, cervical spine injury, and Medico-legal cases (e.g., road traffic accidents and assault) it should be written boldly on the cover page of the Medical record to capture the attention of all members of the health care team.

Progress Notes and Doctors Orders

This detail the progress of the patient in the hospital preoperatively and postoperatively as well the drugs, intravenous fluids to be administered daily, and the nutritional management of the patient.

Any new laboratory tests to be performed or consultations to be done are to be listed here for quick reference. For example, a Diabetic patient on Insulin will require a periodic assessment of blood sugar, urine sugar, and Medical consultation as and when required for adjusting the dose of Insulin. All these should be included in the progress note for easy reference.

Laboratory Results

Results of the examination of blood, urine, sputum should be entered in the sheet provided. Whenever the same investigation is repeated and the result has entered the date and time also should be mentioned.

ECG (electrocardiogram) results and Blood group also should be included. Positive findings of radiographic examination,
Computerized Tomography scan (CT or CAT scan) or Magnetic Resonance Imaging scan (MRI scan), and biopsy report also should be entered and the full report attached to the case record.

Preoperative, Operative and Postoperative Notes

Preoperative Notes

Those patients who are being prepared to undergo surgery under general Anesthesia require Pre-anesthetic consultation
a day or two before surgery. Those who patients who have Cardiac diseases are mandatory to get a clearance of the Cardiologist before sending the patient for pre-anesthetic evaluation.

Similarly, approval of the Physician is advisable in case of patients with systemic disease.

Ensure that the following investigations are completed before sending the patient for pre-anesthetic evaluation.

Routine blood examination: TLC (Total Leucocye Count),DC (Blood Differential Count), Hb (Hemoglobin concentration), BT (Bleeding Time), CT (Clotting Time), Blood Sugar, Blood Urea (Liver function test, renal function test, and Serum electrolytes whenever it is required).

1. *Urine examination:* Albumin, Sugar, Deposits; and Acetone in Diabetic patients.
2. Blood grouping and cross-matching.
3. ECG: All leads.
4. X-ray chest: PA (Posteroanterior) view.
5. Any other relevant investigation results particular to the case.

While writing pre-anesthetic consultation, the following points should be included for the information of the Anesthesiologist:

1. Time and date of surgery.
2. Type of anesthesia required (GA/LA).
3. Diagnosis.
4. Type of surgery being performed.
5. Approximate duration.
6. Whether hypotensive anesthesia is required.
7. Whether severe bleeding is anticipated and the quantity of blood arranged.
8. Type of intubation required (Orotracheal/Oronasal).

The above information will be of invaluable help to the Anesthesiologist in the Pre-anesthetic evaluation of the patient and planning the anesthetic procedure.

Operative Notes

It summarizes all events that has occurred during and immediately after the surgery until the patient is transferred from the Operation Theatre to the recovery room.

It consists of Anesthesiologist's Notes and Surgeon's Notes. The former is written from the induction of anesthesia, continues during the procedure till the recovery of the patient from Anesthesia. Usually, the Anesthesiologist or the assistant does the writing.

The surgeon's note is written by the surgeon. It abridges all activities that have occurred during the surgery.

The following points should be included in the surgeon's note:

1. Date.
2. Name of the operation.
3. Name of surgeons and Anesthesiologists.
4. Type and duration of Anesthesia used.
5. Preoperative diagnosis.
6. Postoperative diagnosis.
7. Summary of the procedure: Incision, the operative procedure in brief, operative findings, discussion of any complications, type and location of drains, type of suture and suturing method, description of pathology specimen and whether it has been send for frozen section or routine Histopathological examination.

8. Amount and type of fluids including blood transfusion.
9. Patient's condition on leaving the OT (Operating Theater).

Consultations

In the management of a hospital patient, the knowledge and skill of other specialists are often needed. For this, the patient has to be evaluated by other specialists, and these are referred to as consultation.

The following information should be included in the request for consultation:

1. Date and time of the request.
2. Salutation (Sir/Madam/Name of the Physician).
3. A brief history of the patient.
4. Reason for request for consultation.
5. Anything particular expected from the consultation.
6. Name of requesting doctor or service.
7. Means of contact in case of emergency consultation.

The doctor, after examining the patient, should include the following information in the response:

1. The date and time of examination.
2. Acknowledging the request by thanking for the consultation.
3. Confirmation of the history of the patient.
4. Review of pertinent clinical findings.
5. Opinion regarding the present condition.
6. Suggestions/Advice regarding the management of the patient.
7. Name of the Doctor or service.
8. Means of contact in case of emergency.

Nursing Notes

Nursing notes also forms an integral part of the Medical record. They provide vital information regarding the patient's status, as seen from the viewpoint of the nurse's approach to
patient care.

Discharge criteria

a) Cardiovascular function and airway patency are satisfactory and stable.
b) Pre-sedation level of responsiveness achieved.
c) The patient can sit up unaided (if age appropriate).
d) The patient can talk (if age appropriate).
e) The patient is easily arousable.
f) The state of hydration is adequate.

Discharge Summary

It summarizes all the events that have occurred during the patient's stay in the hospital. It should be written at the time of discharge and a copy given to the patient for future reference.

It generally includes the following:

1. Name, age/date of birth, sex, and address.
2. Referring doctor's or hospital's name.
3. Date of admission and discharge.
4. Admitting diagnosis and discharge diagnosis.
5. Name of the attending surgeon and the unit.
6. Summary of pertinent findings from history, physical examination, and lab investigations.

7. Consultation by specialists.
8. Diagnostic and therapeutic procedures performed.
9. Surgery performed and the date of operation.
10. Postoperative period and progress.
11. Condition at the time of discharge (relieved/unchanged).
12. Discharge medications.
13. Discharge instructions, including follow-up date, diet instructions, and restriction of activity.

MAKING CORRECTIONS IN THE MEDICAL RECORD

This is an area Doctors should exercise restraint and extreme caution.

1. A Medical record that is unaltered is essential for medicolegal aspects and also for maintaining the trust of the patient. Any change in the Medical record is sure to be noted and highlighted if there is litigation.
2. Any corrections made while writing the record should be made by drawing a line through the incorrect entry and then initialing, dating and recording the time of correction and reason for change.
3. Make note that the original entry must never be covered or eliminated.
4. One of the strongest defenses in any Medical negligence litigation is a complete and accurate Medical record showing chronological entry and continuous care of the patient.
5. Incomplete, altered or destroyed Medical record can be catastrophic.

INFORMED CONSENT

Informed consent is a concept that is more than 300 years old. The Doctor must disclose in a reasonable manner all significant Medical information that he/she possesses that is pertinent to the intelligent decision by the patient.

It benefits the patient/guardian as well as the surgeon by the exchange of information and unanimous agreement on treatment. It empowers the patient to make the final decision regarding the treatment.

Informed consent is the legal embodiment of the concept that the right of a person over his own person is inviolable except under certain conditions.

Section 13 of Indian Contract Act defines consent as "the two or more persons are said to consent when they agree upon the same thing in the same sense".

The law protects the individual's right to give informed consent by requiring the disclosure of information by the party to whom consent is given.

In the case of Doctor-patient relationship the onus of disclosure of information lies with the doctor and the right to decide the manner in which his/her body will be treated lies with the patient. So, the Doctor is duty bound to disclose information as to the risks, which can arise from the treatment of the patient.

Risk may be defined as "exposure to a chance of an injury or loss."

Medical informed consent law requires the disclosure of risks of and alternatives to suggested Medical procedures to enable patients to make knowledgeable decisions about the course of their Medical case.

Consent is an act of reason accompanied with deliberations, the mind weighing as in a balance, the good and evil on each side. The consent that is given must be intelligent and informed and should be given after understanding what is given for and the risks involved. None is allowed to give consent to anything intended to cause his/her death.

Currently the courts nearly unanimously treat lack of informed consent as a matter of negligence of the Physician to disclose necessary information to patients. As in all other substantive areas of tort law, there must be a causal link between the defendant's failure to disclose the risk and the injury suffered by the plaintiff/patient.

A Doctor performing a Medical or surgical procedure must obtain the patient's written informed consent to the procedure. Simple sharing of information does not offer protection from lawsuits.

An oral consent (implied consent) is not a substitute for a written consent and the latter should be obtained whenever possible. This does not imply that written consent is an absolute defense in an "informed consent" case.

Even a standardized written consent form may be inadequate to prevent legal proceedings.

Hence, many authorities are against the use of standardized consent form and recommend tailoring the consent form to the particular procedure preferably written in patients own handwriting.

Depending on the situation, the consent form varies but must include the following elements:

1. Diagnosis and nature of patient's conditions.
2. Purpose of treatment and its benefits (including no treatment).
3. Options and alternatives.
4. Treatment procedure.
5. Risks involved.
6. Expectations.
7. Course of action if treatment is not accepted.

General Principle

There is more to consent than getting a patient's signature on a consent form. The principles forming the cornerstone of informed consent are enunciated by Lord Scarman in the case of Sidaway V Board of Governors of Bethlehem Royal Hospital.

a) Evaluates the patient's level of understanding and additional education needed if it is inadequate It is a basic concept that an individual of adult years and sound mind has a right to choose what shall happen to his/her body.
b) Helps to build a trusting relationship between the Doctor and the patient.
c) If the patient does not have the mental capacity to consent, the Doctor must document that and then a family member or a close friend may sign on patient's behalf.
d) If the patient is physically unable to sign the form, after full discussion with and consent by the patient, the Doctor may sign the form. It must then include a written note indicating the reason for the absence of patient's signature.
e) It is advisable to enjoin the close relative's if needed, and the consent has to be obtained from then also in such situations.
f) It will be advisable not to emotionally disturb or rather upset the patient by explaining all sorts of risks and complications involved.
g) Patient education regarding the nature and extent of the condition, proposed treatment, risks of the treatment, prognosis, alternatives to proposed treatment and no treatment.
h) Prepares the patient for negative outcomes.
i) The consent form should be signed by the patient or by the guardian in case of a minor.
j) The consent is the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant on each.
k) The Doctor must therefore disclose all material risks. What risks are materials is determined by the prudent patient test, which determines what a reasonable patient in the position of the patient would attach significance to in coming to a decision on the treatment advice given. There is a therapeutic privilege for the Doctor to withhold information, which is considered to be to the "Psychological detriment" of the patient.
l) There is no requirement in law that every possible complications and side effects should be informed to the patients. Recent court cases show a trend by the judges to require more detailed explanations to be given than earlier.

Standard of Disclosure of Information

There are two dominant approaches to defining the standard of disclosure of information by which the Physician's duty to their patient is measured.

1. A majority of courts require the Physician to disclose information that other Physician possessed of the same skills and practicing in the same or similar community would disclose in the same situations.
2. A large minority of courts apply the materiality of "prudent patient" approach allowing them to decide whether risk or other information would have been considered significant by the reasonable patient in making a decision.

When therapeutic privilege for the Doctor to withhold information, which is considered to be to the 'Psychological detriment' of the patient, is taken as a defense for not making the disclosure, it has to be supported by other Physicians possessed of the same skill and practicing in the same or similar community.

The duty of the Dental Surgeon is to warn the patient of the possible damage to the sensory nerve supply to soft tissues of lip, tongue and cheek due to difficult extraction of teeth. Omission to inform the patient of the accidental fracture of teeth, or jaw, or breaking of root during extraction of teeth is negligence on the part of the Dental surgeon.

It is obligatory on the part of the Dental Surgeon to remove the broken root of teeth if it is considered necessary, or to explain the patient about the risk of complications if the removal of broken root is considered to be of greater risk of damage to the patient.

Prior consultation with the patient about the matching of color and shape of the restored teeth is mandatory, where crowns, veneers, or bridges are to be constructed.

Failure to warn the patient of the stark reality that replacement by dentures of natural teeth can never recreate the chewing and masticating ability of the patient's natural teeth, may be considered negligence.

Omission to advise the patient adequately of the scope of treatment—the likely outcome and risks of failure may also amount to negligence.

Types of Consent

a) Implied Consent

It is a situation where a patient by virtue of his action gives consents. When a patient approaches a Dental Doctor for tooth extraction, it implies his willingness to get his tooth extracted by the Doctor. It is always safer to get a written consent showing the position of the tooth to be extracted.

b) Express Consent

Express consent is given when a patient states agreement in clear terms, orally, or in writing to a request. A perfectly valid consent may be given orally.

A written consent is preferable as it provides documentary evidence of the agreement. Legal action regarding consent may take place years after the consent was given, and it will be difficult to remember the terms of the consent. It is always better to get a written informed consent where any treatment or procedures carry some risk of injury.

It also would be advisable to seek written consent in the case of those whom the Physician regards as troublesome patient.

c) Blanket Consent

Some hospitals when admitting the patients obtain consents to the effect that they are willing to undergo any type of treatment including surgeries without mentioning any particular procedure. These are known as blanket consents. These consents have no legal validity as they do not mention any specific procedures or their complications.

d) Proxy Consent

It is a situation when some other person is responsible for giving consent for a patient who is unable to give the consent. This is so in the case of a legal guardian who is giving the consent on behalf a minor or a near relative of an unconscious patient.

Proxy consent is not legally valid if the patient is a major and of sound mind and is in a position to give the consent himself/herself.

e) Informed Consent

In Medical practice, anything beyond the routine would require this type of consent. Here the Doctor explains to the patient relevant details regarding the nature of his disease, the diagnostic procedures involved, the course and alternatives to the treatment proposed, risks involved, and the prognosis.

The relative chance of success or failure is explained so that the patient can take an intelligent decision after attaining a comprehensive view of the situation.

In practice things are not that simple. The patient maybe indirect need for treatment, but revealing the risks involved—the law of "full disclosure" may frighten him to a refusal. This situation calls for the common sense and discretion of the Doctor.

What should not be revealed may, at times, be a problem?

In such situation "Therapeutic privilege" is an exception to the rule of "full disclosure". The Doctor may in confidence, consult his colleagues to establish that the patient is emotionally disturbed. Apart from this, it is good for the Doctor to reveal all risks involved, in confidence to one of the close relatives and involve them in decision-making.

Informed consent has now become a must in all operation, anesthetic procedures, complicated therapeutic procedures and any procedures, which carry some risk.

f) Emergencies and Consent

A Doctor can lawfully operate or give other treatment to adult patients who are incapable of consent to his doing so, provided that the operation or treatment is in the best interest of such patients.

The operation or treatment will be in their best interest only if it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health.

It is clear that in cases of emergency or unconsciousness all considerations regarding consent will be set aside and doctor will do whatever is necessary to save the life of a patient, child or adult, to save him from permanent disability or from unnecessary pain and sufferings.

Consent and Treatment of Children Section 3 of Indian Majority Act 1875 speaks of attainment of majority on completion of the age of eighteen years. A person who has not completed the age of 18 years is a minor.

Any person of sound mind who has attained the age of 18 years may give a legally valid consent to surgical, Medical or Dental treatment or procedures.

Section 90 of the Indian Penal Code specifically excludes consent given by a child under 12 years of age as invalid. What has been less clear is the validity of consent given by patients who are above 12 years of age and under 18 years of age.

As a matter of law, the parental right to determine whether or not a patient of such an age will have Medical treatment, terminate if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.

A patient belonging to this age group of between 12 and 18 years and who is capable of appreciating the nature fully and consequences of a particular operation or treatment can give an effective a valid consent to that and in such cases the consent of the parent or guardian is not necessary. This capacity to understand is a question of fact to be determined by the court to based on evidence adduced during the trial.

Under the common law, the natural guardian has the power to do all acts, which are necessary or reasonable and also proper for the benefit of the minor.

In the absence of the natural guardian, the District Court is authorized to appoint the guardian for the welfare of the minor under with the law to which the minor is subject and such a guardian must look after the health of the minor.

The court under wardship jurisdiction can authorize to carry out the treatment by overriding the decision of the parents.

Obtaining Consent

Whichever consent is obtained, whether express or implied, oral or written, the paramount consideration is that care should be taken to explain the intention, nature, and purpose of what is proposed so that the party signing it truly comprehends what is involved when his/her agreement is sought.

It would not be realistic to insist upon a written request for all examination and procedures and common sense is required in deciding whether the consent should be evidenced in writing. It is prudent to seek written consent for procedures involving general anesthesia (GA) and surgeries and for more complex and hazardous

procedures and in any procedures, which carry some risk. It is advisable to make the person who is giving the consent to write in his handwriting so that the validity of the consent cannot be questioned later on.

In many cases, consent is too necessary a topic to be delegated to junior staffs or others since it often calls for careful clinical judgment and explanation. It is necessary to obtain appropriate consent. Where two or more procedures are planned it is necessary to have consent for each.

Sometimes when the procedures which was envisaged were amended, some hospital staff have the habit of crossing the original description and adding the amended procedure without getting it resigned by the person giving the consent. This consent has no validity. If a change is made to a planned procedure, it must be explained to the patient, and a new form should be completed, signed, and witnessed. Never get blanket consents from the patient.

The Validity of the Consent

The following situation will make the consent invalid:

1. Consent given by a minor who is not competent to give it.
2. A person of unsound mind gives consent.
3. Consent obtained when the patient was under sedation.
4. If it was obtained by fraud.
5. If it was obtained by misrepresentation as to the nature of the procedure.
6. If it was obtained by undue influence or threat of violence.
7. To be valid, the consent must be real.
8. When a different Physician than the one to whom consent was given, carries out the procedure.
9. When the Doctor performs a substantially different procedure than the one for which consent was given.
10. When the procedure performed exceeds the scope of consent.
11. When there is a failure in giving proper information and sufficient disclosure regarding the procedure.

Refusal of Treatment

The patient has a right to control his own body. The tort of battery protects the interests in bodily security from unwanted physical interferences. A competent adult is entitled to reject a specific treatment or all treatment or to select an alternative form of treatment even if the decision may entail risks as severe as even death.

The Doctor cannot disregard a patient's advance instructions, though in an emergency the doctrine of necessity may protect the Physician who acts without consent.

The interest of the state in protecting and preserving the lives and health of its citizen may override the individual's right to self-determination in order to eliminate a health threat to the community.

It does not prevent a competent adult from refusing life-preserving Medical treatment. So an adult of sound mind who went on hunger strike could refuse to receive nutrition and hydration whether by artificial means or otherwise as long as he retains the capacity to refuse the same and the Medical personals will have to abide by his decision.

Consent is implied in the case of a patient who submits to the Doctor, and the person who takes the defense that consent was not given must make out the absence of consent.

When a Surgeon or Medical man advances a plea that the patient did not give his consent of the treatment suggested by them, the burden is on them to prove that no administration of the treatment was on account of the refusal of the patient to give consent to it.

If the refusal involves the welfare of a minor or an unborn baby, the court can override the objection of parents. In situations where there is a refusal of treatment, the consequences should
be explained to the patients in the form of a witness, and it is better to get the refusal signed by them. The Doctor has also got the freedom to refer the patient elsewhere if he/she refuses treatment.

The Exception to the Requirement of Consent

The courts recognize certain situations where a Physician's non-disclosure will be excused:

1. If a patient is incompetent to make a reasoned decision, then disclosure to the patient may not be required.
2. Under the therapeutic privilege, the Physician may withhold information if disclosure would be upsetting or otherwise would interfere with treatment or adversely affect the condition or recovery of the patient.
3. The emergency exception applies in situations where attempting to secure consent could detrimentally delay proper treatment. Generally, Physicians need not disclose risks of which the patient is already aware of, risks that are commonly known.
4. Consents by minors, lunatic, intoxicated persons and persons in the coma are invalid. In such cases, the guardian's consent holds validity.
5. In cases of operations where the patient is not in apposition to give valid consent and delay can result in loss of life, a doctor may go ahead on his own.
6. Medical emergencies: In emergency cases involving
   a child, an accident victim, an insane person, or a person who is unconscious or delirious, consent is not necessary. The doctor should have no hesitation in proceeding to do what is necessary. The next of kin's consent is not legally necessary, nor will it justify a practitioner in treating an unconscious patient unless he is otherwise justified because it is a situation of urgent necessity. If no relative or responsible person is available, permission of the Superintendent of the hospital, police or judicial officer can be obtained. It is also advisable to get a written statement from a professional colleague that emergency surgery or procedure was indicated.

The situation where, Consent may not be obtained

a) Handlers of food and dairy milk.
b) Immigrants.
c) In case of a person where a court may order for a Psychiatric examination or treatment.
d) In the case of a person suffering from a modifiable disease.
e) Members of armed forces.
f) New admission to prisons.
g) Under S.53 (1) of the Craps, a person can be examined at the request of the police by the use of force. S53 (2) lies down that whenever a female is to be examined, it shall be made only by or under the supervision of a female doctor.

Legal Provision Regarding Informed Consent

The prototypical informed consent case can arise when a patient suffers an injurious no negligently caused the outcome of a diagnostic or therapeutic Medical procedure.

An outcome that is no negligently caused is one which arises in a certain percentage of cases regardless of the care of Physician due to Physiological differences from the norm or particular susceptibilities of a patient and where there is no fall in standard medical care.

The problem arises when Penal Provision Regarding Informed Consent, the Indian Penal Code, makes the offense punishable with a fine or imprisonment depending on the circumstances of the case.

WARD ROUNDS

Ward rounds are essential daily activities that provide a means of updating the status of the patients in the ward, and are particularly crucial for house officers and students as a teaching exercise in total patient care.

The following points should be observed while performing ward rounds:

1. Arrive early and make sure you are familiar with the case details for each of the patients on the ward, and take particular note of any new admissions over the preceding 24 hours.
2. Avoid raising contentious issues within earshot of the patient.
3. Before commencing the ward rounds, brief senior colleagues of any major, urgent or confidential problems before entering the wards.

4. Have all radiographs and updated results available for perusal by senior colleagues.
5. Inform the in-charge sister of the ward when the rounds will be commencing so that a representative of the nursing staff can be present to take notes on clinical decisions made during the rounds.
6. Keep an eye on the patient during the round in case comments have been misconstrued, and if so, return to the patient's bedside at the end of the ward round to clarify.
7. Keep notes during the rounds so that at the end you can record in the patient's notes what future management has been decided.
8. Lead the ward round to each patient's bedside and present a concise clinical summary with a brief mention of the important results of any procedures and relevant investigations.
9. Ward rounds should be conducted at least once a day, preferably first thing in the morning.

INTRODUCTION TO CASE HISTORY TAKING

It is better to know what kind of patient has the disease than what kind of disease the patient has.

—Sir William Osler

Diagnosis means 'through knowledge' and entails an acquisition of data about the patient and their complaint using the senses:

a) Observing.
b) Hearing.
c) Touching.
d) Sometimes smelling.

The purpose of making a diagnosis is to be able to offer the most:

a) Accurate prognostication.
b) Effective and safe treatment.

Diagnosis: dia = through; gnosis = knowledge

Components of a case record

Case history has 6 major components:

1. *Personal information-Interview*: taking and recording Case History (Health History).
2. *Examination of the patient*: Clinical examination/findings.
3. *Establishing a provisional diagnosis on the basis of history and examination*: Diagnostic sequence assessment & diagnostic impression.
4. *Conducting the necessary investigation*: Diagnostic test/diagnostic probing.
5. *Formulation of final diagnosis*: on the basis of the results of the investigations.
6. *Making a plan of the treatment and Medical risk assessment:* for Dental patients.
7. *Discharge summary, recommendations and Recall visit*.

Types of diagnosis

a) ***Clinical diagnosis:*** made from the history and examination.
b) ***Deductive diagnosis:*** made after due consideration of all facts from the history, examination, and investigations.
c) ***Diagnosis by exclusion:*** identification of disease by excluding all other possible causes.
d) ***Diagnosis ex-juvantibus:*** made on the results of response to treatment. For example, the pain of Trigeminal neuralgia may be atypical, and the diagnosis can sometimes be confirmed only by a positive response to the drug Carbamazepine.
e) ***Differential diagnosis:*** the process of making a diagnosis by considering the similarities and differences between similar conditions.

f) ***Direct diagnosis:*** made by observing pathognomonic features. This is occasionally possible, for example, in Dentinogenesis imperfecta where the abnormally translucent brownish teeth are characteristic.
g) ***Pathological diagnosis:*** provided from the pathology results.
h) ***Provisional (working) diagnosis:*** the more usually made diagnosis. This is an initial diagnosis from which further investigations can be planned.
i) ***Provocative diagnosis:*** the induction of a condition in order to establish a diagnosis. This is rarely needed, except in possible drug reactions or allergies, when the patient may need to be re-exposed to the potentially culpable substance, but this should always be carried out where appropriate Medical support and resuscitation are available.

Case history is defined as:

1. *The information gathered from the patient and or parent and or guardian to aid in the overall diagnosis of the case*.
2. *As planned professional conversation that enables a patient to communicate his/her feelings, fear and sequence of events leading to the problem for which the patient seeks professional assistance, to the clinician so that patients' real or suspected illness and mental attitude of the patient can be determined*.

The objective of Case history:

1. A case history can be considered to be a planned professional conversation that enables the patient to communicate his symptoms, feeling, and fears to the clinician.
2. Acts as evidence in legal matters.
3. Categorizing and labeling these grouped items according to a standardized system for the classification of disease.
4. Eliciting accurate, detailed, and unbiased information from a patient is a skilled task and not merely a matter of recording the patient's responses to a checklist of questions.
5. Evaluation of other possible undiagnosed problems.
6. For effective treatment planning.
7. Gives an insight into emotional and Psychological factors.
8. Grouping these items into primary versus secondary symptoms, acute versus chronic problems, and high versus low priority for treatment.
9. Listing those items that either indicates an abnormality or that suggests the possibility of a significant health problem requiring further evaluation.
10. Record maintenance for future reference and periodic follow-up.
11. Reviewing the patient's history and physical, radiographic, and laboratory examination data.
12. To provide information regarding etiology and establish diagnosis of oral conditions.
13. To reveal any Medical problem necessitating precautions, modifications during appointments to ensure that Dental procedures do not harm the patient and also to prevent emergencies situations.

GENERAL GUIDELINES FOR EXAMINING PATIENTS IN A DENTAL SETTING/COMMUNICATION SKILLS

Communication skills are notoriously hard to teach and describe. There are too many possible situations that one might encounter to be able to draw rules or guidelines. Besides, your actions will depend significantly on the personalities present, not least of all your own.

Patient-centre communication: In recent years, there has been a significant change in the way healthcare workers interact with patients. The biomedical model has fallen out of favor. Instead, there is an appreciation that the patient has a unique experience of the illness involving the social, psychological, and behavioral effects of the disease.

1. ***The Biomedical model:***
   a) Doctor is in charge of the consultation.

b) The focus is on disease management.

2. ***The patient-centered model:***
   a) Power and decision-making are shared.
   b) Address and treat the whole patient.
   c) Explore the disease and the patient's experience of it:
      - Understand the patient's ideas and feelings about the illness.
      - Appreciate the impact on the patient's quality of life and psychosocial well-being.
      - Understand the patient's expectations of the consultation.
   d) Understand the whole person.
      - Family.
      - Social environment.
      - Beliefs.
   e) Find common ground on management.
   f) Establish the doctor-patient relationship.
   g) Be realistic.
      - Priorities for treatment.
   h) Resources.

General Guidelines

1. Becoming an excellent communicator

a) Learning

As in all aspects of Medicine, learning is a lifelong process. One part of this, particularly relevant to communication skills and at the beginning of your career, is watching others.

The student should take every opportunity to observe Doctor–patient and other interactions. Look carefully at how patients are treated by a staff that you come across and consider every move that is made . . . is that something that you could try yourself? Would you like to be treated in that way?

You should ask to be present during difficult conversations.

Instead of glazing over during consultations in the clinic or on the ward round, you should watch the interaction and consider if the behaviors you see are worth emulating or avoiding. Consider how you might adjust your future behavior.

b) Spontaneity versus learned behaviors

If you watch an excellent communicator (in any field), you will see them making friendly conversation, spontaneous jokes, and using words and phrases that put people at ease. It seems natural, relaxed, and spontaneous.

Watching that same person interact with someone else can shatter the illusion as you see them using the very same 'spontaneous' jokes and other gambits from their repertoire.

This is one of the keys to good communication—an ability to judge the situation and pull the appropriate phrase, word, or action from your internal catalogue. If done well, it leads to
smooth interaction with no hesitations or misunderstandings.

The additional advantage is that your mental processes are free to consider the next move, mull over what has been said, or consider the findings, while externally you are partially on 'auto-pilot.'

During the physical examination, this is particularly relevant. You should be able to coax the necessary actions from the patient and put them at ease while considering the findings and your next step.

2. Essential considerations

a) Adjusting your manner

You would not talk to another Doctor as you would someone with no medical knowledge. This is a problematic area; you should try to adjust your manner and speech according to the patient's educational level. This can be

extremely difficult—you should not make assumptions on intellect or understanding based solely on educational history.

A safe approach is to start in a relatively neutral way and then adjust your manner and speech based on what you see and hear in the first minute or two of the interaction—but be alert to whether this is effective and make changes accordingly.

b) Attitudes

Patients are entrusting their health and personal information to you—they want someone confident, friendly, competent, and above all, is trustworthy.

Establishing rapport with the patient is an essential pre-requisite for obtaining an adequate history.

c) Avoid Medical Jargon

The problem is that medics are so immersed in Jargon that it becomes part of their daily speech. The patient may not understand the words or may have a different idea as to the meaning.

Technical words such as 'myocardial infarction' are in obvious need of avoidance or explanation. Consider terms such as 'exacerbate,' 'chronic,' 'numb,' and 'sputum'—these may seem obvious in meaning to you but not to the patient.

Be very careful to tease out the exact meaning of any pseudo-Medical terms that the patient uses.

You may also think that some terms such as 'Angina' and 'Migraine' are well known—but these are very often misinterpreted.

d) Cross-cultural communication

Cultural background and tradition may have a significant influence on disease management. Beliefs about the origin of disease and prejudices or stigma surrounding the diagnosis can make dealing with the problem challenging.

Be aware of all possible implications of a person's cultural background, both in their understanding of disease, expectations of healthcare, and in other practices that may affect their health. Above all, be aware of prejudice—yours and theirs.

e) Define your role

Along with the standard introductions, you should always make it clear who you are and what your role is. You might also wish to say who your seniors are, if appropriate. Be sure that anyone else in the room has also been introduced by name.

f) Demeanour

Give the patient your full attention. Appear encouraging in
a warm, friendly manner. Use appropriate facial expressions—don't look bored!

g) Difficult questions

Apologize for potentially offensive, embarrassing, or upsetting questions ('I'm sorry to have you ask you this, but . . .').

h) Fear-words

There are certain words which immediately generate fear, such as 'Cancer' and 'Leukemia'. You should only use these if you are sure that the patient wants to know the full story.

Beware, of avoiding these words and causing confusion by not giving the whole story.

You should also be aware of certain words that people will instinctively assume mean something more serious.

i) Greeting

Beware of 'good afternoon' and 'good morning'. These can be inappropriate if you are about to break some bad news or if there is another reason for distress. Consider instead a simple 'hello'.

Greet the patient and always check if you have the case sheet of the right patient, this can be ensured by cross-checking the name of the patient and his/her age and address.

j) Interruptions

Apologize to the patient if you are interrupted.

k) Introductions

This is a potential minefield! You may wish to alter your greeting depending on circumstances—choose terms that suit you.

Title—them

Older patients may prefer to be called Mr. or Mrs; younger patients would find it odd. A difficulty arises with females when you do not know their marital status. Some younger or married patients may find the term 'Ms' offensive.

Using the patient's first name may be considered too informal by some—while a change to using the family name mid-way through the encounter will seem very abrasive and unfriendly. There are no rules here and common sense is required to judge the situation at the time. When unsure, the best option is always to ask.

Title—you

The title 'Doctor' has always been a status symbol and a badge of authority—within the healthcare professions, at least. Young doctors may be reluctant to part with the title so soon after acquiring it but, in these days when consultations are becoming two-way conversations between equals, should you really introduce yourself as 'Dr'?

Many patients will simply call you 'doctor' and the matter doesn't arise.

Introducing yourself by the first name only seems too informal for most Medical situations. Some young-looking students and Doctors, however, may feel the need to introduce themselves using their title to avoid any misunderstanding of their role—particularly since the demise of the white coat. Perhaps worth considering is a more extended introduction using both your names and an explanation along the lines of 'Hello, my name is Jane Smith; I am one of the Doctors.'

l) Personal appearance

First impressions count—and studies have consistently shown that your appearance (clothes, hair, and make-up) has a great impact on the patients' opinion of you and their willingness to interact with you. Part of that intangible 'professionalism' comes from your image.

The white coat is no longer part of the Medical culture in the UK. National guidance has widely been interpreted as 'bare below the elbow' with no long sleeves or jewelry. This does not mean that you should look scruffy.

Many hospitals are now adopting uniforms for all their staff, which helps solve some potential appearance issues. Fashions in clothing change rapidly, but some basic rules still apply:

1. Clean surgical scrubs may be worn if appropriate.
2. Ensure you have a good standard of personal hygiene.
    a) Any perfume or deodorant should not be overpowering.
    b) Many people believe men should be clean-shaven. This is impossible for some religious groups.
    c) Facial hair should, however, be clean and tidy.
    d) Hair should be relatively conservatively styled, and no hair should be over the face. It is advised to wear long hair tied up.
3. Follow universal precautions of care: use gloves and mouth masks. Always use clean, sterile instruments.
4. Men should usually wear a shirt. If a tie is worn, it should be tucked into the shirt when examining patients.
5. *Name badge:*
    a) The name badge should be visible.

b) Name badge worn at the belt or on a lanyard around the neck is acceptable depending on hospital policy.
c) Wearing a name badge at the belt means people have to look at your crotch—not necessarily ideal.
d) Lanyards should have a safety mechanism that will allow them to break open if pulled hard. Most hospitals supply these—are cautious about using your lanyard from a shop or conference.

6. Neutralize any extreme tastes in a fashion that you may have.
7. Shoes should be polished and clean.
8. Stethoscopes are best carried—worn at the neck is acceptable but a little pretentious, according to some views.
9. The belly should be covered—even during the summer.
10. The shoulders, likewise, should usually be covered.
11. Try not to tuck items in your belt—use pockets or belt-holder's formable phones, keys, and wallets.
12. Women may wear skirts or trousers, but the length of the skirts should not raise any eyebrows.

Psychiatry, Pediatrics, and a handful of other specialties require different dress code as they deal with patients requiring differing techniques to bond.

m) Reflective comments

Use reflective comments to encourage the patient to go on and reassure them that you are following the story.

n) Remember the name

Forgetting someone's name is what we all fear but it is easy to disguise by simple avoidance.

The use of a name will make you seem to be taking a greater interest. It is particularly important that you remember the patient's name when talking to family. Getting the name wrong is embarrassing and seriously undermines their confidence in you.

Aside from actually remembering the name, it is a good idea to have it written down and within sight—either on a piece of paper in your hand or on the desk, or at the head of the patient's bed. To be seen visibly glancing at the name is forgivable.

o) Setting

Students, Doctors, and others tend to see patients on busy wards which provide distractions that can break the interaction. Often this is necessary during a busy day.

If you are intending to discuss a matter of delicacy requiring concentration on both your parts, consider the following conditions:

- Arrange the seats close to yours with no intervening tables, or other furniture.
- Chairs should be comfortable enough for an extended conversation.
- The room should be quiet, private, and free from disturbances.
- There should be enough seating for everyone.

p) Standing

Although this might be considered old-fashioned by some younger people, standing is a universal mark of respect.

You should always stand when a patient enters a room and take your seat at the same time as them.

You should also stand as they leave but, if you have established a good rapport during the consultation, this isn't necessary.

q) Staying on topic

You should be forceful but friendly when keeping the patient on the topic, you want or moving the patient on to a new topic. Do not be afraid to interrupt them—some patients will talk for hours if you let them!

r) Style of questioning

The Dentist can ask two general types of questions when interviewing: Open and closed.

Initial interview should be conducted free of any protective eyewear/mask, otherwise, facial expressions are concealed and speech is muffled.

s) The importance of silence

In conversations that you may have with friends or colleagues, your aim is to avoid silence using filler noises such as 'um' and 'ah' while pausing.

In Medical situations, silences should be embraced and used to extract more information from the patient. Use silence to listen.

The practice is needed as the inexperienced may find this uncomfortable. It is often useful, to remain silent once the patient has answered your question. You will usually find that they start speaking again—and often impart useful and enlightening facts.

t) Timing

If in a hospital setting, make sure that your discussion is not during an allocated quiet time—or immediately before one is to start! You should also avoid meal times or when the patient's long-lost relative has just come to visit.

If taking the patient from the bedside, ask the supervising Doctor (if not you) and the nursing staff—and let all concerned know where you have gone in case the patient is needed.

3. Body language

Body language is rarely given the place it deserves in the teaching of communication skills. There are over 600 muscles in the human body; 90 in the face of which 30 act purely to express emotion. Changes in your position or expression—some obvious, others subtle—can heavily influence the message that you are communicating.

We have all met someone and thought 'I did not like him' or 'she seemed trustworthy'. Often these impressions of people are not built on what is said but how people handle themselves. You subconsciously pick up cues from the other person's body.

Being good at using body language means having awareness of how the other person may be viewing you and getting your subconscious actions and expressions under conscious control. If done well, you can influence the other person's opinion of you, make them more receptive to your message, or add particular emphasis on certain words and phrases.

a) Touching

Touching is one of the most powerful forms of non-verbal communication and needs to be managed with care.

i. *Dominance:* touch is a potent display of dominance. Touching someone on the back or shoulder demonstrates that you are in charge—this can be countered by mirroring the action back. Avoid resting arms or hands over the patient's shoulder; always maintain a comfortable distance from the patient.

ii. *Greetings:* touch is part of greeting rituals in most cultures. It demonstrates that you are not holding a weapon and establish intimacy.

iii. *Shaking hands:* A problematic issue which, again, needs to be judged at the time. Physical contact always seems friendly and warms a person to you—but a hand-shake maybe seen as overly formal by some.

It may be inappropriate if the patient is unable to reciprocate through paralysis or pain. Perhaps consider using some other form of touch—such as a slight guiding hand on their arm as they enter the room or a brief touch to the forearm.

Remember also that members of some religious groups may be forbidden from touching a member of the opposite sex. Maintain a warm and dignified atmosphere.

iv. *Sympathy:* the lightest of touches can be very comforting and is appropriate in the medical situation where another touch may be misread as dominance or intimacy (you should not hug a patient that you have only just met!). Display sympathy by a brief touch to the arm or hand.

b) Open body language

This refers to a cluster of movements concerned with seeming open. The most significant part of this is the act of opening—signaling a change in the way you are feeling.

Openness demonstrates that you have nothing to hide and are receptive to the other person. Openness encourages openness. This can be used to calm an angry situation or when asking about personal information. The key is not to have your arms or legs crossed in any way.

i. *Arms open:* either at your side or held wide. Even better, hold your hands open and face your palms to the other person.
ii. *Legs open:* this does not mean legs wide but instead not crossed. You may hold them parallel. The feet often point to something of subconscious interest to you—point them at the patient!

c) Emphasis

You can amplify your spoken words with your body—usually without noticing it. Actions include nodding your head, pointing, or other hand gestures. A gesture may even involve your entire body.

Watch newsreaders—often only, their heads are in view so, they emphasize with nods and turns of their heads much more than one would during normal conversation.

i. *Precision:* The signal that the words currently being spoken are worth paying attention to with delicate, precise movements. You could make an 'O' with your thumb and index finger or hold your hands such that each finger is touching its opposite counterpart—like a splayed prayer position.
ii. *Synchrony:* this is key. Time points of the finger, taps of the hand on the desk, or other actions with the words you wish to emphasize.

d) Eye-level/Eye-contact

Make eye-contact and look at the patient when they are speaking. Make a note of eye-contact next time you are in conversation with a friend or colleague.

In regular conversations, the speaker usually looks away while the listener looks directly at the speaker. The roles then change when the other person starts talking . . . and so on.

In the Medical situation, while the patient is speaking, you may be tempted to make notes, read the referral letter, look at a test result, or similar—you should resist and stick to the 'normal' rules of eye-contact.

Make an eye contact, but do not stare, as this may be intimidating.

This is a potent tool. In general, the person with their eye level higher is in control of the situation. You can use this to your advantage. When asking someone personal questions or when you want them to open up, position yourself such that your eyes are below theirs—meaning they have to look down at you slightly. This makes them feel more in control and comfortable.

Likewise, anger often comes from a feeling of lack of control—put the angry person in charge by lowering your eye level—even if that means squatting next to them or sitting when they are standing.

Conversely, you may raise your eye level to take charge of a difficult situation: looking down on someone is intimidating. Stand over a seated person to demonstrate that you are in charge.

e) Watch and learn

There is much that could be said about body language. You should watch others and yourselves and consider what messages are being portrayed by non-verbal communication.

Stay aware of your movements and consider purposefully changing what would typically be subconscious actions to add to, or alter, the meaning of your speech.

4. Interpreters

A code of ethics binds official communicators impartiality, and confidentiality—friends and relatives are not. It is often impossible to be sure that a relative is passing on all that is
said rightly.

Sometimes, the patient's children are used to interpret—this is not advisable for several reasons. This not only places too much responsibility on the child, but they may not be able to explain complicated concepts.

Besides conversations about sex, death, or other difficult topics may be unsuitable for the child to be a part.

Using an official interpreter.

a) Before you start

- Allow enough time (at least twice as long as healthy).
- Allow the interpreter to introduce themselves to the patient and explain their role.
- Arrange to seat so that the patient can see the interpreter and you equally.
- Brief the interpreter on the situation; clarify your role and the work of the department, if necessary.

b) During the exchange

- Avoid complicated terms and grammar.
- Avoid Jargon.
- Avoid slang and colloquialisms, which may be hard to interpret correctly.
- Be patient, and some concepts are hard to explain.
- Check to understand frequently.
- Speak to the patient, not the interpreter. This may be hard at first, but you should speak to and look at the patient at all times.

c) Finishing off

- Allow time for questions.
- Check to understand.
- If the conversation has been distressing, offer the interpreter support, and let their manager know.

d) Written information

- If interpreting written information, read it out loud. The interpreter may not necessarily be able to translate written language as easily.
- Many departments and charities provide some written information in a variety of languages—some also provide tapes. You should beware of what your department has to offer.

5. Communicating with deaf patients

People who are hard of hearing may cope with the problem by using a hearing-aid, lip-reading, or using sign language. Whichever technique is used (if any), some simple rules should always apply:

a) Be patient and take the time to communicate properly.
b) Check to understand frequently.
c) Consider finding an amplifier—many elderly medicine wards will have one available.
d) Do not repeat a sentence if it is misunderstood—say the same thing differently.
e) Speak clearly but not too slowly.
f) Use plain English and avoid waffling.
g) Write things down if necessary.

i. Lip-readers

Patients who are able to lip-read do so by looking at the normal movements of your lips and face during a speech. Exaggerating movements or speaking loudly will distort these and make it harder for them to understand.

When talking to lip-readers:

- Do not exaggerate your oral or facial movements.
- Don't shout.
- Maintain eye-contact.
- Speak clearly but not too slowly.

ii. British Sign Language (BSL)

a) For BSL users, English is a 2nd or 3rd language, so using a pen and paper may not be valid or safe for discussing complex topics organizing consent.

b) It should be appreciated that BSL is not a signed version of English—it's a distinct language with its own grammar and syntax.
c) Seek an official BSL interpreter, if possible, and follow the rules on working with interpreters.

6. Telephone communication

The essential rule of confidentiality is that you must not impart personal information to anyone without the express permission of the patient concerned—except in a few specific circumstances.

- You must not give out any confidential information over the telephone, as you cannot be sure of the identity of the caller. All communication should be done face-to-face. This may cause difficulty if a relative call to ask about the patient, but you should remain strict.
- If telephone communication is essential, but you are in doubt as to the caller's identity, you may wish to take their number and call them back.

a) SBAR

SBAR was created as an easy to remember mechanism to frame conversations and install some uniformity into telephone communication, particularly those requiring a clinician's immediate attention and action. There are four sections to help you order the information with the right level of detail and reduce repetition.

i. S: Situation
- Describe your concern in one sentence.
- Identify the patient by name and the reason you are calling.
- Identify yourself (name and designation) and where you are calling from.
- Include vital signs where appropriate.

ii. B: Background
- Describe any relevant treatment so far.
- Explain the background to the current problem.
- State the admission diagnosis and date.
- You should have collected information from the patient's charts, notes, and drug card and have this at your fingertips. Include current medication, allergies, pertinent laboratory results, and other diagnostic tests.

iii. A: Assessment
- State your assessment of the patient including vital signs, early warning score (EWS), if relevant, and your overall clinical impression and concerns.
- You should have considered what might be the underlying reason for the patient's current condition.

iv. R: Recommendation
- Explain what you need and the time-frame in which you need it.
- Make suggestions and clarify expectations.
- Record the details of the conversation in the patient's notes.
- Record the name and contact details of the person you have been speaking to.

7. Other specific situations

Talking about sex

This is a cause of considerable embarrassment for the patient and the inexperienced professional. Sexual questions are usually inappropriate to be overheard by friends or relatives—so ask them to leave.

You aim to put the patient at ease and make their responses more forthcoming. The key is to ask direct, clear questions and show no embarrassment yourself.

i. You should maintain eye-contact.
ii. You should also show no surprise whatsoever—even if the sexual practices described differ from your own or those that you would consider acceptable.

iii. Try to become aufait with sexual slang and sexual practices, which you might not be familiar with previously.
    - Failure to understand slang may lead to an immediate barrier in the consultation.
iv. In general, you should not use slang terms first. You may wish to consider mirroring the patient's speech as you continue the conversation.

Angry patients

Use body language to take charge of the situation without appearing aggressive. Throughout the exchange, you should remain polite, avoiding confrontation, and resist becoming angry yourself.

i. Look to your safety first.
ii. Calm the situation, then establish the facts of the case. Anger is often secondary to some other emotion, such as loss, fear, or guilt.
iii. Acknowledge their emotions.
    - 'I can see this has made you angry'.
    - 'It' is understandable that you should feel like this.'
iv. Do not incriminate colleagues—the patients may remember your throw-away comments which could come back to haunt you. Avoid remarks like 'he should not have done that'.
v. Emphasize any grounds for optimism, or plans for resolving the situation and putting things right.
vi. Steer the conversation away from the area of unhappiness towards the positive and plans to move the situation forward.

Do not take offence or get annoyed

As well as being directly aggressive or offensive, people may be thoughtless in their speech or manner and cause offence when they don't mean to.

As a professional, you should rise above this and remember that apparent aggression may be the patient's coping mechanism, born from a feeling of helplessness or frustration—it is not a personal insult or affront.

8. Breaking bad news

Breaking bad news is feared by students and, indeed, no-one likes doing it. However, knowing that you have broken difficult news in a sensitive way and that you have helped the patient through a terrible experience can be one of the most uplifting aspects of working in healthcare.

a) Before you start

- Confirm all the information for yourself and ensure that you have all the information to hand, if necessary.
- Speak to the nursing staff to get background information on what the patient knows, their fears, and details of the relationship with any family or friends who may be present.

b) Choose the right place

- Arrange the chairs so that everyone can be seen equally.
- Ensure there is no intervening desk or another piece of furniture.
- Hand your bleep/mobile phone to a colleague.
- Pick a quiet, private room where you will not be disturbed.

c) Ensure the right people are present

- Invite a member of the nursing staff to join you—particularly if they have already established a relationship with the patient.
    - Remember, it is usually the nursing staff that will be dealing with the patient and relatives when you have left so, they need to know exactly what was said.
- Would the patient like anyone present?

d) Establish previous knowledge

It is essential to understand what the patient already knows. The situation is very different in the case of a patient who knows that you have been looking for cancer to one who thinks their cough is due to a cold.

e) How much do they want to know?

This is key. Before you consider breaking bad news, you have to discover if the patient wants to hear it.

- Ask an open question such as:
  - ‘What do you know so far?’
  - ‘What have the other doctors/nurses told you?’
- You can also ask directly if they want to hear bad news. Say:
  - ‘Are you the sort of person who likes to know all the available facts and details, or would you rather a short version?’

f) Honesty, above all else

- Above all, you should be honest at all times. Never guess or lie.
- The patient may break your pre-prepared flow of information, requiring you to think on your feet. Sometimes you simply can’t stick to the rules above. If asked a direct question, you must be honest and straightforward.

g) Warning shots

You should break the news step-wise, delivering multiple ‘warning shots’. This gives the patient a chance to stop you if they have heard enough, or to ask for more information.

Keep your sentences short, clear, and straightforward. You could start by saying that the test results show that things are more serious than first thought and wait to see their reaction. If they ask what you mean, you can tell them more, and so on.

Inexperienced practitioners sometimes feel that they ‘ought’ to tell the patient the full story but they must understand that many people would much rather not hear the words said aloud—this is their coping strategy and must be respected.

h) Allow time for information to sink in

You should allow time for each piece of information to sink in, ensure that the patient understands all that has been said, and repeat any important information.

Remember also that patients will not be able to remember the exact details of what you have said—you may need to reschedule at a later time to talk about treatment options or prognosis.

i) Do not rush to the positive

When told of bad news, the patient needs a few moments to let the information sink in. Wait in silence for the patient to speak next. The patient may break down in tears—in which case they should be offered tissues and the support of relatives, if nearby. If emotionally distressed, the patient will not be receptive to what you say next—you may want to give them some time alone with a relative or nurse before you continue to talk about prognosis or treatment options.

Above all, you should not give false hope. The moment after the bad news has been broken is uncomfortable, and you must fight the instinctive move to the positive with ‘there are things we can do’, ‘on the plus side . . .,’ ‘the good news is . . .’ or similar.

j) Questions about time

‘How long have I got?’ is one of the most common questions to be asked—and the hardest to answer.

- As always, do not guess and do not lie.
- It’s often impossible to estimate and is perfectly acceptable to say so.
  - Giving a figure will almost always lead to you being wrong.
- Explain that it is impossible to judge and ask if there is any date in particular that they do not want to miss—perhaps they want to experience Christmas or a relative’s birthday.

k) Ending the conversation

Summarize the information given, check their understanding, repeat any information as necessary, allow time for questions, and make arrangements for a follow-up appointment or a further opportunity to ask questions again.

You should not make promises that you cannot keep. Do not offer to come back that afternoon if you are going to be in the clinic.

9. Law, ethics, and consent

The four bioethical principles about which much has been written elsewhere.

Four bioethical principles

a) *Autonomy:* a respect for the individual and their ability to make decisions regarding their health.
b) *Beneficence:* acting to the benefit of patients.
c) *Non-maleficence:* acting to prevent harm to the patient.
d) *Justice:* 'fairness' to the patient and the wider community when considering the consequences of an action.

Confidentiality

Confidentiality is closely linked to the ethical principles described above. Maintaining a secret record of personal information shows respect for the individual's autonomy and their right to control their information. There is also an element of beneficence were releasing the protected information may cause harm.

As a doctor, healthcare worker, or student, you are a party to personal and confidential information. There are specific rules that you should abide by and times when confidentiality must or should be broken.

The essence for day-to-day practice is: Never tells anyone about a patient unless it is directly related to their care. This includes relatives. Withholding information from family can be very difficult at times, particularly if a relative asks you directly about something confidential.

You can reinforce the importance of confidentiality to relatives and visitors. If asked by a relative to speak to them about a patient, you should approach the patient and ask their permission, preferably within view of the relative. This rule also applies to friends outside of Medicine.

As doctors and others, we come across many amazing, bizarre, amusing, or uplifting stories on a day-to-day basis but, like any other kind of information, these should not be shared with anyone, however juicy the story is.

If you do intend to use an anecdote for some after-dinner entertainment, at the very least you should ensure that there is nothing in your story that could lead to the identification of the person or persons involved.

Breaking confidentiality

The rules surrounding the maintenance of confidentiality have been mentioned. There are many circumstances where confidentiality can, or must, be broken. The exact advice varies slightly between different bodies. See the links under 'further reading'. In general, confidentiality may be broken in the following situations:

- If disclosure is in the patient's interest but consent cannot be gained.
- If it is necessary for national security or where prevention or detection of a crime may be prejudiced or delayed.
- If it is overwhelmingly in the public interest.
- If required by law.
- In certain situations, related to medical research.
- When there is a statutory duty such as reporting of births, deaths, and abortions and in cases of certain communicable diseases.
- With the consent of the individual concerned.

Consent and capacity

There are three main components to valid consent. To be competent (or have capacity) to give consent, the patient:

- Must be able to retain and weigh-up the information.
- Must believe that information.

- Must understand the information that has been given.

Besides for consent to be valid, the patient must be free from
of duress.

It should be noted that an assessment of capacity is valid for the specific decision in hand.

It is not an all-or-nothing phenomenon—you cannot either have 'capacity' or not. The assessment regarding competence must be made for each new decision faced.

The consent of the parent or the guardian is required for children under 16 years old.

Young people and capacity

- All persons aged 18 and over are considered to be a competent adult unless there is evidence to the contrary.
- Children of 16 and younger are considered competent to give consent if they meet the three conditions mentioned previously. Their decisions can be, however, overridden by the courts or people with parental responsibility.
- People aged between 16 and 18 are treated as adults (Family Law Reform Act 1969). However, the refusal of
  treatment can be overridden by someone with parental responsibility or the courts.

Gillick competence

In 1985, the well-known Gillick case was considered by the House of Lords and from these two principles (often known as the Fraser Guidelines) was established:

- A parent's right to consent to treatment on behalf of the child finishes when the child has sufficient understanding to give consent themselves (when they become 'Gillick competent').
- The decision as to whether the child is Gillick competent rests with the treating doctor.

Powers of attorney

People lacking mental capacity may need someone to manage their legal, financial, and health affairs. This is done through the power of attorney as laid out in the Mental Capacity Act 2005.

Enduring powers of attorney (EPA)

Before 2007, people could grant EPA so a trusted person could manage their finances. Those with EPA do not have the right to make other decisions on a person's behalf.

Lasting powers of attorney (LPA)

- *Property and affairs LPA*
  Those with property and affairs LPA can make decisions regarding paying bills, collecting income and benefits, and selling property, subject to any restrictions or conditions the patient may have included.
- *Personal welfare LPA*
  This allows the 'attorney' to make decisions relating to living situation and other personal care. They can also make medical decisions *if this power has been expressly given in the LPA*.

10. Others

a) Avoid spot diagnosis.
b) Before any investigation or procedure, tell the patient when and why you are doing it. A patient surprised by any action may become frightened, leading to a possible loss of trust.
c) Drape the patient and avoid placing instruments/instrument tray over the patient's chest.
d) Ensure that diagnosis of a disease should always be revealed to the patient, and with only the patient's consent the patient's attender should be informed (exception are child patient's, mentally challenged patient's, and patient's with hearing disabilities)
e) Examine the patient under sufficient unobstructed light.
f) Listen attentively to the patient problems. Impatient or unsympathetic to the patient creates several problems.

g) Position the Dental chair so that the patient is comfortably seated. (Special care needs to be taken in pregnant women and patients with spinal disorders).
h) Promote the ability to view the problem from his/her viewpoint.
i) The Medical/Dental should be dated, complete, legible, indelible, and signed by the Clinicians. Hence it is an vital record does not enter any disparaging remarks, neither hide it nor omit it.
j) The oral Physician should ideally be seated to the right of the patient and facing the patient. The ideal position would be a 10 o' clock or 11 o' clock position.
k) The patient should be reasonably close to the clinician. (Approx-1meter away)
l) Treat the patient as an individual and not as a disease requiring treatment.

OPERATOR X-RADIATION PROTECTION GUIDELINES

Used to provide necessary safety information that is needed when working with X-radiation. Operator protection guidelines include a recommendation on distance, position, and shielding.

1. A Dental radiographer must avoid the primary beam.
2. Never hold a tube head during X-ray exposure.
3. Should stand behind a protective barrier like lead screens.
4. Stay 6 feet away from the X-ray tube during X-ray procedure.
5. The dental radiographer must never hold a film in place for a patient during X-ray exposure.
6. To avoid the primary, beam the Dental radiographer must be positioned at "90–135" angles to the beam.
7. Use protective barriers.
8. X-ray machines should be monitored for leakage radiation.
9. Amount of X-radiation that reaches the body of the Dental radiographers can be monitored by the use of personnel monitoring devices known as film badges. This should be worn at the waist level. After the dental radiographer has worn the film badge for a specific time interval, it has to be returned to the service Company for dosage calculation.

TECHNIQUES FOR OBTAINING A PATIENT HISTORY

The Dentist can ask two general types of questions when interviewing: Open and closed.

The two primary methods for obtaining patient history are:

(1) Questionnaires and forms.
(2) Patient interviews. It involves requesting information from another healthcare practitioner.

Questionnaires and forms

Advantages

a) Questionnaires save time, do not require any special skills to administer, and provide a standardized method for obtaining information from a variety of patients. Many types of forms are available commercially, or the practitioner can create his or her own.

Disadvantages

a) The dentist only gets answers to the questions asked on the form, and significant findings may be missed.
b) The severity of a condition may not be reflected in a simple positive response.
c) Patients may misinterpret questions, resulting in incorrect answers. It may be necessary to have the forms printed in other languages to facilitate information gathering. The more comprehensive the questionnaire is, the longer it must be, which can be frustrating to patients.
d) Many Dental clinics have implemented electronic health records (EHR), and patients may now enter their health information directly into electronic forms. One advantage of using this method is that the

initial questionnaire can be brief, with the patient being prompted for more information if there is a positive response to a higher-level question. This individualized approach to delving into the positive responses would be challenging to duplicate efficiently with a paper form.

e) With a questionnaire or form, patients can more easily falsify or fail to completely reveal important information then when confronted directly in an interview.

Patient interviews

Advantage

a) Being a good listener is key to facilitating information flow from the patient. The desired outcome of the interviewing process is the development of a good rapport with the patient by establishing a co-operative and harmonious interaction.

b) If the interviewer does not speak the patient's language, it may be necessary to have translation services available. A sign language translator may also be required if the patient is hearing impaired. Older patients may require more time for interviewing, mainly if their health histories are complicated.

c) The Clinician must adapt these skills to interact with patients from varying cultural, gender, and socioeconomic backgrounds.

d) The patient interview serves a problem-solving function and develops quite differently from a personal conversation. There is a level of formality to the discussion, which centers on the patient's health and oral care needs, problems, and desires.

e) The practitioner can tailor questions to the individual patient.

f) To obtain accurate information and avoid influencing the responses, the dentist must be a systematic and unbiased information gatherer and must have excellent communication skills.

g) The dentist can ask two general types of questions when interviewing: open and closed.

Clarifying questions

Use clarifying questions to get the full details, particularly if there are terms used which may have a different meaning to the patient than to you.

In general, the examiner should use open questions when beginning to inquire about a problem. Later, closed questions can be asked to obtain answers to specific questions.

It is usually best to start with an 'open' question. Medical jargon should be avoided and even regular hospital at attenders who appear to understand medical terminology may use it wrongly and misunderstand.

Table 1.1 Types of Questions			
Type of question	**Advantages**	**Disadvantages**	**Example**
Open	• Allows patients to use their own words and summaries their view of the problem. • Allows patients to partly direct the history-taking, gives them confidence and quickly generates rapport. • Open questions usually begin with "what" or "how" and should avoid leading the patient to a specific answer. • Use open-ended questions when investigating positive responses to items from the health questionnaire.	• Clinicians must listen carefully and avoid interruptions to extract the relevant information. • Patients tend to decide what information is relevant. • Open questions cannot be answered with a simple response, such as "yes" or "no."	• Tell me about the pain? • How may I help you? • What do you think is your biggest Dental problem? • Tell me about your past Dental care. • Tell me more about your heart problems.
Closed	• Elicits specific information quickly. • Useful to fill gaps in the information given in response to open questions. • Prevents vague patients from rambling away from the Complaint. • Simple to answer with one or two words.	• Patients may infer that the clinician is not really interested in their problem. • Important information may be lost if not specifically requested. • Restricts the patient's opportunities to talk. • They permit specific facts to be obtained or clarified but do not give insight into patient beliefs, attitudes, or feelings.	• What does the pain feel like? Do any of your teeth hurt? • Which tooth is sensitive to cold? • How long has it been since your teeth were last examined? • Do you have a heart problem?
Leading			• Does the pain feel like an electric Shock?

Principles for Effective Interviewing:

a) Avoid adding personal feelings.
b) Be an attentive, active listener.
c) Be an objective, unbiased interviewer.
d) Explain to the patient why you are asking a question if he or she is hesitant or refuses to answer.
e) Eye contacts are important, so position the Dental chair upright and sit facing the patient.
f) Raise or lower the operator's stool so that your eyes are at the same level as the patient's.
g) The "golden rule" of interviewing is to listen more than speak.
h) The primary goals during the interview are to accumulate and assess the facts, not to influence them.
i) Use verbal facilitators like "yes" and "uh huh" to encourage patients to share information. Be aware of the patient's nonverbal communication, such as crossing arms or legs or avoiding making eye contact.
j) Both positive and negative findings are written down as later one may wish to check that at the first visit, no abnormality was found in specific structures.
k) After interview, summarize positive findings with the patient to confirm accuracy.

DIAGNOSTIC ARMAMENTARIUM

Seat the child comfortably either in a chair designed for him or an adult chair adjusted for him with proper illumination.

The name of each instrument should be told to the child if the child is curious.

a) Mouth mirror.
b) Periodontal probe.
c) Sharp right-angled explorer.
d) Tweezers.
e) B.P. Apparatus.
f) Cotton pellets.
g) Cotton pliers.
h) Cotton rolls.
i) Ethyl chloride or ice.
j) Gutta Percha.
k) Rubber dam. (5"×5")
l) Sponges. (2"×2")
m) Stethoscope.
n) Tongue blades.
o) Vitalometer.

EXAMINATION

The examination includes all additional methods used by the dentist beyond the interview and history, such as radiographs, clinical examination, and other diagnostic aids and modalities.

Types of Examination

There are several types of examinations which may be performed for various purposes.

1. *Emergency examination*
   When an emergency arises, it is often necessary to proceed quickly, and this examination should include basic patient information, a good health history, and only the dental history necessary to assess the chief complaint being addressed as an emergency. Radiographs, clinical examination, and other tests are limited to the specific problem at hand. Patients should be reminded that this is not a complete examination.
2. *Screening examination*

When large numbers of people are to be treated in, for example, an institutional setting, screening examinations are often employed as a means of triage to allocate time and resources most efficiently.

Screening examinations also be employed in research, together specific bits of information about a population. The limitations of this procedure should be discussed with the patient.

3. *Triage*
   This is a concept developed by the military for dealing with multiple casualties most effectively. Patients are quickly assessed and divided into three (hence the term 'triage') groups: those who can safely wait for treatment; those who need immediate treatment for survival but have a reasonable prognosis if treated; and those who are likely to expire despite treatment, or whose treatment would use so much of the available resources as to preclude treating those in the second group.

   Most Dental screening examinations do not have implications quite this grave, but the term has come into more general use to include screenings intended to classify patient groups.

4. *Comprehensive examination*
   Given the appropriate setting and adequate time, the comprehensive examination is employed in order to gather ALL the relevant data about a dental patient.

Techniques of Examination (in detail refer to General examination)

The Dentist may use several techniques in the examination process.

a) Inspection.
b) Palpation.
c) Percussion.
d) Auscultation.
e) Olfaction.

SCREENING

Screenings is the practice of investigating apparently healthy individuals with the objective of detecting unrecognized disease or its precursors in order that measures can be taken to prevent or delay the development of disease or improve the prognosis.

In many diseases the pathological process is established long before the appearance of the symptoms and signs which alert people of the need to seek medical advice. By this time the disease process and the consequent damage may be irreversible or difficult to treat.

Screening is the process of testing for infection or diseases in populations or in individuals who are not seeking healthcare.

Uses of Screening

a) Case Detection (Prescriptive Screening) – The presumptive identification of unrecognized disease which does not arise from a patient's request, i.e., people are screened for their own good.
b) Controls of Disease (Prospective Screening) – People are examined for the benefit of others.
c) Research Purposes – For many chronic diseases whose natural history is not fully known. Participants should be informed that no follow-up therapy will be available.
d) Educational Opportunities – Opportunity for creating public awareness and for educating health professionals.

Types of Screening

1. ***Mass Screening*** – is the screening of a whole population or a subgroup. There is no reference to risk and usually no follow-up. It is performed in a community setting.
2. ***High risk or Selective Screening*** – is done to detect
   a specific disease or predisposing condition in people who are known to be at high risk of having or developing the condition.

3. ***Multiphase Screening*** – is the application of two or more screening tests in combination to a large number of people at one time.
4. ***Opportunistic Screening*** – is done only when the opportunity arises, it is usually done in a clinical setting.
5. ***Two Stage Screening*** – is conducted on those who screen positive the first time and are recalled for further testing. This process is less expensive as the less invasive and less uncomfortable test is done first.

Criteria for Screening

a) Case finding should be a continuous process and not a "one off" procedure.
b) Facilities for the diagnosis and treatment should be available (adequate follow-up for positive cases).
c) The condition should be an important health problem (high mortality, disability, discomfort, financial cost).
d) The cost of case finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole.
e) The natural history of the condition, including development from latent to declared disease, should be adequately understood.
f) The test should be acceptable to the population (safe and acceptable).
g) There is a substantial burden of the disease in the community (not too rare).
h) There should be a recognizable latent or early symptomatic stage so that individuals benefit by early detection.
i) There should be a suitable test or examination (quick, easy, inexpensive, sensitivity, specificity).
j) There should be an acceptable treatment for patients with recognized disease.
k) There should be an agreed policy concerning who to treat as patients.

Characteristics of a Screening Test

For a screening test to be useful it should have the following characteristics.

1. Validity

a) *Validity is the ability of the test to measure what it intends to measure.*
b) It has two components, sensitivity and specificity. The validity of a test is affected not only by the characteristics of the test but by host factors such as stage of disease and presence of other conditions.
c) The sensitivity and specificity characteristics of the tests help in making the decisions on whether or not to use the test. They are generally regarded as independent of disease prevalence.

2. Sensitivity

a) *It is defined as the ability of a test to identify correctly those who have the disease, i.e., the true positives.*
b) Sensitive tests are used in cases where there is
an important penalty for missing a dangerous but treatable disease, e.g., TB, syphilis, and to rule out diseases in the early stages of diagnostic work up. If the test is not sensitive it will fail to detect some of the people with the disease. These are called false negative.
c) The importance of false negative is that serious diseases could be missed, and if the disease is curable in the early stages a false negative result may mean a virtual death sentence to the individual. The lower the sensitivity the larger will be the false negatives.

3. Specificity

a) *It is defined as the ability of a test to identify correctly those who do not have the disease, i.e., the true negatives*.
b) It is useful to confirm the diagnosis that has been suggested by other data. If the test is not specific it will detect a large number of people who are false positive, i.e., they are shown to have disease when they do not have it.

c) The disadvantage is that it causes a lot of anxiety and worry to the individual and in some diseases a stigma. Further, it puts a burden on the health care system.

DOCUMENTATION

All examination results and diagnoses must be clearly documented in the patient record. The progress notes, or chronologic record of treatment (CRT), document each appointment. These notes can include appointment specific diagnoses, evidence of health history review, details of treatment provided, patient behavior, and plans for the next visit.

Treatment detail should include the teeth or soft tissue area treated, medications administered, and the details surrounding the treatment procedures. Records, including radiographs, must be maintained in good condition and be retrievable even after the patient has left the dental practice.

Good record keeping, complete examination documentation, and the ability to retrieve the record represent essential elements in dental practice. In the event of litigation, good documentation can protect the Dentist by demonstrating a high level of professional competence.

Good records help prevent litigation, win a mal-practice suit, or decrease damages. Patients who change practitioners have a legal right to obtain copies of recent radiographs. An additional important reason for maintaining complete diagnostic and treatment-related information for each patient is that the dentist may have the unpleasant duty of providing dental records, postmortem, for the purpose of patient identification.

Several worksheets and Dental charts are available for recording findings, diagnoses, and treatment recommendations. The choice of forms is a personal decision. Ideally, entries should be in pen for permanence and in black ink to facilitate photocopying. Some computerized information systems have the capability to chart existing restorations, caries, and periodontal findings.

The retention of study models for all patients presents storage problems. No specific guidelines exist, but many Dentists retain casts for patients who have had orthodontic treatment or extensive Prosthodontic work. Color photographs and digital images of patients are excellent methods for recording patient findings, both before and after treatment. Some practitioners, especially orthodontists, routinely take photographs of all their patients. Intra oral video cameras are used to educate patients about problems in their mouths.

Many systems can instantaneously print still images that can be given to the patient or placed in the record. The union of digital photographs and digital radiography with electronic charting and procedural notes has led to the creation of an electronic patient record. It remains to be seen whether this influx of technology will address the insufficiencies.

POINTS TO REMEMBER

1. A Doctor can lawfully operate or give other treatment to adult patient who are incapable of consent to his doing so, provided that the operation or treatment is in the best interest of such patients.
2. A patient may be admitted to the hospital in either Elective admission, Non-elective admission.
3. Any corrections made while writing the record should be made by drawing a line through the incorrect entry and then initialing, dating and recording the time of correction.
4. Blanket Consent-Some hospitals when admitting the patients obtain consents to the effect that they are willing to undergo any type of treatment including surgeries without mentioning any particular procedure.
5. Case history has 6 major components.
6. Case history is defined as: “The information gathered from the patient and/or parent and/or guardian to aid in the overall diagnosis of the case”.
7. Consent and Treatment of Children Section 3 of Indian Majority Act 1875 speaks of attainment of majority on completion of the age of eighteen years. A person who has not completed the age of 18 years is a minor.
8. Discharge summary – all the events that have occurred during the patient’s stay in the hospital. It should be written at the time of discharge and a copy given to the patient.

9. Emergency service/casualty service – The admitting service is responsible for the care of the inpatients as well their discharge and follow-up. It is prepared to care for patients requiring immediate and emergency care. Patients seldom seek emergency care for routine.
10. Express Consent – Express consent is given when a patient states agreement in clear terms, orally or in writing to a request.
11. Implied Consent – It is a situation where a patient by virtue of his action gives consents.
12. Informed Consent – Section 13 of Indian Contract Act defines consent as "the two or more persons are said to consent when they agree upon the same thing in the same sense".
13. Proxy Consent – It is a situation when some other person is responsible for giving consent for a patient who is unable to give the consent.
14. Risk may be defined as "exposure to a chance of an injury or loss."
15. Screenings is the practice of investigating apparently healthy individuals with the objective of detecting unrecognized disease or its precursors in order that measures can be taken to prevent or delay the development of disease or improve the prognosis.
16. Sensitivity – It is defined as the ability of a test to identify correctly those who have the disease, i.e., the true positives.
17. Specificity – It is defined as the ability of a test to identify correctly those who do not have the disease, i.e., the true negatives.
18. The Medical record is the document that charts the patient's stay in the hospital from admission till discharge.
19. The Medical record is the document that charts the patient's stay in the hospital from admission till discharge.
20. Validity – Validity is the ability of the test to measure what it intends to measure.

REVIEW QUESTIONS

1. Characteristics of a screening test.
2. Components of case record.
3. Consultations.
4. Definition of oral diagnosis.
5. Discharge summary.
6. General guidelines for examining patients in a dental setting/communication skill:
7. Informed consent:
8. Operator x-radiation protection guidelines:
9. Techniques for obtaining a patient history:
10. Techniques of examination.
11. Types of consent.
12. Types of diagnosis.
13. Types of examination.
14. Types of screening.